**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) **or fax to: 214-590-2150**

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

***Adding Provider to the PCHP Directory:***Choose an item.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Requester Name: | | | | | Requester Phone: | | | |
| Requester Email: | | | | | Requester Fax: | | | |
| Signatory Name:  Signatory Title: | | | | | 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 Taxonomy Number: | | | | | | | | |
| Group Name: | | | | | Group NPI: | | | |
| Group Tax ID: | | | | | Group THSteps TPI: | | | |
| Group TPI: | | | | | Is TPI Attested? Choose an item. | | | |
| **“For Health Plan use only”** | | | | | Billing ID Number: 47800533  Market Number**:**47800590 | | | |
| **Website Address/Link:** | | | | | | | | |
| **\*Credentialing Contact Name:** | | | | | | | | |
| \*Credentialing Contact Email: | | | | | | | | |
| Credentialing Contact Address: | | | | | | | | |
| City, State, Zip Code: | | | | | | | | |
| \*Credentialing Contact Phone: | | | | | Office Fax: | | | |
| \*Please Select Provider Type: Choose an item. | | | | | Billing Type Choose an item. | | | |
| **PROVIDER / GROUP 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)