friday health plans of North Carolina, inc.
700 Main Street
Alamosa, CO 81101

fridayhealthplans.com
844-465-5500

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.”