CARECORE NATIONAL NPI INTAKE FORM

All fields required. Please print

CCN Practice/ Site ID_____

Radiology GroupPractice/ Group Name_____

Practice/ Group *NPI _____ **Tax ID Number** _____

Facility Name (specify if different than Practice/Group Name) _____

Facility *NPI (if different than Practice/ Group NPI) _____

First Name	Last Name	NPI #	License #	UPIN	P# CCN Internal Use

For additional providers please duplicate and attach the NPI Intake Form. Please return completed form to the Credentialing Department via fax to 8452988384. Completed by

(print)_____Title:_____ Email:_____

Signature:_____ Telephone:_____ Date:_____