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:

_____
(Primary Clinic Name)
_____
(Street)
_____
(City, State, Zip)
_____
(Telephone)
_____
(Fax no.)

Primary Practice **Tax ID #**: _____
Start date @ this location: _____

Check if Billing Address is same as above: ☐
Type of Practice (Primary Office): Hospital ☐
Solo ☐ Partnership ☐ Corporation ☐ Employee ☐

Secondary Practice Information:

_____
(Secondary Clinic Name)
_____
(Street)
_____
(City, State, Zip)
_____
(Telephone)
_____
(Fax no.)

Secondary Practice **Tax ID #**: _____
Start date @ this location: _____

Check if Billing Address is same as above: ☐
Type of Practice (Secondary Office): Hospital ☐
Solo ☐ Partnership ☐ Corporation ☐ 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: _____
Phone _____ Fax _____
Address (if different from practice address):
Street _____
City, State, Zip _____
Email _____

Name of Credentialing Contact: _____
Phone _____ Fax _____
Address (if different from practice address):
Street _____
City, State, Zip _____
Email _____

If Billing Information is <u>different</u> from Primary Practice information, please indicate:

Billing Office Name _____
Street _____
City, State, Zip _____
Billing Contact Name _____ Phone _____
Email _____ Fax _____