Montgomery County Hospital District
Healthcare Assistance Program

- ☐ Add
- ☐ Change
- ☐ Delete

PROVIDER INFORMATION FORM

Please print CLEARLY and complete this form for EACH provider at EACH location.

Provider Name: ______________________ **Degree:** ______________

Provider Specialty: ____________________________________

PRACTICE INFORMATION (as to appear in the Provider Directory):

Facility and/or Office Name: ______________________________

Office Address: ______________________________

____

Practice Phone: ________________ **Practice Fax:** ______________

Contact Person: ________________ **E-mail Address:** ____________

BILLING INFORMATION

Billing Tax ID: ________________ **NPI:** ________________

Office Address: ______________________________

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Billing Office Phone: ______________ **Billing Office Fax:** ______________

Billing Contact: ________________ **Email Address:** ______________

Hospital Privileges:

Location: ____________________ **Type:** ________________
Location: ____________________ **Type:** ________________
Location: ____________________ **Type:** ________________

Send ALL Provider Information sheets to one of the following below:

Attention: Montgomery County Hospital District
Ana Hernandez
Fax: 936-523-5060
Email: ahernandez@mchd-tx.org
Questions: 936-523-5170