LOS ALAMOS
Physician & Hospital Organization

Member Information Sheet

(1) FULL NAME:_____ Licensure_____

(2) Practice Address:_____

(3) Secondary Practice Address (if applicable):_____

(4) Mailing Address:_____

(5) Billing/Claims Address:_____

(6) Office Phone:_____ Office Fax:_____

(7) Cell Phone:_____

(8) Email:_____Website:_____

(9) DOB:_____ SEX: M _____ F_____

(10) Specialty:_____

(11) Do you speak other languages? Y ____N____ If yes, which Languages? _____

(12) NAME or GROUP You Bill Under:_____

TIN You Bill Under:_____

TAXONOMY NUMBER:_____

IND. PROVIDER NPI#: _____

GROUP NPI#:_____

CHC or CAQH#: _____

STATE LICENCE NUMBER: _____ EXPIRATION:_____

DEA NUMBER: _____ EXPIRATION:_____

(13) MEDICAL SCHOOL (if applicable)_____ GRADUATION YR: _____

RESIDENCY: _____ DATE COMPLETED: _____

(14) BOARD CERTIFICATION:_____ EXPIRATION: _____

(15) Are you associated with a: Group____ Clinic____ Facility____ JOCHO Accredited: Y ____ N____

(16) Are you associated with a Hospital Affiliation: Y ____ N_____

(17) If offered by plan, how are you to be listed in the Provider Directory: PCP _____ Specialist _____ Hospitalist____

(18) Office Manager: _____ Office Hours:_____

Office Manager's email:_____ Phone:_____

PLEASE ATTACH A COPY OF CURRICULUM VITAE

_____ _____ _____

Signature (person completing this form) Printed name Date

EFFECTIVE DATE WITH PHO:_____

To be completed by PHO