Highlands Physicians Health Network

Confirmation of Provider Information Form

Please complete the information below and return it to HPI along with the appropriate par forms and/or signature sheets for plans of participation as well as a W-9 as soon as possible. *** * Please complete this form in its entirety * ***

Effective Date of this request: _____

*** * * In order to complete processing and to notify payors in a timely manner, please complete this form and return via email to: ProviderRelations@highlandsphysicians.com or fax to: 423-392-0006 as soon as possible. * * * Thank You.**

Please Check One: _____ New Provider _____ Additional Location _____ Change _____ Relocation

Please Check One: _____ PCP _____ SPEC _____ Hospitalist _____ Urgent Care

Name (First, MI, Last, Title): _____ Date of Birth: _____

CAQH #: _____ Social Security Number: _____ Gender: _____ Ethnicity: _____

Languages Spoken (**other than English**): _____ Cultural Competency Course taken? _____

IRS Name: _____

Provider's Preferred Email Address: _____

Supervising Phys. (First, MI, Last, Title): **(For Mid-Level Providers ONLY)** _____ Supervising Physician Specialty: _____

Group (**DBA**) Name: _____ Group NPI#: _____

Federal Tax ID #: _____ Taxonomy Code: _____ Individual NPI#: _____

Medicare #: _____ Medicaid#: _____ **Practicing** Specialty: _____

Board Certification: _____ Bd. Cert. Eff. Date: _____

Board.Specialty: _____ Bd. Cert. Exp. Date: _____

License #: _____ License State: _____ License Expiration Date: _____

DEA #: _____ DEA State: _____ DEA Exp. Date: _____ Liability Limits: _____

Liability Carrier: _____ Liability Policy#: _____ Liability Exp. Date: _____

Hospital Affiliation: _____ Hospital Effective Date: _____

Practicing Address: _____ Billing Address: _____

_____ _____

_____ _____

Is the above named provider accepting new patients at this practicing location?: _____ YES _____ NO

Should this location be listed in on-line and/or paper provider directories? _____ YES _____ NO

Is the above physical address this provider's primary practicing location under this tax id number? _____ YES _____ NO

If " No " which physical location is his/her primary practicing location?: _____

Practice Office Phone #: _____ Mailing Address **(for misc. correspondence mail)**:

Office Fax#: _____ _____

Office Mgr: _____ _____

OM Direct Phone # or Extension : _____ _____

Office Manager Email Address (if available): _____

_____ _____

Signature (Office Manager or Person completing form) (Date)

Revised: 04/01/2018; 11/28/2018; 11/20/2019; 02/04/2021; 12/01/2021;