Practitioner Credentialing Request Form – Individual Practitioner

Send inquiries and completed form to: cchp-credentialing@chorushealthplans.org

*Required fields in **bold blue**.

Date submitted:		
Requester's Name:		
Requester's Title:		
Requester's Email:		
Requester's Phone:	Fax:	

Practice Name:		
Practice Address:		
Practice NPI:		
TIN:		
City:	State:	Zip:
Phone:	Fax:	

Effective Date:		
Practitioner Name:		
NPI:	**CAQH#**	
Licensure#:	Other Lic#:	
Specialty:	**Gender:**	
Collaborative Physician (for APNPs only)		

Additional Practice Location

Address:		
City:	State:	Zip:
Phone:	Fax:	
Email:		

Additional Practice Location

Address:		
City:	State:	Zip:
Phone:	Fax:	
Email:		

Should you have additional locations, please use the comments section or include an additional page as needed

Comments: