Please fill out all necessary fields based on request, and return via fax (702) 522-1357 or email to WH_Contracting@hcpnv.com

GROUP ACT FORM

General Information

Practice Name (DBA) ______________________

Legal Entity Name ______________________
(if different from above)

Tax ID # ______________________ Group NPI ______________________

Practice Manager ______________________

Phone ______________________ Fax ______________________

Email ______________________

PROVIDER (select one):

☐ **ADD*** ☐ **CHANGE** ☐ **TERM**

Name ______________________ NPI ______________________

Specialty ______________________ License # / Expiry ______________________

Sub-Specialty ______________________ CAQH # ______________________

Hospital Based? YES ☐ NO ☐

Effective Date ______________________

Practice Location(s) - Please list all locations **this provider** will practice at.

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** To avoid delays in processing, ACT Forms must be submitted with the credentialing application(s) or CAQH number for all providers being added. Providers may **NOT** see members until they have received an Effective Date Letter.*

LOCATION (select one):

☐ **ADD** ☐ **CHANGE** ☐ **TERM**

Location Type ☐ Primary ☐ Billing ☐ Other ______________________

Address ______________________

Administrative Use Only

STANDARD CL EXP DR

NOTES