PROSPECTIVE PROVIDER FORM

Please scan and email to: PCHP.ProviderRelations@PHHS.ORG or fax to: 214-590-2150

PROVIDER INFORMATION: ☐ **MD** ☐ **DO** ☐ **NP** ☐ **Other: ____________**	
Last Name:	First Name:
DOB:	Gender: ☐ Male ☐ Female
SSN:	Specialist or PCP:
Specialty:	NPI:
Individual TPI:	Is TPI Attested? ☐ YES ☐ NO
Current Insurance Limits:	

GROUP INFORMATION	
Group Name:	
Group Tax ID:	Group NPI:
Group TPI:	Group THSteps TPI:
Is TPI Attested? ☐ YES ☐ NO	
Credentialing Contact Name:	
Credentialing Contact Email:	
Credentialing Contact Address:	
City, State, Zip Code:	
Credentialing Contact Phone:	Fax:

PROVIDER PRIMARY OFFICE ADDRESS – attach sheet for additional locations	
Physical Address:	
City, State, Zip Code:	
Phone:	Fax:
County:	
Accepting New Members: ☐ Yes ☐ No	

OFFICE HOURS

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

Proprietary