915.532.3778 • Fax: 915.298.7870 • contracting_dept@elpasohealth.com

PROVIDER DEMOGRAPHIC FORM

Group/Facility Name: _____

Group/Facility Specialty: _____

Tax ID: _____ Group NPI: _____ Group TPI: _____

Program Participation: ☐ Medicaid ☐ CHIP ☐ CHIP Perinatal ☐ Preferred Administrators ☐ Health Care Options

Please check off provider type: ☐ PCP ☐ Specialist ☐ PCP/Specialist ☐ Hospital Based

Last Name: _____ First Name: _____ Middle: _____

Individual NPI: _____ API: _____ TPI: _____ EPSDT: _____

Specialty: _____ Subspecialty: _____ Medical License: _____

Professional Category: ☐ MD ☐ DO ☐ FNP ☐ ACNP ☐ PA ☐ CRNA ☐ Other: _____

Primary Practice Address: _____

City, State, ZIP: _____ Office Hours/Days: _____

Phone: _____ Fax: _____ Website URL: _____

Secondary Location: _____ City, State, ZIP: _____

Office Hours/Days: _____ Phone: _____ Fax: _____

Taxonomy number: _____ Additional Taxonomy Numbers: _____

Languages Spoken: ☐ English ☐ Spanish ☐ American Sign Language (ASL) ☐ Other: _____

Accepting New Patients: ☐ Yes ☐ No ☐ Established Only ☐ Age Range: _____

Practice Limitations: ☐ Male only ☐ Female Only ☐ None ☐ Other: _____

CLIA Type: _____ Radiology Certificate: ☐ Yes ☐ No ☐ N/A

Completed cultural diversity training? ☐ Yes ☐ No

Do you offer: ☐ Telemedicine ☐ Telehealth ☐ Telemonitoring ☐ Targeted Case Management

Does this office meet American Disabilities Act (ADA) accessibility requirements? ☐ Yes ☐ No

Billing Information **(Must Reflect W-9)**: _____

Doing Business As: _____

Pay to Address: _____ Tax ID: _____

Primary Contact: _____ Phone: _____ Email: _____

Reason for submission: _____

FOR OFFICE USE ONLY: ☐ New Load ☐ Update ☐ Term Effective Date: _____

Provider Type Code: _____ Provider Specialty Code: _____ Sub Specialty: _____ LTSS X Code: _____

Products: ☐ STAR w TPI ☐ STAR w/o TPI ☐ CHIP ☐ CHIP Perinatal ☐ STAR+PLUS ☐ TPA ☐ HCO ☐ CM

Contract Type: ☐ Individual ☐ Group ☐ Ancillary/Facility ☐ Amendment ☐ LOA ☐ Par ☐ Non Par

Comments: _____