CHAMBERCARE

PROVIDER DATA SHEET

Please Print or Type

GENERAL INFORMATION FOR CORPORATION

Name of Corporation as shown on legal tax I.D. | # of Providers in Group

Primary Office Address | City | ST | Zip Code | County

Federal Tax I.D. (please attach a W-9) | Group NPI

Billing Address (if different from primary office address) | City | ST | Zip Code | Billing Phone

Primary Office Contact | Title | ***Secure Email Address**

Office Phone | ***Secure Office Fax** | Clearinghouse | Submitter ID

PROFESSIONAL PROVIDER INFORMATION
(This information may be included in a spreadsheet format for multiple providers.)

Provider Last Name | Provider First Name | Initial | Title

Clinical Specialty *(as you wish it listed in the directory)* | Sub-Specialty | CAQH# | UPIN #

_____/_____/_____ Date of Birth | Provider NPI | DEA # | Board Certification

_____ - _____ - _____ Social Security Number | License # – Indiana | License # - Other State

Taxonomy Code | Medicare ID # | Medicaid ID #

HOSPITAL AFFILIATIONS

Hospital | City, State | Type of Privileges

Hospital | City, State | Type of Privileges

Signature of Applicant | Date of Application

Printed Name of Applicant

Internal Use Only: _____
Signature, Date and File Code

*By supplying a secure fax &email address the provider agrees to accept communication from ChamberCare in this manner. If you wish to decline communication via fax/email please notify your Provider Relations Service Representative.