



# Provider Information

Return to: PO Box 5406, Boise ID 83705  
 Fax to: 208-433-4605  
 Email to: [ipn@ipnmd.com](mailto:ipn@ipnmd.com)  
 Website: [www.ipnmd.com](http://www.ipnmd.com)

The information provided on this form is **required** for claims processing and directory information.

Please use additional forms for additional practice locations or practitioners/organizations.

<b>EFFECTIVE DATE OF CHANGE:</b>		<b>PLEASE NOTE: IPN IS UNABLE TO GUARANTEE A RETROACTIVE PAYOR IMPLEMENTATION DATE</b>			
<input type="checkbox"/> Add Provider to Group		<input type="checkbox"/> Change Information		<input type="checkbox"/> Add a New Location	
<input type="checkbox"/> Termination		<b>Reason:</b>			
<b>Provider Information (name as shown on CMS 1500 Field 31 OR UB box 1)</b>					
<input type="checkbox"/> Individual Practitioner		Name:			
<input type="checkbox"/> Organizational Provider		NPI:		SSN (TRICARE required):	Degree:
License No.:		DEA No.:		DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
				Is Practitioner Currently Active Military or Reserve? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Practice Location Information (for patient visits and directory listing)</b>					
Practice Name (as it should appear in directories):					
Physical Address (Address, City, State, Zip):				County:	
*Required eff. 1/1/2022 per Title I – No Surprises Act, Sec. 116 *Office Email:			*Required eff. 1/1/2022 per Title I – No Surprises Act, Sec. 116 *Web Address:		
Practitioner Specialty (as practicing at this location):					
Location to appear in a directory for this practitioner? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Location NPI:			Tax ID No. (Attach IRS W9):		
Practice Phone (where patients call to make an appointment):				Practice Fax:	
<input type="checkbox"/> Clinic Hours of Operation (complete specific hours below) (ex. 8-5 – do not include midday closures)			<input type="checkbox"/> Hospital Based Location <sup>1</sup> (hours are 24/7)		
Mon	Tues	Wed	Thurs	Fri	Sat  Sun
Practice Contact Name:			Practice Contact Email:		
<b>Billing Information (as billed on CMS 1500 Field 33 OR UB box 2)</b>					
Billing Name (as it should appear on claims):					
Billing Address (Address, City, State, Zip):				County:	
Billing Contact Name:			Billing Contact Email:		
Billing Contact Phone:			Billing Contact Fax:		
<b>Summary of Changes/Notes</b>					
Form completed by (Name):			Email:		Phone:

<sup>1</sup>Hospital-Based Provider: A practitioner is not required to credential with IPN and is considered “Hospital-Based” if he/she:

1. Provides health care services within an IPN-credentialed hospital,
2. Is privileged by the hospital,
3. Does not accept appointments for health care services at the hospital, and
4. Exclusively sees patients who have been directed to the hospital for health care services.

If the practitioner provides health care services at any other location not identified as a hospital, credentialing is required.