GROUP ADD REQUEST FORM

DATE: ______________

PRACTICE NAME: ____ **TAX ID** ________________

CREDENTIALING CONTACT / ADDRESS:

CONTACT / TITLE ____

ADDRESS ____
Street City ST Zip

PHONE ________________ FAX ______________ EMAIL ______________________

INFORMATION ABOUT PROVIDER BEING ADDED TO PRACTICE:

PROVIDER NAME: ____

SPECIALTY 1: ________________________ **SPECIALTY 2.** ________________________

START DATE WITH GROUP: ____________________ **NPI#:**________________________

PRACTICE LOCATION(S) ADDRESS:

[1] ADDRESS: ____
☐ Inpatient only
Street
____
City ST Zip Phone Fax

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[2] ADDRESS: ____
☐ Inpatient only
Street
____
City ST Zip Phone Fax

---

[3] ADDRESS: ____
☐ Inpatient only
Street
____
City ST Zip Phone Fax

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[4] ADDRESS: ____
☐ Inpatient only
Street
____
City ST Zip Phone Fax

UPON COMPLETION, PLEASE FAX TO ONEHEALTH AT: 775-982-8003

8930 W. Sunset Rd., #200 Las Vegas, NV 89148
Phone: 702-997-0079 Fax: 775-982-8003