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 SIHO in this manner. If you wish to decline communication via fax/email please notify your Provider Relations Service Representative.

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