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:	

PROVIDER INFORMATION		
Add Provider: ☐ Yes ☐ No Effective Date:	Change Provider: ☐ Yes ☐ No Effective Date: Reason:	
Last name:	First name:	Middle Initial:
Gender:	Date of birth:	SSN:
Email:	Degree: (MD, DO, DC, APRN, NP, ND, etc.):	
Provider specialties:		
Individual NPI:	CAQH number:	
Locum Tenens? ☐ Yes ☐ No	If yes, dates of coverage: Start: End:	

PRACTICE INFORMATION LOCATION #1		
Add Provider: ☐ Yes ☐ No Effective Date:	Change Provider: ☐ Yes ☐ No Effective Date: Reason:	
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:		

PRACTICE INFORMATION LOCATION #2		
Add Provider: ☐ Yes ☐ No Effective Date:	Change Provider: ☐ Yes ☐ No Effective Date: Reason:	
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:		

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PRACTICE INFORMATION LOCATION #3			
Add Provider: ☐ Yes ☐ No Effective Date:	Change Provider: ☐ Yes ☐ No Effective Date: Reason:		
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:			

PRACTICE INFORMATION LOCATION #4			
Add Provider: ☐ Yes ☐ No Effective Date:	Change Provider: ☐ Yes ☐ No Effective Date: Reason:		
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:			

PRACTICE INFORMATION LOCATION #5			
Add Provider: ☐ Yes ☐ No Effective Date:	Change Provider: ☐ Yes ☐ No Effective Date: Reason:		
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:			

PRACTICE INFORMATION LOCATION #6		
Add Provider: ☐ Yes ☐ No Effective Date:	Change Provider: ☐ Yes ☐ No Effective Date: Reason:	
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.