



HEALTHCARE PROVIDER INTEREST FORM

(All applicable information for each provider/practice must be completed. Any information left blank may cause a delay in processing.)

Date: _____ Completed by: _____

Title: _____ Phone: _____

GROUP/PRACTICE INFORMATION

Name: _____

Specialty: _____

New Provider Request: Y N Adding Provider to an Existing Group: Y N

Federal Tax Identification Number (TIN): _____

Legal Entity Name Associated With TIN:

National Provider I.D. (NPI) Number (*Organization/Billing*): _____

(For NPI number information, call 1-800-465-3203 or visit <https://nppes.cms.hhs.gov>)

Credentialing Contact: _____ Phone: _____

Fax: _____

Does the office provide: _____ Radiology _____ Laboratory

Foreign Languages (spoken fluently at office): _____

Physical Address of Office:

Phone: _____ Fax: _____

Correspondence/Mailing Address: *(if different than above)*

Billing/Remit Address: *(if different than above)*

Website: _____

Office Hours: _____

INDIVIDUAL PROVIDER INFORMATION

Last Name: _____
First Name: _____ Middle Initial: _____
Provider Type (i.e. MD, ARNP): _____ Specialty: _____
Ages Treated: _____ Date of Birth: _____ National Provider I.D. (NPI)
Number (*Rendering**) _____
FL State License Type/Number: _____
Board Certified? (Y/N) _____ If Yes, Board Name: _____
If No, Status: _____
Hospital Affiliations: _____
Are you registered with **CAQH?*** (Y/N) _____ If Yes, CAQH Provider I.D. _____

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**This process can be completed online at www.caqh.org or by calling CAQH at 1-888-599-1771.*