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 _____
CAQH # _____

☐ Change information
☐ Add provider to new/additional location
☐ Add provider at hospital-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) _____
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: hospital-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 _____

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 _____

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

How to submit form: If credentialing a new provider, email to: Credentialing@PacificSource.com. For all other reasons, please email form to: ProvNetSup@PacificSource.com. **Questions?** Please contact your Provider Service Representative.