The HARRIS CENTER for Mental Health and IDD

Transforming Lives

(formerly MHMRA of Harris County)

Medicaid/Medicare Provider Interest Group Form
(FOR LICENSED MENTAL HEALTH PROVIDERS ONLY)

Provider Name: _____

Provider Mailing Address: _____

Provider Email Address: _____

Provider Fax#: _____

Provider Office#: _____

Service Locations: _____

_____

Service Hours: _____

Services Provided: _____

License: _____

Accreditation/Certification: _____

_____

Populations Served:
- ☐ Children and Adolescents
- ☐ Adults

Diagnosis(es) Served:
- ☐ MDD
- ☐ Bipolar D/O
- ☐ Schizophrenia
- ☐ Other: _____

- ☐ Provider/ Facility **Medicaid** #_____(required)
- ☐ Provider/Facility **Medicare** #_____(required)
- ☐ Other Insurance Name/ #_____

Languages Spoken: _____

Appointment Phone Number: _____

Interest Statement

I would like The Harris Center to share my information with potential patients as a possible service option for patients transitioning out of care.

_____ _____

Signature of Provider/Title Date

Please mail, fax to 713 970-3387, or email this form to MHNetworkDevelopment@TheHarrisCenter.org. Form is also available on our website www.theharriscenter.org under Business Opportunities.

Disclaimer: This list is solely a resource list based on provider response of interest in treating our patient population. The Harris Center for Mental Health and IDD Services in no way endorses these providers. All information (including licensure/accreditation) on this list was provided to The Harris Center for Mental Health and IDD Services by the provider listed and needs to be verified by the patient including the insurance the company accepts.