**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

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

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

***Adding Provider to the PCHP Directory:*** 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: Male |
|  Provider SSN:  | \*Specialty Type Choose an item. |
| \*Individual TPI:  | \*Is TPI Attested? Choose an item. |
| \*Taxonomy Number:  | Individual CAQH:  |
| \*Individual NPI:  | Curent 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: YES 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)