COMMON GROUND HEALTHCARE COOPERATIVE PROVIDER INFORMATION FORM

Instructions: The information requested on this form is necessary any time you add a practitioner (in addition to credentialing) or if any information submitted on this form changes. If you do not wish to use this form, you may submit this data in another format as long as **all** the required information from all fields is included. You must submit this information electronically to providerchanges@commongroundhealthcare.org or fax it to 262-754-9690.

Steps to completing the form: Please fill out **all** fields on the form except for those marked with an asterisk which are optional. **Step 1:** Enter the date this information becomes effective. **Step 2:** Enter the locations associated with your practice, noting which location is assigned to A, B, C and D. If you need additional columns, please use a second form. **Step 3:** Enter the corresponding letter(s) to clinic location from Section 1, then input billing/payment information for the clinic(s). **Step 4:** Enter provider demographic information. If you have additional providers, please submit additional copies of page 2.

Section 1 - Date effective:

Section 2 - Clinic Location Information	**Office Location A**	**Office Location B**	**Office Location C**
Clinic Name			
Tax ID Number			
Location Address			
Location Address 2*			
City			
State			
Zip			
Phone Number			
Fax Number*			
Email Address			

Section 3 - Billing/Payment Remittance Information	**Payment/Remittance Address 1**	**Payment/Remittance Address 2**	**Payment/Remittance Address 3**
Billing information applies to which clinic location(s) - A, B or C from Section 2?			
Billing Name (If different from Clinic)			
Billing Address			
Billing Address 2*			
Billing City			
Billing State			
Billing Zip			
Billing Phone Number			
Billing Fax Number *			
Do you want Electronic Funds Transfer (EFT)?			

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Section 4 - Provider Demographic Information	**Provider 1**	**Provider 2**	**Provider 3**
This provider practices in which clinic location(s) - A, B or C from Section 2?			
Last Name			
First Name			
Middle Initial			
Suffix (Jr, Sr, etc)			
Degree			
Primary Specialty			
Primary Specialty Board Certified?			
Secondary Specialty			
Secondary Specialty Board Certified?			
NPI			
State License Number			
DEA Number			
Include in provider directories?			
Admitting Hospital Privileges 1			
Admitting Hospital Privileges 2			
Admitting Hospital Privileges 3			
Admitting Hospital Privileges 4			
Primary Language			
Secondary language if any *			
Languages Spoken in Office			