FIDELIS SecureCare™ The Essence of Care

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:	I would like to be listed in the Directory as:	I will submit my Credentialing Application by:
❒ Primary Care Physician ❒ Specialist ❒ Mid-Level ❒ Other: _____	Primary Specialty: _____ Sub-Specialty: _____	❒ Completing a State Mandated Credentialing Application ❒ CAQH Provider ID: _____

Service Counties:

❒ Alamance ❒ Cabarrus ❒ Davidson ❒ Forsyth ❒ Guilford ❒ Mecklenburg ❒ Stanly

Additional Location(s):

Remittance Location:

Address: _____ **Phone**: _____

_____ **Fax**: _____

Billing Contact: _____

E-Mail: _____

Alternate Location: **Directory Listing: Y or N**

Address: _____ **Phone**: _____

_____ **Fax**: _____

Office Contact: _____

Phone: _____

Alternate Location: **Directory Listing: Y or N**

Address: _____ **Phone**: _____

_____ **Fax**: _____

Office Contact: _____

Phone: _____

Alternate Location: **Directory Listing: Y or N**

Address: _____ **Phone**: _____

_____ **Fax**: _____

Office Contact: _____

Phone: _____

Completed By: _____

Title: _____ **Date:** _____

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

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.