NEW PROVIDER APPLICANT INFORMATION

Date:_____

Provider Name:_____ Individual NPI:_____

Primary Specialty:_____Provider Type:_____

**CAQH ID:**_____ Are you a hospital based physician?_____

Collaborating Physician (CRNP):_____

Collaborating Physician Specialty:_____

Supervising Physician (PA):_____

Supervising Physician Specialty:_____

Practice Name:_____

PracticeNPI:_____Practice Tax ID:_____

Hospital Affiliation:_____

Circle if applicable: Privileges or Hospitalist Group

Call Coverage:_____

If none, please explain (solo practitioner, answering service, etc)_____

**For practice addresses, please only include addresses where you accept patient appointments. This information will be used in VIVA Health's provider directory. Include additional locations on a separate sheet or a practice location roster.**

Primary Practice Address:_____

Phone:_____ Fax:_____E-mail:_____

Secondary Practice Address:_____

Phone:_____Fax:_____

**Please include a W9**

Primary Billing Address:_____

Phone:_____Fax:_____