PLEASE COMPLETE THIS FORM AND EMAIL TO:
PROVIDER.CHANGES@CHPW.ORG

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):
(Press enter for additional lines)

License Number	State	Issue date	Expiration date

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 Available for auto-assign? 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: ____
Street City State Zip

Billing address: ____
Street City State Zip

Phone Number: _______________________ Fax Number: _________________________

Notes:

Required Provider Add/Change/Term Data
03/16/2012 JI