PROVIDER CONTRACTING INFORMATION FORM

Name of Provider/Organization:____

Please type or print full name of the Provider / Organization

Please complete the contracting information below. Please attach additional pages if necessary.*

(1) What type of entity is this? Solo practitioner Group practice Facility(**)

***If this is a Group Practice,** please submit an Excel Spreadsheet of the providers who render service under the Tax ID for the practice with the information listed in 1b below.

** Includes ancillary (i.e. Home Health Agency, Transportation, ASC's, SNF's, etc.)

(1b) All Others (Solo and Facility) - At a minimum please provide the following:

(a) Provider's Name: ____
(b) Billing Tax ID: ______________________ NPI: ____________________________
(c) Primary Specialty: ____
(d) CAQH ID # (if applicable): ____
(e) Full address for the Primary service location: ______________________________
____
(f) Member appointment telephone number: _________________________________

(2) Electronic Billing - Does your practice currently billing electronically? Yes No

Billing Format: CMS 1500 (formerly HCFA 1500) UB-04

(3) Authorized signatory – please provide the information below for the authorized signatory for the practice/facility. The authorized signatory is the person authorized to sign documents, including, but not limited to contract for the practice.

Name: ____ **Title:** ___________________________________

Telephone: ____________________________ **Alternate Telephone:** ______________________________

Does the signatory have ownership or control interest (5% or more) in the practice? ☐ **Yes** ☐ **No**

(4) Legal Notices – please provide the following information for the person who receives legal notices for the practice/facility**.**

Name: ____ **Title:** ___________________________________

Address:____

____

Email: ____

Owner Information – Please be reminded to complete the ownership information on page 2 of the ***Disclosure of Ownership and Control*** Attestation Form.