PROVIDER INTEREST FORM

Provider Network Dept.
PO Box 7068
Springfield, OR 97475
Fax: 541.225.3643

- Please print legibly and complete in its entirety.
- Please return completed form to your Provider Contracting Representative.

	Date Submitted

PROVIDER INFORMATION	
Provider Name	Degree/Title
Practice Name/Facility	Practice Effective Date
Specialty	Specialty Effective Date
Clinic Contact	Specialty Expiration Date
Email	Language Fluency

PROVIDER ID NUMBERS			
License	State	Effective	Expires
DEA		Effective	Expires
NPI		TIN/SSN	
Medicare		Effective	
DMAP		Effective	

PRACTICE LOCATION			
Street address			
City	State	County	Zip Code
Phone		Fax	Effective Date

MAILING ADDRESS			
Street address			
City	State	County	Zip Code
Phone		Fax	Effective Date

PAY TO NAME & ADDRESS		
Name		NPI
Street address		TIN
City	State	MA
County	Zip Code	Effective Date
Phone	Fax	

FORM COMPLETED BY	
Signature	*Date*
Print Name	*Contact #*
Email	