**PROSPECTIVE PROVIDER FORM**

**Thank you for your interest in becoming a Parkland Community Health Plan, Inc. Provider**. **Please scan and email with a current W9 to:** PCHP.ContractingDepartment@phhs.org **or fax to: 214-590-2150**

**Please Select Provider Type:** Choose an item.

***Adding Provider to Existing Group Contract*** Choose an item.

|  |  |
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| **Requester Name** |  **Requester Phone:**  |
| **Requester Email:**  | **Requester Fax:** |
| **Signatory Name:**  | **Signatory Email:**  |
| **\*PROVIDER INFORMATION**  | Choose an item. |
| \*Last Name: | \*First Name: |
| \*Date of Birth:  | \*Gender: Choose an item. |
|  Provider SSN: | \*Specialty Type Choose an item. |
| \*Individual TPI:  | \*Is TPI Attested? Choose an item. |
| \*Taxonomy Number:  | Individual CAQH: |
| \*Individual NPI:  | Current Insurance Limits:  |
| \*Offer Telemedicine | **Choose an item.** |
| **GROUP INFORMATION** |
| Group Name: |  |
| Group Tax ID: | Group NPI: |
| Group TPI: | Group THSteps TPI: |
| Is TPI Attested? Choose an item. |
| **Website Address/Link:** |
| **Credentialing Contact Name:**  |
| Credentialing Contact Email:  |
| Credentialing Contact Address:  |
| City, State, Zip Code:  |
| Credentialing Contact Phone:  | Fax:  |
| Billing Type | Choose an item. |
| **PROVIDER PRIMARY OFFICE ADDRESS – attach sheet for additional locations**  |
| Physical Address: (if additional locations please attached a roster) |
| City, State, Zip Code: |
| Office Phone: | Office Fax: |
| County:Choose an item. |
| **Mailing Address:** (*Contract will be emailed unless indicated here where to send)* |
| **\*Handicap Accessible: Choose an item. Accepting New Members:** **Choose an item.** |
|  \***OFFICE HOURS** | **Do You Offer After Hours and Weekend Care Choose an item.** |
| **Monday**  | **Tuesday**  | **Wednesday**  | **Thursday**  | **Friday**  | **Saturday**  | **Sunday**  |
|  |  |  |  |  |  |  |

(\*note required for contracting)