

Practitioner Data Form										
Instruct				•	eted in its entirety to <u>PHWProviderDa</u>	•	ach additional pages <u>'ellness.com</u>	for location		
Applicati	ion Date:			-	ou registered wi			No		
Individua	al NPI:				s, CAQH Provider		is authorized to access y	our aata)		
Last Name:				irst	Name:		Middle Initial:			
Date of Birth:				Social Security #:			PROMISe ID #:			
Gender:				Race/Ethnicity:						
Provider Type (MD, DO, PhD, LCSW, LPC, NP, etc):				Are you a Hospital-based only provider not practicing in an office setting? ☐ Yes ☐ No						
	nformation 1 of _				vider PROMISe II	D #:				
Location N	lame:		Group NP	l:		Tax ID:				
Location S	treet Address:		Location C	City/	State:	Location Zip Code:				
Location C	County:		Primary P	hon	e:	Primary Fax:				
Email Add	ress:									
Cradential	ling Contact Info	rmation (Na	me Address F	-ma	ail)·					
Credericia	mig contact inio	Thation (Na			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
Applying a	ns: ☐ Specialist☐ Primary Ca	ra Providar	Primary S _l	Specialty:			Taxonomy:			
Secondary		Taxonomy:		[Display in Find-A-					
Office	Monday	Tuesday	Wednesd	lav	☐ Yes ☐ N Thursday	No Friday	Saturday	Sunday		
Hours		•		<u>,</u>	,	,	,	•		
☐ 24 Hours ☐ 8 – 5 Monday – Friday					Do You Provide Telehealth Service? ☐ Yes ☐ No					
License Number: License				State: Exp. Date:						
Are you board certified? If yes, board nan				e:		Exp. Date:				
					ents? (REQUIRED		□Yes □ No	- doctato -		
A copy of the Hospital Privileges or Admitting Arrangements <u>must</u> be returned with this form. If No, a copy of the admitting procedures <u>must</u> be attached or enrollment/credentialing cannot be completed.										
Do you have a CLIA Certificate? Do you have a CLIA Waiver? Type of Service Provided: □ Yes □ No □ Yes □ No										
Certificate Number:					CLIA Name:					
Certificate Expiration Date:					Tax ID #:					
If PCP, are you accepting new patients?					Gender or Age restrictions?					
□Yes □ No				Gender: ☐ None ☐ Female Only ☐ Male Only						
				Age: None Age Limits: Lowest Age Highest Age						

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Location Information 2 of		Provi	der PROM	ISe ID #:				
Location Name:	Grou	Group NPI:			Tax ID:			
Location Street Address:	Locat	Location City/State:			Location Zip Code:			
Location County:	Prima	Primary Phone:			Primary Fax:			
Email Address:								
Credentialing Contact Information	on (Name, Addre	ess, E-mail)):					
Applying as: ☐ Specialist☐ Primary Care Pro		Primary Specialty:			Taxonomy:			
Secondary Specialty: Taxon	omy:	Display in Find-A-F ☐ Yes ☐ No			der? Languages Spoken:			
Office Monday Tu Hours				lay Frida	Saturday	Sunday		
☐ 24 Hours ☐ 8 – 5 Monda	y – Friday		D	o You Provide T	Telehealth Service?	☐ Yes ☐ No		
License Number:	se State:	ate: Exp. Date:						
Are you board certified? ☐ Yes ☐ No	name:	Exp. Date:						
Do you have Hospital Privileges of A Copy of the Hospital Privilege procedur	_	rangements	must be re	turned with this f	form. If No, a copy of th	ne admitting		
Do you have a CLIA Certificate? ☐ Yes ☐ No	Do you have □Yes		niver? Type of Service Provided:					
Certificate Number:		CLIA Name:						
Certificate Expiration Date:		Tax ID #:						
If PCP, are you accepting i	Δσο·	Gender or Age restrictions? Gender: □ None □ Female Only □ Male Only Age: □ None □ Age Limits: Lowest Age Highest Age						
Are you board certified? Yes No Do you have Hospital Privileges of A Copy of the Hospital Privilege procedur Do you have a CLIA Certificate? Yes No Certificate Number: Certificate Expiration Date: If PCP, are you accepting in the service of the procedur.	If yes, board of the property	rangements rangements ned or enrol e a CLIA Wa	must be relement/credeaiver? Typ CLIA Nam Tax ID #:	Exp. Date RED for NP & PA) turned with this fentialing cannot be e of Service Pro e: Gender or a er: None	e: Yes \(\) No form. If No, a copy of the completed. ovided: Age restrictions? Female Only \(\) Male	Only		

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Location Na	Group NPI:	Group NPI:			Tax ID:				
Location St	Location Ci	Location City/State			Location Zip Code:				
Location Co	Primary Ph	Primary Phone:			Primary Fax:				
Email Addre	ess:								
Credentialir	ng Contact Info	rmation (N	lame, Address, E-	-mail)	:				
Applying as		Primary Specialty:				Taxonomy:			
Secondary S	':	Display i □ Y			rovider?	Languages Spoken:			
Office	Monday	Tuesda	y Wednes	day	Th	ursday	Friday	Saturday	Sunday
Hours									
☐ 24 Hou	rs 🗆 8 – 5 N	/londay – F	riday			Do You	Provide Tele	ehealth Service?	Yes 🗆 No
License Number: License Sta				ite:	Exp. Date:				
Are you board certified? If yes, board name ☐ Yes ☐ No					Exp. Date:				
Do you have	e Hospital Privi	leges or Ac	dmitting Arrange	ment	:s? <u>(RE</u>	QUIRED fo	r NP & PA)	□Yes □ No	
. ,	pr	ocedures <u>m</u> ı	<u>ust</u> be attached or	enroll	lment/c	redentialir	ng cannot be o	-	admitting
Do you have a CLIA Certificate? Do you have a CLI					iver?	Type of S	ervice Provi	ded:	
□Yes □ No □Yes □					_				
Certificate Number:				CLIA Name:					
Certificate Expiration Date:				Tax ID #:					
If PCP, are you accepting new patients?					Gender or Age restrictions?				
□Yes □ No				Gender: ☐ None ☐ Female Only ☐ Male Only Age: ☐ None ☐ Age Limits: Lowest Age Highest Age					

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