CHCN Provider Add Form

This form is for CHCN contracted groups that need to add a new individual specialty provider under their contract/MOU. Please complete this form to add a new individual provider specialist and submit it to **providerservices@chcnetwork.org** or fax to **510-297-0445**.

To report new multiple providers (more than 5), please use the ***CHCN Provider Roster Form for Contracted Providers*** found in our provider portal: https://connect.chcnetwork.org/Provider-Library/Provider-Relations

*Please note that providers must be credentialed with Alameda Alliance for Health (AAH) for them to be added as contracted. (This does not apply to MOU participating providers)

For any questions, please contact Provider Services at **providerservices@chcnetwork.org.**

Group Information	
Today's Date:	
Name/title of the person completing this form:	
Group/Business Name:	
Tax ID:	
Organizational NPI:	
Contact Name:	
Contact's Title/Position:	
Contact's Phone:	
Contact's E-mail:	
New Provider Information	
Provider's effective date with Group:	
Provider's Name:	
Provider's DOB:	
Provider's NPI:	
Specialty:	
Sub-specialty:	
Area of focus:	
Age range of patients served:	☐ Pediatrics Age range: ____________ ☐ Adults Age range: ____________
CA Medical License Number/Expiration Date:	Medical License #: ____________ Medical License Expiration Date: ____________

Alameda Alliance for Health(AAH) Credentialing Status?	☐ Completed ☐ Pending ☐ Not yet started If AAH credentialing is complete, please provide AAH Credentialing Effective Date:_______________
Hospital Privileges/Privilege Type	Hospital Name: Privilege Type (Full, Other, etc.): Primary: ________________________ ____________________________ Secondary: ______________________ ____________________________ Third: __________________________ ____________________________
Ambulatory Surgery Center Affiliation	Center Name: 1. ____ 2. ____
Primary Practice Location: (Address & Street)	
City, State and Zip:	
Phone:	
Fax:	
Office E-mail Address:	
Hours of operation:	
Secondary Practice Location: (Address & Street)	
City, State and Zip:	
Phone:	
Fax:	
Office E-mail Address:	
Hours of operation:	
Language(s) Spoken by Provider:	
Additional Information/Restrictions:	
Information Confirmation Signature:	

To add additional office locations, attach a separate sheet.