Diversified
HEALTH CARE MANAGEMENT

PRACTICE NAME:_____		
PROVIDER INFORMATION		
First Name:	**Middle Initial:**	**Last Name:**
Other Name-First:	**Middle Initial:**	**Last Name:**
Type of Other Name: __ Former or Maiden Name __Professional Name __Other (describe)_____		
Date of Birth:	**City & State of Birth:**	**Country of Birth:**
Gender: ___Female ___Male	**SSN:**	**NPI:**
Specialty:	**Subspecialty:**	**CAQH ID:** **Password:**
Medicare ID:	**Medicaid ID:**	**DEA:**
Home Address:	**Phone:** **Cell:**	**E-mail:**
	EDUCATION INFORMATION	
Undergraduate School:	**Year of Graduation:**	**Degree:**
Medical or other Professional School:	**Year of Graduation:**	**Degree:**
Internship:	**From:** **To:**	
Residency:	**From:** **To:**	**Specialty:**
Fellowship:	**From:** **To:**	**Specialty:**

BOARD CERTIFICATION	
Name of Issuing Board:	**Specialty:**
Effective Date:	**Expiration/Renewal Date:**

IMPORTANT: Diversified Health Care Management will not begin billing your professional charges until we have all required paperwork and provider specific identifiers on file. Please be thorough in completing all paperwork.

Please provide copies of, or answer, the following:

- **Medical/Professional School Degrees/Diplomas**
- **Board Certification**
- **Professional License(s)**
- **CV**
- **DEA**
- **Certificate of Professional Liability Insurance Coverage**
- **NPI Notification, User Name & Password to access**
- **Professional Sanctions, Criminal, Litigation, Malpractice Actions (if any)**
- **CAQH ID & Password**
- **PECOS User ID & Password**
- **Medicare Welcome Letter**
- **Effective Date of Employment**