



PHYSICIAN INFORMATION FORM

Please complete the form below and return with all required documentation to:
CareCore National, LLC
Attention Credentialing Department
400 Buckwalter Place Boulevard
Bluffton, SC 29910

Or fax all documentation to CCN Credentialing Department at 845-298-8384.
If you have questions, contact the CCN Credentialing Department at 800-918-8924,
ext 10190.

Revised 11.06.2007

I. PHYSICIAN INFORMATION

Name: _____ Gender (M/F): _____
Last, First Middle

Practice Name: _____ CCN ID#: _____

Practice Address: _____

City, St., Zip: _____

Contact Name: _____ Phone #: _____

Effective Date of Physician Practice: _____ Fax#: _____

LICENSING INFORMATION: ** COPY REQUIRED**

State	License Number	Date of Expiration

Federal UPIN # _____ Medicare Provider #: _____ ECFMG ID #: _____

Federal DEA # _____ (Include Current Copy, if available)

National Provider Identifier (NPI) ID # _____

Attach copy of National Provider Identifier notification received from National Plan & Provider

Enumerator System (NPPES)

PHYSICIAN'S SPECIALTY: _____

CERTIFICATION STATUS: **COPY REQUIRED**

1.) Certified by * American Board of _____ Date: _____

2.) If not yet certified, completion date of most recent accredited training program _____

3.) Fellowship Training in sub-specialty (list) _____

II. MEMBERSHIP (Hospital Staff - Present)

Hospital _____ Date: _____

Position (indicate department): _____

Street address _____

City _____ State _____ Zip _____

Department chairman _____ Tel. # _____

Senior attending _____ Tel. # _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE.

SIGNATURE: _____ DATE: _____
(Physician signature required)

NAME (Please print): _____

***LEAD PHYSICIAN OR PRACTICE MANAGER MUST ALSO SIGN*:**

SIGNATURE: _____ DATE: _____

NAME (Please print): _____

TITLE/ POSITION: _____