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:
PAYMENT PREFERENCE: **CHECK** ☐ **ACH/EFT** ☐ *If ACH/EFT is selected, please complete ACH/EFT enrollment form.* *If ACH/EFT is not selected, please provide reason.* **REASON:**

HOSPITAL PRIVILEGES

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

PLEASE PROVIDE MOST RECENT W-9 FORM

Submit forms via email to:

Claims@mchd-tx.org