PHP

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

PROVIDER PARTICIPATION APPLICATION REQUEST FORM

Send completed forms to
Fax: (260) 969-2421 or
E-Mail: providerservices@phpni.com

CONTACT INFORMATION

Contact Name/Title:		**Date:**
Address:	**Phone #:**	**Fax #:**
	E-mail:	

GENERAL INFORMATION

Practice Name:

Practitioner Last Name:	**First Name/ Middle Initial:**	**Credentials:**
Gender: ☐ **Male** ☐ **Female** / **Date of Birth:**	**Soc. Sec #:**	
Speciality:	**DEA #:**	**NPI #:**

☐ **Check if applicable - Admitting Physician:** **Physician Name:** _____

Board Certification: ☐ **No** ☐ **Yes**

Name of Board (If not Board Certified, Completion Date of Residency or Fellowship):

Check If Applicable	**Practice Status**	**Are Radiology Services Performed in Office:**
☐ **Emergency Medicine** ☐ **Hospitalist** ☐ **Locum Tenens**	☐ **Currently practicing at this address** ☐ **NEW PRACTICE - OR -** ☐ **JOINING EXISTING PRACTICE - *ANTICIPATED START DATE*** _____	☐ **No** ☐ **Yes**

Primary Office Address (*Additional Locations Attach sheet if needed - Include Zip+4*):	**Phone #:** **Fax #:**
Address to Obtain Medical Records:	**Phone #:** **Fax #:**

CAQH

Providers are now responsible to obtain their own CAQH numbers. Please provide CAQH number: _____

BILLING INFORMATION

W-9 Name and D/B/A Name (*Attach Copy of W-9*):	**Payment Address (*Include Zip+4*):**	
Tax I.D. #:	**Organizational NPI #:**	**Phone #:**

PHP USE ONLY

Contract Sign-off: _____ **Date:** _____
Membership: ☐ **No** ☐ **Yes** **$** _____ **Check Received:** _____ **$** _____ **Date:** _____
Credentialing Approval / Insurance Date: _____ **Contract Effective Date:** _____
Provider I.D.: _____ **Pay To I.D.:** _____ **Directory:** ☐
Contract ID: _____

CONTRACT DEMOGRAPHICS

Date Completed: _____
☐ **LTR** ☐ **EDUC** ☐ **ATTH**

Add Provider To: ☐ **New Contract**
☐ **FWPG** ☐ **PG** ☐ **H.S.A.**
☐ **IND** ☐ **PHO** ☐ **LOU**
☐ **HMO** ☐ **SF** ☐ **SELECT**
☐ **OTHER** _____

Provider Change Form:

☐ **CHANGE NAME**
☐ **ADD Pay-To**
☐ **CHANGE Pay-To**
☐ **ADD Location(s)**
☐ **CHANGE Address** _____

Input Stamp

☐ **In-Credentialing**
☐ **Approved**

Audit Stamp

☐ **In-Credentialing**
☐ **Approved**