WELLHEALTH Quality Care
A MedSource Health Care Company

Please return this form to Network Development
via email at WH_NetworkRelations@hcpnv.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 _____

Please return this form to Network Development
via email at networkrelations@wellhealthqc.com
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)

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Provider NPI ______________ Provider License State / Number ______________

Languages Spoken by Provider other than English ______________

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