

Provider Credentialing and Change Form

Note: This form is for contracted providers only. All fields on this form must be completed prior to submission. Each section of this form must be filled out to be considered complete. If a section does not apply, please indicate with N/A.

FORM COMPLETION INFORMATION						
Form completed by:		Form completed date:				
Email:						
Mailing address line 1:		Mailing address line 2:				
City:		State:	Zip code:			
Phone:		Fax:				
PROVIDED INFORMATION						
PROVIDER INFORMATION	Character Day Salary					
Add Provider: Yes No Effective Date:	Change Provider: Yes No Effective Date: Reason:					
Effective Date.	Effective Date.	Reas	On.			
Last name:	First name:		Middle Initial:			
Gender:	Date of birth:	oirth: SSN:				
Email:		Degree: (MD, DO, DC, APRN, NP, ND, etc.):				
Provider specialties:						
Individual NPI:	CAQH number:					
Locum Tenens? Yes No	If yes, dates of cove	fyes, dates of coverage: Start: End:				
DE ACTICE INFORMATION I CONTINUE						
PRACTICE INFORMATION LOCATION #1						
Add Provider: Yes No	Change Provider:					
Effective Date:	Effective Date:	Reas	on:			
Contracted entity name:						
Practice name:						
Practice address line 1:		Practice address line	e 2:			
City:			State:	Zip:		
Practice phone:		Practice fax:				
Group NPI:		Tax ID:				
Practice as: ☐ PCP ☐ Specialist ☐ H	ospitalist Acceptii	ng new patients: 🔲 `	Yes 🔲 No	In directory: 🗌 Yes	s □ No	
Languages spoken by office staff:						
PRACTICE INFORMATION LOCATION #2						
Add Provider: Yes No Effective Date:	Change Provider: Effective Date:		0.01			
Effective Date.	Effective Date.	Reas	On.			
Contracted entity name:						
Practice name:						
Practice address line 1:		Practice address line 2:				
City:			State:	Zip:		
Practice phone:		Practice fax:				
Group NPI:		Tax ID:				
Practice as: PCP Specialist H	ospitalist Accepti	ng new patients: 🔲 `	Yes No	In directory: 🔲 Yes	s □ No	
Languages spoken by office staff:						

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PRACTICE INFORMATION LOCATION #3								
Add Provider: Yes No	Change Provider:	☐ Yes ☐ No						
Effective Date:	Effective Date:	Reas	son:					
Contracted entity name:								
Practice name:								
Practice address line 1:	Practice address line 1:			Practice address line 2:				
City:			State:	Zip:				
Practice phone:		Practice fax:						
Group NPI:		Tax ID:						
Practice as: ☐ PCP ☐ Specialist ☐ Ha	ospitalist Acceptin	g new patients: 🔲 `	Yes 🔲 No In direc	ctory: 🗌 Yes 🔲 No				
Languages spoken by office staff:								
PRACTICE INFORMATION LOCATION #4								
Add Provider: Yes No	Change Provider:] Yes □ No						
Effective Date:	Effective Date:	Reas	son:					
Contracted entity name:								
Practice name:		D .: 11 1:	0					
Practice address line 1:		Practice address line		7.				
City:		D 1: C	State:	Zip:				
Practice phone:		Practice fax:						
Group NPI:		Tax ID:						
Practice as: PCP Specialist Hospitalist Accepting new patients: Yes No In directory: Yes No								
Languages spoken by office staff:								
PRACTICE INFORMATION LOCATION #5								
Add Provider: Yes No	Change Provider:] Yes □ No						
Effective Date:	Effective Date:	Reas	son:					
Contracted entity name:								
Practice name:								
Practice address line 1:		Practice address line	e 2:					
City:			State:	Zip:				
Practice phone:		Practice fax:						
Group NPI:	Tax ID:							
Practice as: ☐ PCP ☐ Specialist ☐ Hospitalist Accepting new patients: ☐ Yes ☐ No In directory: ☐ Yes ☐ No								
Languages spoken by office staff:								



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PRACTICE INFORMATION LOCATION #6								
Add Provider: Yes No Effective Date:	Change Provider: Effective Date:	Yes No Reasc	on:					
Contracted entity name:								
Practice name:								
Practice address line 1:		Practice address line 2:						
City:		State:	Zip:					
Practice phone:	Practice fax:							
Group NPI:	Tax ID:							
Practice as: ☐ PCP ☐ Specialist ☐ Hospitalist Accepting new patients: ☐ Yes ☐ No In directory: ☐ Yes ☐ No								
Languages spoken by office staff:								

Special Instructions/Notes

Please email to: DataIntegrity@HealthOptions.org or fax to (207) 520-6242.