PROVIDER ROSTER

Provider Contracting
PO Box 7068
Springfield, OR 97475
Fax: (541) 225-3643

This form is only required for practices with more than one provider. Please complete in full and return to your Provider Contract Representative.

Clinic Name: _____ **Date Completed:** _____

Tax ID Number: _____

Provider Name	Degree	Specialty	License #	DEA #	NPI #	PTAN #	DMAP #