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

GROUP ACT FORM

General Information

Practice Name (DBA) ____________________

Legal Entity Name ____________________
(if different from above)

Tax ID # ____________________

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.*

LOCATION (select one):

☐ **ADD** ☐ **CHANGE** ☐ **TERM**

Location Type ☐ Primary ☐ Billing ☐ Other ____________________

Address ____________________

Administrative Use Only

STANDARD CL EXP DR

NOTES