PROVIDER INFORMATION FORM

PROVIDER NAME:
DEGREE:
SPECIALTY:

PRACTICE INFORMATION

FACILITY AND/OR OFFICE NAME:
PHYSICAL ADDRESS:
PHONE NUMBER:
FAX NUMBER:
CONTACT PERSON:
EMAIL:

BILLING INFORMATION

BILLING TAX ID NUMBER:
NPI:
BILLING MAILING ADDRESS:
BILLING PHONE NUMBER:
BILLING FAX NUMBER:
BILLING CONTACT PERSON:
BILLING EMAIL:

HOSPITAL PRIVILEGES

LOCATION:	**TYPE:**
LOCATION:	**TYPE:**
LOCATION:	**TYPE:**

PLEASE ATTACH COPY OF MOST RECENT W-9 FORM

Submit forms via email to:

MCHDHCAPclaims@mchd-tx.org