CareLink

University Health System

REQUIRED INFORMATION FOR CARELINK PROVIDERS

☐ **New Provider**
☐ **Re-Credentialed Provider**
☐ **Provider Information Change**
☐ **Provider Termination Date**

Last Name:

First Name:

Social Security Number:

Title: ☐ Medical Doctor ☐ Doctor of Osteopathy
☐ Physician Assistant ☐ Nurse Practitioner ☐ Other: ______

Provider Type: ☐ Primary Care ☐ Specialist ☐ Mid-level ☐ Other ______

National Provider Identifier NPI: ______

Specialty ______

TX State License Number: ______ Expiration Date: ______

DEA Number: ______ Expiration Date: ______

Credential Date: Recredential Date:

Practice Location: Address: ______
City: ______ State: ______ Zip: ______

Affiliation: ☐ UMA ☐ FQHC ☐ Independent ☐ CHCS ☐ Other: ______

Billing Information
Please Check the Affiliation Above **<u>OR</u>** Provide your Billing Address Below

Pay to: ______

Address: ______

City ______ State: ______ Zip: ______

Tax Identification Number (Form W-9):

<u>CareLink Use Only</u>

Date Received: ______ Date Completed: ______ Reviewed By: ______

CareLink Provider Number: ______

Comments:

<u>Fax to</u>: CareLink, Network Development Office (210) 358-3863

http://www.universityhealthsystem.com/patients/support/carelink/provider-information

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