Provider Information Sheet

Provider First Name _____

Provider Middle Name/Initial _____

Provider Last Name _____

Gender _____

Degree _____

PCP Provider or Specialist Provider (Please circle one)

Specialty _____

Telehealth Services Yes or No (Please circle one)

Practice Location _____

Mailing Address _____

Phone Number _____

Fax Number _____

Office Email _____

Website Address _____

Tax Number _____ **DEA Number** _____

State of Illinois License Number _____ **Medicare Number** _____

NPI Number _____ **Medicaid Number** _____

Board Certified Yes or No (Please circle one)

Effective Date _____

Initial Credential Approval Date _____

Name of Affiliation _____

Hospital(s) where you have admitting privileges _____

_____

Date _____

Name and title of person completing this form _____

_____