



PARTICIPATION APPLICATION REQUEST FORM

8101 W. Jefferson Blvd.
Fort Wayne, IN 46804
Phone: 260-432-6690

Fax completed forms to
Credentialing Coordinator
at (260) 436-4809

CONTACT INFORMATION	Contact Name:		Title:	Date:	
	Address:		Phone #:		
			Fax #:		
	E-mail:				
	Facility Name:				
GENERAL INFORMATION	Practice Name:				
	Practitioner Last Name:		Title:	First Name:	Middle Initial:
	NPI #:		DEA #:	Soc. Sec #:	
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Specialty/Services: Check if applicable: <input type="checkbox"/> Locum Tenens <input type="checkbox"/> Hospitalist		
	Board Certification: <input type="checkbox"/> No <input type="checkbox"/> Yes	Name of Board (If not Board Certified, Completion Date of Residency or Fellowship):			
	Are Radiology Services Performed in Office: <input type="checkbox"/> No <input type="checkbox"/> Yes				
	Practice Status:	<input type="checkbox"/> Currently practicing at this address <input type="checkbox"/> NEW PRACTICE - OR - JOINING EXISTING PRACTICE- ANTICIPATED START DATE _____			
	Primary Office Address: (Include Zip+4)			Phone #:	
				Fax #:	
	Other Office Address: (Additional Locations Attach sheet if needed - Include Zip+4)			Phone #:	
			Fax#:		
APPLICATION	Effective July 1, 2005 The state of Indiana mandates the use of the CAQH credentialing application. Please check application preference: <input type="checkbox"/> Prefer to utilize CAQH database/CAQH Provider I.D.: _____ (Please note PHP requires your authorization) <input type="checkbox"/> Prefer to utilize CAQH database but pending Provider I.D. Would like PHP to obtain. <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Prefer to submit paper application directly to PHP.				
	W-9 Name and D/B/A Name:		Tax I.D. #:		
			Phone #:		
BILLING INFORMATION	Payment Address: (Include Zip+4)				
	Select One: <input type="checkbox"/> UB04 Form <input type="checkbox"/> CMS1500 Form <input type="checkbox"/> ADA Form (Dental)			Organizational NPI #:	
PHP USE ONLY	Contract Sign-off: _____		Date: _____		
	Membership: <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____	Check Received: _____ \$ _____		Date: _____	
	Credentialing Approval / Insurance Date: _____		Contract Effective Date: _____		
	Provider I.D.: _____	Pay To I.D.: _____	Directory: <input type="checkbox"/>		
	Contract ID: _____	Input: _____		Audited By: _____	
In-service: <input type="checkbox"/> Yes Date Schedule: _____ <input type="checkbox"/> Declined Material Mailed _____					
Comments: _____					
Practice Contact: _____ Contract Contact: _____					