



MANAGED HEALTHCARE NORTHWEST, INC.

422 E. BURNSIDE, SUITE 215, PO BOX 4629, PORTLAND, OREGON 97208-4629
(503) 413-5800 FAX (503) 413-5801

Additional Information

CONFIDENTIAL

Name of Applicant _____
Last First Middle Initial Degree (s)

NPI# _____ SSN# _____ DOB: _____

Provider directory specialty listing preferred:

Languages Applicant speaks fluently: _____

Primary Practice Information:

Secondary Practice Information:

(Primary Clinic Name)

(Secondary Clinic Name)

(Street)

(Street)

(City, State, Zip)

(City, State, Zip)

(Telephone)

(Telephone)

(Fax no.)

(Fax no.)

Primary Practice Tax ID #: _____

Secondary Practice Tax ID#: _____

Check if Billing Address is same as above:

Check if Billing Address is same as above:

Type of Practice (Primary Office):

Type of Practice (Secondary Office):

Solo Partnership Corporation Hospital Employee

Solo Partnership Corporation Hospital Employee

*** Please list practice information for additional office's on a separate piece of paper and attach to this form***

Name of Authorized Contract Signer: _____

Name of Credentialing Contact: _____

Phone _____ Fax _____

Phone _____ Fax _____

Address (if different from practice address):

Address (if different from practice address):

Street _____

Street _____

City, State, Zip _____

City, State, Zip _____

Email _____

Email _____

If Billing Information is different from Primary Practice information, please indicate:

Billing Office Name _____

Street _____

City, State, Zip _____

Billing Contact Name _____ Phone _____

Email _____ Fax _____