Provider Information Request

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 ☐ Add Provider to Group ☐ Change Information ☐ Add Provider to Hospital-based Location[1]

CAQH # _____ ☐ Termination Date ___ / ___ / ___ Reason _____

Effective date at your organization Date ___ / ___ / ___
For current in-network providers, the effective date will be applied after the 1st of following month.

1. Provider Information (name as shown on CMS 1500 Field 31 or UB Box 1)

☐ Individual Practitioner ☐ Organizational Provider ☐ PCP ☐ Specialist

Name _____

NPI _____ Degree _____ Birth Date _____ ○ Male ○ Female

License No. _____ DEA No. _____

Offers Telemedicine ☐ Yes ☐ No (If it differs from Practice Location, list telemedicine location in Section 4.)
Note: Telemedicine 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 No. (attach IRS W9) _____

Contact Name _____ Contact Email _____

Practice Phone _____ Practice 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 _____

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.*

Return to: 828 Great Northern Blvd, Ste. 101, Helena, MT 59601 | Fax to: (406) 422-1010 | Email to: MTProvNet@pacificsource.