PROSPECTIVE PROVIDER FORM

Thank you for your interest in becoming a Parkland Community Health Plan, Inc. Provider. Please scan and email with a current W9 to: PCHP.ContractingDepartment@phhs.org or fax to: 214-590-2150

Please Select Provider Type: Choose an item.

Adding Provider to Existing Group Contract Choose an item.

Requester Name	**Requester Phone:**
Requester Email:	**Requester Fax:**
Signatory Name:	**Signatory Email:**
***PROVIDER INFORMATION**	Choose an item.
*Last Name:	*First Name:
*Date of Birth:	*Gender: Choose an item.
Provider SSN:	*Specialty Type Choose an item.
*Individual TPI:	*Is TPI Attested? Choose an item.
*Taxonomy Number:	Individual CAQH:
*Individual NPI:	Current Insurance Limits:
*Offer Telemedicine	**Choose an item.**
GROUP INFORMATION	
Group Name:	
Group Tax ID:	Group NPI:
Group TPI:	Group THSteps TPI:
Is TPI Attested? Choose an item.	
Website Address/Link:	
Credentialing Contact Name:	
Credentialing Contact Email:	
Credentialing Contact Address:	
City, State, Zip Code:	
Credentialing Contact Phone:	Fax:
Billing Type	Choose an item.
PROVIDER PRIMARY OFFICE ADDRESS – attach sheet for additional locations	
Physical Address: (if additional locations please attached a roster)	
City, State, Zip Code:	
Office Phone:	Office Fax:
County:Choose an item.	
Mailing Address: (*Contract will be emailed unless indicated here where to send)*	
***Handicap Accessible:** **Choose an item.** **Accepting New Members:** **Choose an item.**	
***OFFICE HOURS**	**Do You Offer After Hours and Weekend Care** **Choose an item.**

Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

(*note required for contracting)