Application for Health Coach

This application is only used for participation with CDPHP

Requested Effective Date:	
This is a: ☐ First-time application or ☐ Demographic change	

Group Name:	
Group NPI #:	Billing Tax ID #:

Last Name:	First Name:	Middle Initial:
Date of Birth:	Gender: Male ☐ Female ☐	
Social Security # *(required)*:	Taxonomy Code *(required)*:	
If applicable to the Specialty of the Provider Type, an active Medicare/ Medicaid ID number is required to be enrolled in each respective Product.	Medicare #:	
	Medicaid #:	

Office Contact Name (Please print or type):
Office Contact Phone (Please print or type):
Office Contact Email (Please print or type):

Race - to be shared with members upon request

☐ American Indian or Alaskan Native	☐ Native Hawaiian or other Pacific Island
☐ Asian	☐ Other
☐ Black or African American	☐ Prefer Not to Say

Ethnicity - to be shared with members upon request

☐ Hispanic or Latino	☐ Not Hispanic or Latino	☐ Prefer Not to Say

Office addresses must be identified by street level information with the corresponding City, State and ZIP Code. PO BOX information is not allowed.

Primary Office Address:			STE:
City:	County:	State:	ZIP Code:
Phone *(required)*:		Fax:	
Is this office Handicap accessible *(required)*: ☐ Yes ☐ No		Is this address used for Telehealth services *(required)*: ☐ Yes ☐ No	

Additional Address:			STE:
City:	County:	State:	ZIP Code:
Phone *(required)*:		Fax:	
Is this office Handicap accessible *(required)*: ☐ Yes ☐ No		Is this address used for Telehealth services *(required)*: ☐ Yes ☐ No	

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Please provide only ONE Correspondence, ONE Remittance, and ONE Medical Records address. Each address can be the same or different, but must be identified as a valid United States Postal Service mailing address. If PO BOX information is used, the corresponding City, State and ZIP Code for the PO BOX must be provided and no street level information present.

Correspondence Address:		STE:
City:	State:	ZIP Code:
Phone:	Fax:	

Remittance Address:		STE:
City:	State:	ZIP Code:
Phone:	Fax:	

Medical Record Address:		STE:
City:	State:	ZIP Code:
Phone:	Fax:	

APPLICANT ATTESTATION: I, the undersigned, hereby attest that the above information is true and accurate to the best of my knowledge.	
Applicant Name Signature *(required)*:	Date:

PROGRAM DIRECTOR ATTESTATION: I, the undersigned, hereby attest that the above applicant has been certified by CMS and that the information and the certification provided is true and accurate to the best of my knowledge.	
Program Director Name	Date:
Program Director Signature *(required)*	

Submit the completed application, a copy of the Medicare and Medicaid Certification forms, W-9, Certificate (or Malpractice) of Liability Insurance, & Operating Certificate/License to us using one of the methods below.

Email: provider.enrollment@cdphp.com
Fax: (518) 641-3209