HealthSmart (PEIA WEST VIRGINIA)
PROVIDER DEMOGRAPHIC DATA FORM

EFFECTIVE DATE: _____

PROVIDER LAST NAME AND SUFFIX: _____

PROVIDER FIRST NAME: _____

PROVIDER MIDDLE NAME: _____

DEGREE: _____

SPECIALITY & SUBSPECIALTY, IF APPL: _____

TAX ID. NO.: _____

NPI NO.: _____

MEDICAL LICENSE NUMBER: _____

PRACTICE NAME: _____

PRACTICE SITE ADDRESS: _____

_____

MAILING ADDRESS (IF DIFFERENT): _____

COUNTY: _____

TELEPHONE NUMBER: _____

CLAIMS PAYMENT ADDRESS: _____

_____

CONTACT PERSON NAME AND TITLE: _____

PERSON COMPLETING FORM: _____

PHONE NUMBER: _____

* HealthSmart does not credential providers. This form will be processed within ten days of receipt.

PLEASE RETURN THIS COMPLETED FORM, A COPY OF THE PRACTITIONER'S LICENSE AND W-9 FORM FOR THE PRACTICE TO: **PEIA.MHP-CCP-PCPFORMS@healthsmart.com**

HEALTHSMART (PEIA WEST VIRGINIA)
PO BOX 2451
CHARLESTON, WV 25329
1-888-440-7342 TOLL FREE 1-304-353-7629 PROVIDER RELATIONS – 1-855-405-0948 FAX NUMBER