LOS ALAMOS
Physician & Hospital Organization

Member Information Sheet

(1) FULL NAME: _____ TITLE:_____

(2) SS#: _____ DOB: _____

(3) EFFECTIVE DATE WITH GROUP:_____ SEX: M ___F___

(4) TAX I.D. NUMBER: _____

STATE LICENCE NUMBER: _____ EXPIRATION:_____

DEA NUMBER: _____ EXPIRATION: _____

PROVIDER NPI#: _____CHC or CAQH#: _____

(5) MEDICAL SCHOOL: _____ GRADUATION YR: _____

RESIDENCY: _____ DATE COMPLETED: _____

ATTACH A COPY OF CURRICULUM VITAE

(6) PRIMARY SPECIALITY: _____

(7) BOARD CERTIFICATION: _____EXPIRATION: _____

If offered by plan, listed in Provider Directory PCP ____ Specialist ____ Hospitalist ___

(8) Are you associated with a: Group__ Clinic__ Facility__ JOCHO Accredited: Y __N__

(9) Are you associated with a Hospital Affiliation: Y __N__

(10) Do you speak other languages? Y __N __ If yes, which Languages? _____

(11) PRACTICE NAME: _____

Primary Office Address:

_____

_____

Practice NPI: _____

Office Phone: _____

Office Hours: _____

Fax: _____

Office Manager: _____

Office Manager's email:

_____

Secondary Office Address (if applicable):

_____

_____

Practice NPI: _____

Office Phone: _____

Office Hours: _____

Fax: _____

Office Manager: _____

Office Manager's email:

_____

Billing Contact: _____

Billing Address: _____

_____

MEMBER'S EMAIL: _____

WEBSITE: _____

_____ _____ _____

Signature (person completing this form) Printed name Date

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