Practitioner Credentialing Request Form

Please complete this form to request credentialing for an individual practitioner and email it to cchp-credentialing@chorushealthplans.org.

***Required fields in bold.**

Date Submitted:		**Requestor's Email:**	
Requestor's Name: Title:		Phone: Fax:	
Practice Name:			
Practice Address:		**Practice NPI:**	**Effective Date:**
City:	State:	Zip:	
Phone:	Fax:	**TIN:**	
Practitioner Name:		**NPI:**	**CAQH#:**
Licensure#:		**Specialty:**	
Other Lic#	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:	
Comments:			

Please submit any questions to the email addresses listed above. Thank you.