**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](mailto: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)