Parkland Community Health Plan

PROSPECTIVE PROVIDER FORM

Thank you for your interest in becoming a Parkland Community Health Plan, Inc. Provider.
Please scan and email with a current W9 to: PCHP.ContractingDepartment@phhs.org

***Adding Provider to Existing Group Contract*: ◯ YES ◯ NO** ****Adding Provider to the PCHP Directory*: ◯ YES ◯ NO**

*Requester Name:	*Requester Phone:
*Requester Email:	*Requester Fax:
*Signatory Name: *Signatory Title:	*Signatory Email:
***PROVIDER INFORMATION**	choose one
*First Name:	*Last Name:
*Date of Birth:	*Gender:
*Provider SSN:	*Specialty Type: choose one
*Taxonomy Number:	*Are You Attested? ◯ YES ◯ NO
*Individual NPI:	*Individual CAQH:
*Race Ethnicity: choose one	*Patient Gender Restrictions? choone one
* Patient Age Range:	*Completion of Cultural Competency ◯ YES ◯ NO
GROUP INFORMATION	Group Taxonomy Number:
Group Name:	Group NPI:
* Billing Tax ID:	*Current Insurance Limits:
* Offer Telemedicine: ◯ YES ◯ NO	
"For Health Plan use only"	Billing ID Number: 47800533 Market Number:47800590
Website Address/Link:	
***Credentialing Contact Name:**	
***Credentialing Contact Email:**	
***Credentialing Contact Address:**	
***City, State, Zip Code:**	
***Credentialing Contact Phone:**	**Office Fax:**
***Please Select Provider Type:** choose one	**Billing Type:** choose one
PROVIDER / GROUP PRIMARY OFFICE ADDRESS – attach sheet for additional locations	
Physical Address: (if additional locations please attached a roster)	
*City, State, Zip Code:	
*Office Phone:	*Office Fax:
*County:	
Mailing Address: (*Contract will be emailed unless indicated here where to send)*	
***Handicap Accessible:** ◯ YES ◯ NO	***Accepting New Members:** ◯ YES ◯ NO
***OFFICE HOURS**	**Do You Offer After Hours and Weekend Care?** ◯ YES ◯ NO

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

(*note required for contracting)