Provider Information Sheet

Provider First Name _____

Provider Middle Name _____

Provider Last Name _____

Gender _____

Degree _____

Social Security Number _____

Provider Type _____

Specialty _____

Practice Location _____

Mailing Address _____

Office Contact Name _____

Office Phone Number _____

Office Email _____

Tax Number _____ **DEA Number** _____

State of Illinois License Number _____

NPI Number _____ **UPI Number** _____

Board Certified Yes or No (Please circle one)

Effective Date _____

Initial Credential Approval Date _____

Name of Affiliation _____

Hospitals where you have admitting privileges _____

_____

Date _____

Name and title of person completing this form _____

_____