Please return this form to Network Development
via email at networkrelations@wellhealthqc.com
or fax at (702) 522-1357.

Group Information

Group DBA ______________________________

Group Legal Entity Name ______________________________

Group TIN & NPI (if applicable) ______________ ______________

Website (if applicable) ______________________________

Primary Location Information

(If more than one location, please provide the following information for each additional location)

Street Address ______________________________

City ______________ State ________ Zip ________

Phone ______________ Fax ______________

Email Address ______________________________

Practice Manager Information

Manager Name ______________ Phone ______________

Email ______________________________

Billing Information

Billing Contact Name ______________________________

Address (P.O. Box Acceptable) ______________________________

City ______________ State ________ Zip ________

Phone ______________ Fax ______________

Email Address ______________________________

Credentialing Information

Credentialer Contact Name ______________________________

Address (P.O. Box Acceptable) ______________________________

City ______________ State ________ Zip ________

Phone ______________ Fax ______________

Email Address ______________________________

EHR Information

System Platform ______________ Version ________

Vendor ______________ Analytics Capabilities ______________

EHR Contact ______________ Phone / Email ______________

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or fax at (702) 522-1357.

Group Provider Roster

Provide the following information for EACH provider within your practice, including Mid-Levels.

Provider Name ____
FIRST MI LAST Credentials

Date of Birth ______________ SSN ____________________ Gender M F

Provider Specialty ____

Provider Board Certification (e.g. American Board of Family Medicine)

____

Provider NPI ________________ Provider License State / Number ____________

Languages Spoken by Provider other than English ______________________

Provider's Hospital Admitting Priviledges ____________________________

Provider Name ____
FIRST MI LAST Credentials

Date of Birth ______________ SSN ____________________ Gender M F

Provider Specialty ____

Provider Board Certification (e.g. American Board of Family Medicine)

____

Provider NPI ________________ Provider License State / Number ____________

Languages Spoken by Provider other than English ______________________

Provider's Hospital Admitting Priviledges ____________________________

Provider Name ____
FIRST MI LAST Credentials

Date of Birth ______________ SSN ____________________ Gender M F

Provider Specialty ____

Provider Board Certification (e.g. American Board of Family Medicine)

____

Provider NPI ________________ Provider License State / Number ____________

Languages Spoken by Provider other than English ______________________

Provider's Hospital Admitting Priviledges ____________________________