Provider Information Request

Idaho and Montana

PacificSource HEALTH PLANS

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
☐ Change information
☐ Add provider to new/additional location
☐ Add provider at hospital-based location only[1]

Effective date at your organization _____
CAQH # _____
☐ Termination Date _____
Reason _____

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

☐ Organizational provider ☐ Individual Practitioner (PCP) ☐ Individual Practitioner (Specialist)

Name _____ SSN _____ Birth date _____ ☐ Male ☐ Female

NPI _____ Degree _____

Medical license number _____ DEA number _____

PTAN number (if applicable) _____

Offers telehealth ☐ Yes ☐ No (If it differs from practice location, list telehealth location in section 4.)

Note: Telehealth regulations require practioners 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 _____

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

For Montana, return to:
828 Great Northern Blvd, Ste. 101, Helena, MT 59601 | Fax to: 406-422-1010 | Email to: MTProvNet@PacificSource.com

For Idaho, return to:
408 E Parkcenter Blvd, Ste. 100, Boise, ID, 83706 | Fax to: 208-433-4634 | Email to: IDProvNet@PacificSource.com