PROVIDER PROFILE INFORMATION FORM

Information listed on this profile sheet will assist in accurately maintaining provider information in the Cedar Network Directory. Please type or print legibly. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please refer to the following list of required documents to be submitted with this form.

* IRS Form W9, signed and dated
* Evidence of Board Certification
* State Medical License(s) to practice
* Drug Enforcement Administration Certificate
* Malpractice Insurance Face Sheet
* Summary of any pending or settled malpractice cases
* Current Professional Liability Insurance Policy face sheet, showing expiration dates, limits, and provider’s name

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| **PHYSICIAN / PROVIDER INFORMATION** | | | | | | | | | | |
| First Name: | | MI: | Last Name: | | | | Degree: | | | |
| Is there any other name under which you have been know? Name(s): | | | | | | | | | | |
| Address: | STREET: |  |  |  |  |  |  |  |  |  |
| CITY: | | | | | | | | STATE: | | ZIP CODE: |
| Telephone #: | | Fax #: | | | | Physician Email: | | | | |
| Applying as: | * PCP ☐ Specialist ☐ Urgent Care | | | Gender (optional): | | | | | Date of Birth (MM/DD/YYYY): | |
| Primary Specialty: | | Subspecialties: | | | | | | | | |
| Social Security #: | | Non-English Language(s) Spoken: | | | | CAQH Provider ID #: | | | | |
| Tax ID #: | | Issue Date (MM/YYYY): | | | | Expiration Date (MM/YYYY): | | | | |
| Tax ID Legal Name: | | | | | | | | | | |
| **MEDICAL LICENSURE & CERTIFICATIONS** | | | | | | | | | | |
| DEA #: | | Effective Date (MM/YYYY): | | | | Expiration Date (MM/YYYY): | | | | |
| State Medical License #: | | Effective Date (MM/YYYY): | | | | Expiration Date (MM/YYYY): | | | | |
| Individual NPI #: | | | | | Board Certified ☐ Yes ☐ No | | | | | |
| Name of Certifying Board: | | | | | | | | | | |
| Issue Date (MM/YYYY): | | | | | Expiration Date (MM/YYYY): | | | | | |
| Secondary Specialty: | | | | | Board Certified ☐ Yes ☐ No | | | | | |
| Name of Certifying Board: | | | | | | | | | | |
| Issue Date (MM/YYYY): | | | | | Expiration Date (MM/YYYY): | | | | | |
| Additional Specialty: | | | | | Board Certified ☐ Yes ☐ No | | | | | |
| Name of Certifying Board: | | | | | | | | | | |
| Issue Date (MM/YYYY): | | | | | Expiration Date (MM/YYYY): | | | | | |
| **HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS** | | | | | | | | | | |
| Hospital Privileges ☐Yes ☐No | | Primary Hospital Admitting Privileges: | | | | | | | | |
| Privilege Status (active, provisional, courtesy, temporary, etc.): | | | | | | | | | | |

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For members of

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| List Other Hospitals Admitting Privileges: | | | | | | | | | | |
| Other Hospitals Privilege Status (active, provisional, courtesy, temporary, etc.): | | | | | | | | | | |
| **OFFICE/PRACTICE INFORMATION** | | | | | | | | | | |
| * I am a solo practitioner billing under an individual Tax ID Number * We are a group practice with multiple providers billing under a single Tax ID number. (Please attach a roster) | | | | | | | | | Accepting **new** members?   * Yes ☐ No | |
| Type of Practice (check all that apply):   * Solo Practice ☐Group Practice ☐Group Specialty Group ☐Group Multi-Specialty ☐Urgent Care | | | | | | | | | | |
| Practice/Medical Group Name to Appear in Directory: | | | | | | Group NPI #: | | | | |
| Primary Office Physical Address: | | | | | | | | | | |
| CITY: | | | | | | | | STATE: | | ZIP CODE: |
| Telephone #: | | Fax #: | | | Email: | | | | | |
| Website (if applicable): | | | | | | | | | | |
| Primary Office Hours of Operations: | | | | | | | | | | |
| Non-English Language(s) Spoken by Office Personnel: | | | | | | | | | | |
| Billing Address:  (if applicable) | STREET: |  |  |  |  |  |  |  |  |  |
| CITY: | | | | | | | | STATE: | | ZIP CODE: |
| Email (where correspondence to be sent) | | | | Digital Contact Information (individual and/or facility) | | | | | | |
| Supervising Physician Name (if applicable) | | | | | | | | | | |
| Credentialing Contact Name: | | | Telephone #: | | | | Email: | | | |
| Office Manager or Staff Contact Name: | | | Telephone #: | | | | Email: | | | |
| Billing Company’s Name (if applicable): | | | Telephone #: | | | | Email: | | | |
| Secondary Practice Address (if applicable or provide separate list for additional offices) | | | | | | | | | | |
| CITY: | | | | | | | | STATE: | | ZIP CODE: |
| Telephone #: | | | Fax # | | | | Email: | | | |
| **PROFESSIONAL LIABILITY INSURANCE COVERAGE** | | | | | | | | | | |
| Malpractice Insurance Carrier Name: | | | | | | | | | | |
| Policy #: | | | Effective Date (MM/DD/YYYY) | | | | | Expiration Date (MM/DD/YYYY) | | |
| Telephone #: | | | Type of Coverage   * Shared ☐Individual | | | | | Length of Time with Carrier | | |

Provider Representative Signature: Date: