Fresenius Health Partners
PPO SNP
Accountable Kidney Care

Underwritten by Sterling Life Insurance Company

Participation Provider Change Form

Provider Name:___________________________ *Tax ID #: _______________ **(Attach W-9 Form)**

Company/Legal Name: ____

Please complete the following information if you are adding a new provider.

DOB: ___________SSN: ______________Title: (MD, DO, NP, etc): ___________Gender: _______

Specialty: __________________________Board Certification: ___________________________

Board Certification Eff Date _________________ Board Certification Exp Date___________________

Practice Name (if different than above): ____

Office Location(s) (attach listing if more than one): ______________________________________

City: ________________ State: ______ Zip: ________ County: ___________________________

Phone Number: ___________________________ Fax Number: ___________________________

Accepting New FHP Patients: ____ Not Accepting New FHP Patients: ____Office Hours: ______________

Credentialing Contact's Name: _______________ Email Address: ___________________________

Billing Address:____

____

Billing Phone Number: _________________ CAQH ID #: ______________________

Medicare Number:___________________________ NPI Number: _________________

Medicaid Number:___________________________ Group NPI #: _________________

License Number: ___________________________ State: ____ Expiration Date: _______

DEA Number: _____________________________ Expiration Date: _______________

Hospital Affiliation: ____

Medical Group Affiliations, if applicable: ____

Languages spoken by Provider or Clinical Staff: ___________________________________

____ ____________________

Authorized Signature Date

Please complete a form for each Provider and Mail, Fax or Email to:
Fresenius Health Partners Attn: Provider Database
7100 Commerce Way, Suite 285, Brentwood, TN 37027
615-782-7876 fax or email: Provider.Database@whptn.com

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