



HEALTHCARE COOPERATIVE

## NETWORK PROVIDER CONTACTS

To allow us to best communicate with your practice, please provide contacts for each of the roles below as applicable to your organization. Fax to 262-754-9690 or email to [providerchanges@commongroundhealthcare.org](mailto:providerchanges@commongroundhealthcare.org).

Provider Organization/Practice			
Practice/Entity Name			TIN
Primary Address	City	State	ZIP
Phone	NPI		
Contracting -Questions related to the Agreement/Contract Negotiations <input type="checkbox"/> Receives Provider Newsletter			
Name		Title	
Mailing Address	City	State	ZIP
Phone <input type="checkbox"/> Preferred	Email <input type="checkbox"/> Preferred		
Billing and Claims Contact- Questions related to Billing and Claims received <input type="checkbox"/> Receives Provider Newsletter			
Name		Title	
Mailing Address	City	State	ZIP
Phone <input type="checkbox"/> Preferred	Email <input type="checkbox"/> Preferred		
Credentialing- Responsible for maintaining Provider Rosters/Credentialing <input type="checkbox"/> Receives Provider Newsletter			
Name		Title	
Mailing Address	City	State	ZIP
Phone <input type="checkbox"/> Preferred	Email <input type="checkbox"/> Preferred		
I certify that I have the authority to provide this information on behalf of the organization			
Name		Title	
Signature		Date	