PROVIDER ADD FORM

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

Effective Date: ___/___/_____

PERSONAL INFORMATION

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

Sex: [ ] Male [ ] Female

Birth Date: ___/___/_____

Specialty: _____

Board Certified (*MD/DO only*): [ ] BC

Foreign Language: _____

Tax ID: ____ - _____

Tax ID Name: _____

SSN: _____ - ____ - _____

Type 1 NPI: _____

License: _____ Exp: ___/___/_____

PRACTICE LOCATION

Do Not Publish in Directories: [ ]

Name: _____

Address: _____

_____ ____ _____

Phone: ( ) _____ - _____

Fax: ( ) _____ - _____

E-mail: _____

Type 2 NPI: _____

BILLING ADDRESS

Same as: [ ] Practice Location

Name: _____

Address: _____

_____ ____ _____

Phone: ( ) _____ - _____

Fax: ( ) _____ - _____

E-mail: _____

Type 2 NPI: _____

MAILING ADDRESS

Same as: [ ] Practice Location [ ] Billing Address

Name: _____

Address: _____

_____ ____ _____

Phone: ( ) _____ - _____

Fax: ( ) _____ - _____

SEND PROVIDER ADD FORM TO:

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