CENTRAL HEALTH

PROVIDER PRE-REGISTRATION

I agree to the terms and conditions of the online agreement outlined at www.centralhealth.net/map/for-providers/provider-agreement-enrollment.

☐ I agree

Name

Work Email

Your Organization

Your Department (i.e. Seton Health Plan)

Your Title

Work Phone

Physical Work Address

Please return this form to bpteam@centralhealth.net.