QUALITY CARE PARTNERS

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www.qualitycarepartners.com

COMPLETE A SEPARATE FORM FOR EACH LOCATION AND/OR PROVIDER

For Mid-Levels: Please include copy of Standard Care Agreement (SCA) with collaborating physician

Provider Information Form

☐ New Provider ☐ Change in Information ☐ Deletion of Provider

PROVIDER START or TERM DATE:			
PROVIDER NAME:			
DATE OF BIRTH:	**SOCIAL SECURITY #:**		
SPECIALTY:	**SPECIALTY-CERTIFYING ENTITY:**		
BOARD CERTIFIED BY:			
PRACTICING AS A:	**Primary Care Provider (PCP)** ☐ **OR Specialist** ☐		
NPI #:	**CAQH #:**	**MEDICARE #:**	**MEDICAID #/CAPACITY:**
PRACTICE ADDRESS, PHONE, & FAX:			
GROUP NAME, IF ANY:			
GROUP NPI #:			
BILLING NAME:			
BILLING ADDRESS, PHONE, & FAX:			
BILLING TAX ID # (INCLUDE A COPY OF W9):			
CREDENTIALING CONTACT NAME , PHONE, & EMAIL:			
NOTES:			

Please return completed form(s) to: credentservices@qualitycarepartners.com