CAQH APPLICATION AUTHORIZATION REQUEST FORM

PROVIDER NAME:

Last Name MI First Name Degree

Organization Name

NPI: **CAQH#:**

Tax ID: **License #:**

Home Visit: ☐ Yes ☐ No

Mailing Address:

Identify all practice locations that should be listed on our provider directory?

Specialist ☐ **PCP** ☐

Specialist ☐ **PCP** ☐

Specialist ☐ **PCP** ☐

Provider Contact Name:

Email **Phone Number**

Credentialing Contact Name:

Email **Phone Number**

***By signing here you authorize Network Solutions IPA care to attain the information you have posted on CAQH for the purposes of credentialing, and to proceed with the contracting processes.**

Signature: _____

Date: / /

ADDITIONAL INFORMATION REQUESTED:

DISCLOSURE OF OWNERHIP (If different) _____

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