OhioHealthy

Return To:
OhioHealth
Credentialing Svcs.
3430 OhioHealth
Parkway
Cols, OH 43202
Fax: 614.566.0401

COLLABORATING PHYSICIAN FORM

DEMOGRAPHIC INFORMATION

Mid Level Practitioner Name: _____ Specialty:_____

Specialty Trained: _____Group NPI No: _____

Group Name: _____ Tax ID: _____

Office Address: _____ City: _____ST:_____ Zip:_____

Office Phone:_____ Office Fax:_____

COLLABORATING PHYSICIAN INFORMATION

(IF THERE ARE MORE COLLABORATING PHYSICIANS THAT NEED LISTED, PLEASE ATTACH TO THIS FORM)

Collaborating Physician Name: _____

Collaborating Physician Specialty:_____

Collaborating Physician Name: _____

Collaborating Physician Specialty:_____

Collaborating Physician Name: _____

Collaborating Physician Specialty:_____

Collaborating Physician Name: _____

Collaborating Physician Specialty:_____

Collaborating Physician Name: _____

Collaborating Physician Specialty:_____

_____

Signature, Mid Level Practitioner Date