CareTrust Health Alliance
Provider Partnership Inquiry Form

Please share a few details below so our team can explore partnership opportunities with your practice or facility.

Provider Information

Provider / Facility Name: _____

Primary Contact Name: _____

Title/Role: _____

Email Address: _____

Phone Number: _____

City/State: _____

Provider Type (check all that apply)

■ Primary Care Practice

■ Specialty Practice

■ Hospital

■ Ambulatory Surgery Center (ASC)

■ Other: _____

Services Offered

Primary services or specialties:

_____

_____

Partnership Interest (check all that apply)

■ Advanced Primary Care participation

■ CIN specialist alignment

■ Bundled services or capitation models

■ Cash pricing arrangements

■ Hospital or ASC partnership opportunities

Goals & Expectations

What are you hoping to achieve through a CareTrust partnership?

_____

_____

Next Step

Would you like a CareTrust representative to contact you? ■ Yes ■ Just send information