

Cedar Health Network Provider Application Form

Attached to this PAIF form, please included all documents listed below upon return:

- Completed Provider Information Form (PAF)
- W-9 (should match box 33 of CMS form)
- Physician Roster (attached OR fill in item C)
- Service Inventory (additional services provided by group or physician)

PROVIDER INFORMATION

Contract Name (Provider, should match W-9):	Is Provider Contracted With: Anthem/Blue Cross: ☐ Yes ☐ No
Contract Specialty:	Multiplan: ☐ Yes ☐ No First Health: ☐ Yes ☐ No

CONTRACT & CREDENTIALING INFORMATION

Contact Name:	Email:	Phone:
Credentialing Person:	Email:	Phone:

A. LIST OF ALL PROVIDER LOCATIONS

1	Address:	Suite:	City:	State:	Zip Code:	Phone:	Fax:
2	Address:	Suite:	City:	State:	Zip Code:	Phone:	Fax:
3	Address:	Suite:	City:	State:	Zip Code:	Phone:	Fax:

B. LIST OF ALL HOSPITAL PRIVILEGES

1	Hospital Name:	Address:
	City:	State:
	Zip Code:	Phone:
	Fax:	
2	Hospital Name:	Address:
	City:	State:
	Zip Code:	Phone:
	Fax:	
3	Hospital Name:	Address:
	City:	State:
	Zip Code:	Phone:
	Fax:	

C. LIST OF ALL PROFESSIONAL(S) THAT ARE ACTIVE WITH THIS PROVIDER

1	Name:	Specialty Type/LIC:	Employed or Contracted:	Pt. Age Min-Max:	CAQH #:
2	Name:	Specialty Type/LIC:	Employed or Contracted:	Pt. Age Min-Max:	CAQH #:
3	Name:	Specialty Type/LIC:	Employed or Contracted:	Pt. Age Min-Max:	CAQH #: