



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

WELLHEALTH  
Quality Care

## 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.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*\* 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