

CLINICAL STAFF ADD FORM - PHYSICAL HEALTH

Please complete this form to add a provider from your practice or organization. To submit this form, download it to your computer, complete and save, and attach it to an **email to:** providernetworkservices@coaccess.com. You may also **fax:** 303-755-2368, or **mail:** Colorado Access, Attn: Provider Network Services, PO Box 17580, Denver, CO 80217-0580.

Fields in bold and with an asterisk (*) are required. The form may be denied if any required field is missing data.

*Office's legal name:		
Doing Business As (DBA) office name (if different than legal):	*Tax ID number:	
Office contact name:	Office contact email:	
*Provider last name:	*Provider first name:	Provider MI:
*Provider NPI:	Provider effective date:	CAQH# (please ensure profile is current):
Provider date of birth:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Other <input type="checkbox"/> X	*Degree/suffix:
Practicing Specialty:		
*Is provider practicing ONLY in an inpatient/hospitalist or locum tenens capacity? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Professional liability insurance requirements: \$1,000,000 each occurrence, \$3,000,000 aggregate. Please ensure a current copy is in the CAQH account profile.		

Addresses

<input type="checkbox"/> Affiliate provider with all location NPIs under this tax ID number		
*Primary service location name:	*Service location address:	*Service location NPI:
*Is the service location NPI the same as the billing NPI? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, billing NPI:	
Service location primary phone number:	Service location primary fax:	
Additional service location name:	Service location address:	Service location NPI:
Additional service location name:	Service location address:	Service location NPI:
*Mailing address:		
Does the provider practice at more than three locations for this TIN? Include this data on the CAQH and/or attach as a separate spreadsheet.		

SUBMIT