



Network Development Department  
[nyprelations@beaconhealthoptions.com](mailto:nyprelations@beaconhealthoptions.com)

## CONTRACT COPY REQUEST FORM

Beacon's Provider Service Agreement and Fee Schedule contain proprietary and confidential information and can only be released to the authorized signatory. An email address is required in the space below if you are requesting electronic copies. Electronic copies will be sent through secure email.

### Provider Information

Provider:			
Beacon Provider ID:	National Provider Identifier (NPI):		
Provider Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Telephone Number:	Fax Number		
Email: (If requesting electronic copies)			
Full Name of Contact:			

☐ INDIVIDUAL CONTRACT      ☐ GROUP CONTRACT \*      ☐ FACILITY CONTRACT \*      ☐ FEE SCHEDULE

**\*Important: Request for Group and Facility Contracts should be directed to your Contract Department. If you cannot locate your copy of the contract, please have your Contract Manager or authorized signatory complete and sign this form.**

I have read the information provided on this request form and do hereby acknowledge that I am an Authorized Signatory for the provider mentioned above and fully understand the terms and conditions of this authorization.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Authorized Signatory

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date