



REQUIRED INFORMATION TO ADD/CHANGE/TERM A PROVIDER TO A CLINIC/FACILITY

Add Provider Change Provider Term Provider*

*For Term, Highlighted sections only

PROVIDER INFORMATION: PCP SCP

Provider's name: _____
Last First Middle

Birth date: _____ Gender: _____

Degree: _____ Languages spoken: _____

Primary specialty: _____

Professional license(s):	License Number	State	Issue date	Expiration date
(Press enter for additional lines)				

NPI number: _____

DEA # (If applicable): _____ DSHS/Provider PIN: _____

Start date with Clinic/Facility: _____ **Term date with Clinic/Facility:** _____

Transfer members to: _____

Accepting new patients? YES NO

Publish in provider directory? YES NO

Provider delivers babies? YES NO

Age or sex limits: _____

CLINIC/FACILITY INFORMATION

Clinic/Facility name: _____

Legal Name/DBA: _____

TIN: _____

Group NPI: _____

Physical address: _____
City State Zip

Billing address: _____
City State Zip

Phone Number: _____ Fax Number: _____

Notes: