Provider Information Form

This Box for PHC Use Only
Contract Initials: _____
INV #: _____

Partnership Healthplan of California (PHC) reserves the right to determine network participation.

Purpose for this request:	☐ New Contract	☐ New Site	☐ Ownership/Acquisition

PRIMARY LOCATION			
Legal Name:			
Site/DBA Name:			
Site Specialty:			
NPI:		TIN:	
Address:			
City:	State:	Zip:	County:
Medi-Cal Status:	☐ Medi-Cal Approved	☐ Application Submitted	☐ Other (See Notes)
Phone Number:		Fax Number:	
Note:			

SECONDARY LOCATION			
Legal Name:			
Site/DBA Name:			
Site Specialty:			
NPI:		TIN:	
Address:			
City:	State:	Zip:	County:
Medi-Cal Status:	☐ Medi-Cal Approved	☐ Application Submitted	☐ Other (See Notes)
Phone Number:		Fax Number:	
Note:			

DATA VERIFICATION

I hereby affirm that the information submitted in this application is correct and complete to the best of my knowledge and belief, and furnished in good faith.

Printed Name of Person Completing Form: _____ Date: _____

Signature: _____ Title: _____

Contact Email: _____ Contact Phone: _____

Instruction:
1. Download and save the form to your PC
2. Fill out and sign
3. Email the completed form to **Contracting@partnershiphp.org**