



PROVIDER INFORMATION FORM

Group Name

Provider Name

Provider Address

City

State

Zip

Specialty

Email Address

Website

Hospital Affiliations

Phone

Fax:

Office Manager

Office Hours:

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

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PRELIMINARY CREDENTIALING INFORMATION

CAQH ID:

TIN #

Individual NPI#

Group NPI:

License:DEA:

CLIA:

Medicaid ID#:

Medicare ID#:

PLEASE FAX THE MOST RECENT COPY OF YOUR W-9  
AND MALPRACTICE FACE SHEET (1.3MIL/3.9MIL)  
TO: 845-698-4009 ATTN: DEBBIE

SUBMIT THIS PDF FORM VIA EMAIL

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