Provider Information for HealthSuite

Provider#

Last Name/LBN

First Name/DBA Middle Initial:

Suffix (MD, RN, etc) Provider Type

ADDRESS

Mailing Office

City City

State Zip+4 State Zip+4

County County

Phone Phone

Fax Fax

PHYSICIAN INFO

Federal TIN Effective Date

NPI # Effective Date

Medicare # Effective Date

Medicaid # Effective Date

License # Effective Date Exp Date

DEA# Effective Date Exp Date

PROVIDER INFO

Billing for: Effective Date

>>>>>>>>>>>>>>>>>>>>>>>>>>FOR INTERNAL USE ONLY<<<<<<<<<<<<<<<<<<<<<<

CONTRACT INFO

Circle:

FHP			**FCI**		
Contracted	or	Non Contracted	Contracted	or	Non Contracted
Primary Care	or	Specialist	Primary Care	or	Specialist

MHO		
Contracted	or	Non Contracted
Primary Care	or	Specialist

FCI Rates								
FHP Rates								
MHO Rates								

Date Credentialing Completed:

Today's Date_____ **Track It #**_____