

EL PASO FIRST

Health Plans, inc.

Telephone: (915) 532-3778, Fax: (915)532-2877

IMPORTANT: Completion of this form is not considered a binding contract with El Paso First. For more information on contract plans for participation please contact your Provider Relations Representative.

Demographic Information Form

Please Check off Health Plan Participation (Contract):

- Medicaid/Premier Plan HCO
 CHIP TPA (Preferred Admin)
 CHIP Perinate

Please check off Specialty Type:

- PCP Allied Health (PT,OT, ST, LPC)
 Specialist
 Ancillary (DME, Home Health, Facility)

Group/Facility Name

Group NPI:

Group TPI:

Group Tax-ID:

Provider Name (Last, First, Middle):

Professional Category:

- MD DO CRNA NP PA LPC
 Other :

Individual NPI:

Individual TPI: Pending (in process) Received and Attested

Primary Specialty:

Sub-Specialty:

Medical License:

If applicable EPSDT Number :

Provider Billing Information

W-9 must be submitted along with Demographic Information Form

Official Business Name (as it appears on W-9/IRS Documentation)

Doing Business As (if different from above) ***this information must match Box #33 on claim form*

Billing Address, City State and Zip Code:

Tax ID Number:

Information will be listed in Provider Directories

Primary Practice Location

Secondary Practice Location

Address:

Address:

City, Zip Code:

City, Zip Code:

Phone Number:

Fax:

Phone Number:

Fax Number:

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Languages Spoken: English Spanish

Accepting New Patients

Other

Established Patients Only

Practice Limitations: Male Only Female Only Age Range () Other

Office Days/Hours:

Office Days/Hours:

After Hours:

After Hours:

CLIA: Waiver Certificate

CLIA: Waiver Certificate

Laboratory: Yes No

Laboratory: Yes No

Please list a **primary office contact** for questions surrounding information provided on this form.

Primary Contact Person First and Last Name:

Phone Number:

email address:

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For EP First Provider Relations Staff Only: PR Rep Name: _____

Contract Request Date: / /

Verifications: W-9 NPPES TPI Look Up Other

Credentialed: YES NO (IN PROCESS) Date Application Submitted to Credentialing: / /

Contract Type: Individual Group Attachment D Ancillary Facility LOA

Plans: STAR CHIP CHIP Perinate HCO CM TPA Contract Received Date: / /

Configuration: System Data Analyst Name: _____ Date Entered in QNXT: / /

Claims: Claims Rep Name: _____ Date Submitted to Config: / /

Special Notes: