



**GROUP AND PROVIDER  
INFORMATION FORM**

(Please complete 1 form per provider)

Date: \_\_\_\_\_

Contract Type:      PCP              Specialist              Ancillary

<b>Name of Group:</b>	<b>Group NPI:</b>
<b>Group Authorized Signatory &amp; Title:</b>	<b>Group Tax ID:</b>
<b>Total # of Providers Participating:</b>	<b>Service Area (County or City):</b>
<b>Provider Name:</b>	<b>Specialty:</b>
<b>Provider NPI:</b>	<b>Sub Specialty:</b>
<b>Provider License Number:</b>	<b>Age Limitations:</b>

**Group Mailing Address:** \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Fax: \_\_\_\_\_

**Provider Service Address:** \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Fax: \_\_\_\_\_  
 Office Hours: \_\_\_\_\_

**Claims Remittance Address:** \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Fax: \_\_\_\_\_

**Contracting Contact**

<b>Name:</b>	<b>Phone:</b>
<b>Title:</b>	<b>Email:</b>

**Credentialing Contact**

<b>Name:</b>	<b>Phone:</b>
<b>Title:</b>	<b>Email:</b>

**Specialty limitations:** \_\_\_\_\_

**Clinicals required for referral:** \_\_\_\_\_

**Family of Codes required on referrals:** \_\_\_\_\_

**Family of Codes required on referrals:** \_\_\_\_\_

**CCS Provider:**              Yes              No  
**CPSP Provider:**            Yes              No  
**CHDP Provider:**            Yes              No

