Provider Information Request

Idaho and Montana

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 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 ____________

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

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