INTERWEST Health ®

PROVIDER ADD FORM

This form is to be used by groups covered under a delegated credentialing amendment only.

PERSONAL INFORMATION

Name: _____
(Last Name) *(First Name)* *(MI)* *(Suffix)* *(Degree)*

Sex: [ ] Male [ ] Female Date of Birth: ___/___/_____ Foreign Languages: _____ _____

PROFESSIONAL INFORMATION

Primary Specialty: _____ Board Certified: [ ] Yes

Other Specialty: _____ Board Certified: [ ] Yes

Unique Focus *(if practice is limited)*: _____

PRACTICE LOCATION

Name: _____

Address: _____

_____

Phone: ( ) _____

Fax: ( ) _____

E-mail: _____

SECONDARY PRACTICE LOCATION *

Name: _____

Address: _____

_____

Phone: ( ) _____

Fax: ( ) _____

E-mail: _____

BILLING ADDRESS *(if different from above)*

Name: _____

Address: _____

_____

Phone: ( ) _____

Fax: ( ) _____

E-mail: _____

PROVIDER IDENTIFICATION

Tax ID #: _____

Tax ID Name: _____

SSN #: _____

NPI #: _____

License #: _____

EFFECTIVE DATE: _____

Email: support@interwesthealth.com
or
Fax: (406) 542-8350