oneHealth

PROVIDER INFORMATION SHEET

DATE OF COMPLETION: _____

PRACTICE NAME: _____ **TAX ID** _____

MAILING ADDRESS:

ADDRESS _____
Street City St Zip

PHONE _____ FAX _____ CONTACT NAME/EMAIL _____

BILLING/REMIT ADDRESS: ☐ *Same as above*

ADDRESS _____
Street City St Zip

PHONE _____ FAX _____ CONTACT NAME/EMAIL _____

CREDENTIALING ADDRESS: ☐ *Same as above*

ADDRESS _____
Street City St Zip

PHONE _____ FAX _____ CONTACT NAME/EMAIL _____

SITE LOCATION(S) ADDRESS:

[1] ADDRESS _____
Street City St Zip

PHONE _____ FAX _____ CONTACT NAME/EMAIL _____

PROVIDERS PRACTICING AT ADDRESS 1. PROVIDE NAME AND SPECIALTY:

1. _____ **2.** _____

3. _____ **4.** _____

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[2] ADDRESS _____
Street City St Zip

PHONE _____ FAX _____ CONTACT NAME/EMAIL _____

PROVIDERS PRACTICING AT ADDRESS 2. PROVIDE NAME AND SPECIALTY:

1. _____ **2.** _____

3. _____ **4.** _____

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[3] ADDRESS _____
Street City St Zip

PHONE _____ FAX _____ CONTACT NAME/EMAIL _____

PROVIDERS PRACTICING AT ADDRESS 3. PROVIDE NAME AND SPECIALTY:

1. _____ **2.** _____

3. _____ **4.** _____

IF MORE THAN 3 SITE LOCATIONS OR MORE THAN 4 PROVIDERS AT ANY LOCATION, PLEASE ATTACH A COMPLETE LISTOF SITE LOCATIONS WITH CORRESPONDING PROVIDERS AND SPECIALTIES. ☐ ***Site Roster attached.***