Provider Information Request

PacificSource

The information provided on this form is required for claims processing and directory listings.
Please use separate forms for additional practice locations or practitioners/organizations.

☐ Credential new provider
Effective date at your organization _____

☐ Change information
☐ Add provider to new/additional location
☐ Add provider at facility-based location only*
☐ Termination Date _____
Termination Reason _____

1. Provider information (name as shown on CMS 1500 field 31 or UB box 1)

☐ Facility ☐ Primary care practitioner ☐ Specialist care practitioner

Name _____ SSN _____ Birth date _____

NPI _____ Specialty _____

Medical license number _____ DEA number _____

☐ Male ☐ Female ☐ X Race/ethnicity (optional) _____

PacificSource, along with its affiliates and subsidiaries, does not discriminate or base credentialing decisions on an applicant's race, ethnicity, or language. Providing this information is entirely optional, and choosing not to provide it will not affect your claims processing, directory inclusion, credentialing status, or any other benefit offered by PacificSource.

Languages spoken by provider _____

Offers telehealth ☐ Yes ☐ No (If it differs from practice location, list telehealth location in section 4.)
Note: Telehealth regulations require practitioners to be licensed by the state listed in section 2.

2. Practice location information (for patient visits and directory listing)

Practice name (as it should appear in directories) _____

Address _____

City _____ State _____ Zip _____ County _____

Practitioner specialty (as practicing at this location) _____

List this location in directories? Note: facility-based locations will not be listed. ☐ Yes ☐ No

Location NPI _____ Tax ID number (attach matching IRS W9) _____

Practice contact name _____ Practice contact email _____

Practice contact phone _____ Practice contact fax _____

***Facility-based providers** are those who practice exclusively in an inpatient setting; a credentialing application is not required.

Continued >

3. Billing information (as listed on CMS 1500 field 33 or UB box 2)

☐ Same as above

Billing name (as it appears on claims) _____

Address _____

City _____ State _____ Zip _____ County _____

Billing contact name _____ Billing contact email _____

Billing contact phone _____ Billing contact fax _____

Credentialing contact name _____ Credentialing contact email _____

Credentialing contact phone _____ Credentialing contact fax _____

4. Summary of changes/notes

Form completed by _____

Email _____ Phone _____

How to submit form: If credentialing a new provider, email form to: Credentialing@PacificSource.com.
For all other reasons, please email form to: ProvNetSup@PacificSource.com.

Questions? Please contact your Provider Relations Representative. Visit PacSrc.co/PRV-Reps for contact info.