Provider Information

Return to: PO Box 5406, Boise ID 83705
Fax to: 208-433-4605
Email to: ipn@ipnmd.com
Website: 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.

EFFECTIVE DATE OF CHANGE:			**PLEASE NOTE: IPN IS UNABLE TO GUARANTEE A RETROACTIVE PAYOR IMPLEMENTATION DATE**
☐ Add Provider to Group	☐ Change Information	☐ Add a New Location	☐ Add Provider to Hospital Based Location[1]
☐ Termination	**Reason:**		

Provider Information (name as shown on CMS 1500 Field 31 OR UB box 1)

☐ Individual Practitioner ☐ Organizational Provider	Name:			
NPI:	SSN (TRICARE required):	Degree:	DOB:	☐ Male ☐ Female
License No.:	DEA No.:	Is Practitioner Currently Active Military or Reserve? ☐ Yes ☐ No		

Practice Location Information (for patient visits and directory listing)

Practice Name (as it should appear in directories):	
Physical Address (Address, City, State, Zip):	County:
Practitioner Specialty (as practicing at this location):	
Location to appear in a directory for this practitioner? ☐ Yes ☐ No	
Location NPI:	Tax ID No. (Attach IRS W9):
Practice Phone (where patients call to make an appointment):	Practice Fax:
☐ Clinic Hours of Operation (complete specific hours below) (*ex. 8-5 – do not include midday closures*)	☐ Hospital Based Location[1] (hours are 24/7)
Mon |Tues |Wed |Thurs |Fri |Sat |Sun	
Practice Contact Name:	Practice Contact Email:

Billing Information (as billed on CMS 1500 Field 33 OR UB box 2)

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:

Summary of Changes/Notes

Form completed by (Name):	Email:	Phone:

[1]**Hospital-Based Provider:** An individual participating practitioner who provides health care services exclusively at an IPN-participating hospital. A *credentialing application is not required*.