INTEGRIS HEALTH Partners

Provider Add/Change Form

Instructions: Fill in all required fields (*). Attach W9 and malpractice certificate. For large groups, you may attach a list of providers or a roster. **Return this form to:** IHPCredentialing@integrishealth.org

Select Request Type:

☐ Add Provider (with INTEGRIS Privileges*)
☐ Add Location (to existing IHP provider)
☐ Change/Update Provider Information
☐ Term Location

Provider Information	
*Name:	
*Medical Degree:	Specialty:
*Provider NPI:	
Supervising Physician (APPs Only):	
Accepting New Patients? ☐ Yes ☐ No	PCP? ☐ Yes ☐ No
Provider Email:	
Credentialing Contact Name and Email:	

Group Information	
*Legal Group Name (as listed on W-9):	
*Tax ID (for claims payment):	EMR Type:

Location Information		
Office Name:		
Primary Location? ☐ Yes ☐ No	Term Location? ☐ Yes ☐ No	Term Date:
Office/Physical Address:		
Mailing Address: (if different)		
Telephone:	Fax:	
Office Manager Name and Email:		
Location Start Date: (This will not be the IHP effective date):	Office Hours:	
*In good standing with state and federal regulatory bodies? ☐ Yes ☐ No	Date of last survey:	

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Location Information		
Office Name:		
Primary Location? ☐ Yes ☐ No	Term Location? ☐ Yes ☐ No	Term Date:
Office/Physical Address:		
Mailing Address: (if different)		
Telephone:	Fax:	
Office Manager Name and Email:		
Location Start Date: (This will not be the IHP effective date):	Office Hours:	
*In good standing with state and federal regulatory bodies? ☐ Yes ☐ No	Date of last survey:	

Location Information		
Office Name:		
Primary Location? ☐ Yes ☐ No	Term Location? ☐ Yes ☐ No	Term Date:
Office/Physical Address:		
Mailing Address: (if different)		
Telephone:	Fax:	
Office Manager Name and Email:		
Location Start Date: (This will not be the IHP effective date):	Office Hours:	
*In good standing with state and federal regulatory bodies? ☐ Yes ☐ No	Date of last survey:	

Attestation	
*Form Completed By:	
*Title:	*Date:
*Please ensure you have attached the following items: ☐ Complete W9 ☐ Current Malpractice Certificate	

* If you are using this form to apply for IHP through your hospital privileges, please note that the information provided to INTEGRIS Health, Inc. for the purpose of privileging may be shared with IHP to fulfill their credentialing requirements. As a provider or applicant of IHP, you have certain rights and protections during the IHP credentialing and re-credentialing process. You can find more information on these rights by visiting https://integrishealth.org/ihp/prospective-providers and reading the IHP Credentialing Plan, Policies, and Procedures. If you have any questions regarding IHP Credentialing, feel free to contact IHPCredentialing@integrishealth.org. Please note that the INTEGRIS Hospital bylaws to which you are applying may differ from the IHP Credentialing Plan Policies and Procedures.