

Date: _____

Provider Interest Form

**** W9 is required when returning****

Provider Demographics

Provider Name: _____ Tax ID: _____

NPI: _____ Primary Specialty: _____ Secondary Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

Provider Type

PCP: Specialist: Ancillary: Behavioral Health: Hospital Based: Other:

Is this a group? Yes No

Group Name (if applicable): _____ Group Tax ID _____ Group NPI: _____

Days/Hours of Operation: _____

Hospital Privileges

Do you have hospital privileges: Yes: No:

Please list Hospitals: _____

If no, please explain how you will handle hospital admissions: _____

Service Information:

Languages spoken:

English: Spanish: Other (please list): _____

Services Provided to:

Children: Adults: Age Range: _____

Contact Information:

Contact Name: _____ Telephone: _____ Fax: _____

Email: _____

Please submit this form to nc-providers@fridayhealthplans.com with the subject line "Provider Interest Form."