PROVIDER PARTICIPATION APPLICATION REQUEST FORM

Send forms to: Fax: 260-969-2421 or email: providerservices@phpni.com

Mail to: Attn: Provider Services | 1700 Magnavox Way, Suite 201, Fort Wayne, IN 46804 | Phone: 260-432-6690 | Toll-free: 800-982-6257

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