



101 SE Third Street  
 Evansville, IN 47708  
 Phone: 812-426-6600  
 Fax: 716-541-6362

**NEW PROVIDER APPLICATION**

Listed below is the information required to submit to the WHP Network Strategy Committee who will review your request to become a participating provider. Please complete a separate form if more than one provider is in the practice or you have multiple locations.

Please note providers are not considered participating in the WHP network until credentialing is complete. All questions regarding credentialing should be directed to Vicki Mendel at mendelv@welbornhealthplans.com

**PRACTICE OR FACILITY NAME:** \_\_\_\_\_

**PARENT COMPANY NAME (if applicable):** \_\_\_\_\_

**PROVIDER NAME (including MD, DO, NP, etc.):** \_\_\_\_\_

**GRP NPI#:** \_\_\_\_\_ **IND NPI#:** \_\_\_\_\_

**COI (Certificate of Insurance):** \_\_\_\_\_

**TAX ID #:** \_\_\_\_\_ **DEA #:** \_\_\_\_\_

**STATE LICENSE #:** \_\_\_\_\_ **MEDICARE #:** \_\_\_\_\_

**COMPLETED RESIDENCY:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **BOARD CERTIFIED in:** \_\_\_\_\_

If not board certified, is provider willing to obtain 150 hours of CMEs?  Yes  No

<b>PRACTICE ADDRESS:</b>		<b>BILLING ADDRESS:</b>	
Practice Name:	_____	Pay to/Remit to:	_____
Address:	_____	Address:	_____
City, ST, ZIP:	_____	City, ST, ZIP:	_____
Telephone:	_____	Telephone:	_____
Fax:	_____	Fax:	_____
Office Manager:	_____	Billing Manager:	_____
E-mail:	_____	E-mail:	_____
Effective Date:	_____	Effective Date:	_____

**DO YOU BILL ON A HCFA 1500 OR UB-92?** \_\_\_\_\_

**SPECIALTY:** \_\_\_\_\_ **FOREIGN LANGUAGES:** \_\_\_\_\_

**COVERING PROVIDERS:** \_\_\_\_\_  
 (Who covers for provider in his/her absence - Please state if cross coverage)

**HOSPITAL PRIVILEGES:** \_\_\_\_\_

**MEMBER OF NETWORKS:** \_\_\_\_\_  
 (Other insurances provider is contracted with, please list 4-5)

**NAME & TITLE OF PERSON MAKING REQUEST:** \_\_\_\_\_

⇒ Please attach a W-9 and a completed claim form with patient information blackened out.