

Physician Information Form

Please contact Provider Relations for questions while completing this form.
e-mail: provider.contracting@fidelissc.com

Physician Location and Specialty Information

Primary Location:		Directory Listing: Y or N
Name: _____ (dba): _____		Tax ID: _____
Address: _____		Group NPI: _____
_____		Individual NPI: _____
Phone: _____	Fax: _____	Medicare ID: _____ Medicaid ID: _____
Office Contact: _____		Credentialing Contact: _____
Office E-Mail: _____		E-Mail: _____

I will service your members as: <input type="checkbox"/> Primary Care Physician <input type="checkbox"/> Specialist <input type="checkbox"/> Mid-Level <input type="checkbox"/> Other: _____	I would like to be listed in the Directory as: Primary Specialty: _____ Sub-Specialty: _____	I will submit my Credentialing Application by: <input type="checkbox"/> Completing a State Mandated Credentialing Application <input type="checkbox"/> CAQH Provider ID: _____
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Service Counties:

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|----------------------------------|----------------------------------|------------------------------------|-----------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Allegan | <input type="checkbox"/> Genesee | <input type="checkbox"/> Kalamazoo | <input type="checkbox"/> Macomb | <input type="checkbox"/> Oakland | <input type="checkbox"/> Washtenaw |
| <input type="checkbox"/> Bay | <input type="checkbox"/> Jackson | <input type="checkbox"/> Kent | <input type="checkbox"/> Muskegon | <input type="checkbox"/> Saginaw | <input type="checkbox"/> Wayne |

Additional Location(s):

Remittance Location:	Alternate Location:	Directory Listing: Y or N
Address: _____ Phone: _____	Address: _____ Phone: _____	
_____ Fax: _____	_____ Fax: _____	
Billing Contact: _____	Office Contact: _____	
E-Mail: _____	Phone: _____	
Alternate Location:	Alternate Location:	Directory Listing: Y or N
Address: _____ Phone: _____	Address: _____ Phone: _____	
_____ Fax: _____	_____ Fax: _____	
Office Contact: _____	Office Contact: _____	
Phone: _____	Phone: _____	

Please return completed form to: Provider Relations
 Fax: (866) 852-3141
 e-mail: provider.contracting@fidelissc.com
 Mail: 20 N. Martingale Road, Suite 180
 Schaumburg, IL 60173

Completed By: _____
 Title: _____ Date: _____

Please assist us with having the most accurate and up-to-date information by completing this form and returning it to us promptly. You may also submit future changes to provider.contracting@fidelissc.com.