

Physician Information Form

Please contact Provider Relations for questions while completing this form.
Phone: (877) 372-6200 or
e-mail: provider.contracting@fidelissc.com

Physician Location and Specialty Information

Location: _____	Type: Primary or Remittance	Directory Listing: Y or N
Name: _____ (dba): _____	Tax ID: _____	
Address: _____	Phone: _____ Fax: _____	NPI: _____
	Office Contact: _____	Medicare ID: _____
Billing Contact: _____	E-Mail: _____	Medicaid ID: _____
Credentialing Contact: _____	Phone: _____	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: 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: _____ <input type="checkbox"/> Please send me a CAQH "Start-Up" kit.
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Service Counties:

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| <input type="checkbox"/> Alamance | <input type="checkbox"/> Davidson | <input type="checkbox"/> Durham | <input type="checkbox"/> Guilford | <input type="checkbox"/> Mecklenburg | <input type="checkbox"/> Stanly | <input type="checkbox"/> Wake |
| <input type="checkbox"/> Cabarrus | <input type="checkbox"/> Davie | <input type="checkbox"/> Forsyth | <input type="checkbox"/> Iredell | <input type="checkbox"/> Rowan | <input type="checkbox"/> Union | |

Additional Location(s):

Type: Remit To	Type: Primary or Alternate Directory Listing: Y or N
Address: _____ Phone: _____	Address: _____ Phone: _____
_____ Fax: _____	_____ Fax: _____
Office Contact:	Office Contact:
Name: _____ E-Mail: _____	Name: _____ E-Mail: _____
Type: Primary or Alternate Directory Listing: Y or N	Type: Primary or Alternate Directory Listing: Y or N
Address: _____ Phone: _____	Address: _____ Phone: _____
_____ Fax: _____	_____ Fax: _____
Office Contact:	Office Contact:
Name: _____ E-Mail: _____	Name: _____ E-Mail: _____

Completed By: _____

Title: _____ Date: _____

Please return completed form to: Provider Relations
 Fax: (866) 852-3141
 e-mail: provider.contracting@fidelissc.com
 Mail: : 9300 Harris Corners Parkway, Suite 100
 Charlotte, NC 28269-3790

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 submit future changes to provider.contracting@fidelissc.com.