

# MEMBERSHIP APPLICATION

## eQHealth Solutions

THE MEDICARE QIO FOR LOUISIANA

I, the undersigned, as a practicing physician in the State of Louisiana, hereby request membership in eQHealth Solutions. I am aware there are no membership fees.

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
(Please print)

Business Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Please fill out your membership information below and fax it to us today.

Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Louisiana License #: \_\_\_\_\_

Specialty:  Family Practice  Internal Medicine  General Surgery

Other: \_\_\_\_\_

I would like to receive information about becoming a Physician Reviewer for eQHealth.

I would like to receive health care quality updates, conference notices and other information from eQHealth via:  Mail  E-Mail  No preference

**Questions? Contact eQHealth Solutions at (225) 926-6353**

**Please FAX your completed application to eQHealth toll free: (888) 204-0327**

