SuburbanHealth Organization

Provider Enrollment Form

Date:	Completed by:
Phone:	Email:

Reason for submission of below information:	
☐ New provider joining group	☐ Current provider adding new group
☐ New Physician Extender (ex: PA, NP, etc.)	☐ Other:

A copy of the W-9 Form ***MUST* be attached to this form**

Section 1: Provider Information				
Physician Name:	Last	First	Middle	
Date of Birth:				
Gender:	☐ Female ☐ Male			
Provider Designation:	☐ MD ☐ DO	☐ DPM	☐ Fellow	
	☐ NP ☐ PA	☐ CRNA	☐ Other	
Provider Type:	☐ Primary Care Provider	☐ Specialist		
Practicing Specialty:				
Provider Numbers:	National Provider Identification (NPI):			
	CAQH Number:			
	Social Security Number: (optional if providing CAQH Number)			
Hospital Information:	Hospital Affiliation(s):			
	Hospital Employed:	☐ Yes ☐ No If yes, which hospital?		

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Section 2: Group, Practice and Billing Information		
Group Name:		**TIN:**
Group NPI:		
Start Date:		
Practice Name:		
Practice Address	Address 1:	
	Address 2:	
	City:	
	State:	Zip:
	Phone:	Fax:
Office Manager Information	Name:	
	Phone:	Fax:
	Email Address:	

☐ **Please check here if the Billing Contact Information is the same as the Practice Contact Information**		
Billing Address	Address 1:	
	Address 2:	
	City:	
	State:	Zip:
Billing Contact Information	Name:	
	Phone:	Fax:
	Email Address:	