PROVIDER PARTICIPATION APPLICATION REQUEST FORM

PHP
1700 Magnavox Way Ste 201
Fort Wayne, IN 46804
Phone: 260-432-6690

Send completed forms to
E-Mail: providerservices@phpni.com

CONTACT INFORMATION

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

GENERAL INFORMATION

Practice Name:		**Anticipated Start Date:**
Practitioner Last Name/Suffix:	**First Name/ Middle Initial:**	**Credentials:**
Gender: ☐ Male ☐ Female	**Date of Birth:**	**Soc. Sec #:**
CAQH Number: **[Required]**	**DEA #:**	**NPI #:**
Specialty:	☐ Check if applicable. Admitting Physician Name:	
Board Certification: ☐ No ☐ Yes	**Name of Board (If not Board Certified, Completion Date of Residency or Fellowship):**	

Provider Training Completion	**Cultural Competency?** ☐ Yes ☐ No **Annual FWA Training?** ☐ Yes ☐ No	**Model of Care Training?** ☐ Yes ☐ No **Critical Incident Training?** ☐ Yes ☐ No

Provider Status [check if applicable]	**Office Status** [check if applicable]	**In-Office Services** [check if applicable]
☐ Emergency Medicine ☐ Hospitalist ☐ Locum Tenens ☐ Specialist ☐ PCP	**Telehealth Services?** ☐ Yes ☐ No **Accepting New Patients?** ☐ Yes ☐ No **Do you use NP's or PA's?** ☐ Yes ☐ No	**Offer Radiology Services?** ☐ Yes ☐ No **Offer Lab Services?** ☐ Yes ☐ No

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
OFFICE HOURS							

PRACTICE LIMITATIONS	**Primary:**	**Secondary:**	**Additional:**

Primary Office Address: Additional Locations Attach sheet if needed - Include Zip+4)	**Phone #:** **Fax #:**
What population(s) do you treat (e.g. geriatric, all ages):	
Address to Obtain Medical Records:	**Phone #:** **Fax #:**
Provider Notification – Provider's E-mail	

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:** _____
Credentialing Approval / Insurance Date: _____ **Contract Effective Date:** _____
Provider I.D.: _____ **Pay To I.D.:** _____ **Directory:** ☐
Contract ID: _____

Provider Change Form: ☐ CHANGE NAME ☐ ADD Pay-To ☐ CHANGE Pay-To ☐ ADD Location(s) ☐ CHANGE Address	**Input Stamp**	**Audit Stamp**