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.

_____

_____

_____

_____

_____

** To avoid delays in processing, ACT Forms must be submitted with the credentialing application(s) for all providers being added.*

LOCATION (select one):

☐ **ADD** ☐ **CHANGE** ☐ **TERM**

Location Type ☐ Primary ☐ Billing ☐ Other _____

Address _____

_____

_____