vivanthealth

Provider Data Form

Date of request: ____________________

Office Information

Entity type: ☐ PCP ☐ Specialty ☐ Ancillary ☐ FQHC/RHC/IHS

Exact name of organization (W9): ____________________

Office name (name above the door): ____________________

Group NPI (organizational): ____________________ Tax ID #: ____________________

Specialty: ____________________ Subspecialty: ____________________

Age limitation? ☐ Yes ☐ No If yes, what is the range? ____________________

Primary Contact Information

Credentialing contact: ____________________

Telephone number: ____________________ Email: ____________________

Contracting contact: ____________________

Telephone number: ____________________ Email: ____________________

Office manager: ____________________

Telephone number: ____________________ Email: ____________________

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vivanthealth

Provider Data Form

Primary Location

Name: ______________________________

Address: ______________________________

City: ______________ State: ________ ZIP+4: ________

Telephone: ____________ Fax: ____________ Referral fax: ____________

Office hours: ______________________________

Contact: ______________ Email: ______________

Secondary Location

Name: ______________________________

Address: ______________________________

City: ______________ State: ________ ZIP+4: ________

Telephone: ____________ Fax: ____________ Referral fax: ____________

Office hours: ______________________________

Contact: ______________ Email: ______________

Tertiary Location

Name: ______________________________

Address: ______________________________

City: ______________ State: ________ ZIP+4: ________

Telephone: ____________ Fax: ____________ Referral fax: ____________

Office hours: ______________________________

Contact: ______________ Email: ______________

Billing Address (if not primary)

Name: ______________________________

Address: ______________________________

City: ______________ State: ________ ZIP+4: ________

Telephone: ____________ Fax: ____________ Referral fax: ____________

Office hours: ______________________________

Make copies as needed to complete your office locations.