Provider Demographic Form

Please complete all information so we can update your file correctly.

Name	Medical Degree	
Specialty	Board Certification	
Group Name	Primary Telephone	
Office/Physical Address	Mail Address (if different)	
Primary Email (Physician)	Languages Spoken	
NPI	DEA	
Tax ID (for claims payment) Please attach a W9	Tax ID (for shared savings payment) Please attach a W9	
Office Manager and Email	Credentialing Contact Name and Email	
Include in INTEGRIS Children's Directory? Yes No	Hospital Privileges	
Office Hours	Ages of Patients Accepted	PCP: Yes No

INTEGRIS

SUBMIT FORM VIA EMAIL

INTEGRIS Health Partners

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