



PROVIDER APPLICATION REQUEST FORM
(Non-CAQH participant only)

Medical License/Certification Number:			
NPI Number:			
Date of Birth:			
Provider Last and First Name:			
Requested Contract Entity:	<input type="checkbox"/> Blue Shield of California Health Plan <input type="checkbox"/> Blue Shield of California Promise Health Plan		
Contract Status:	Medical Group Name: <input type="checkbox"/> Contract Established/Existing <input type="checkbox"/> Contract Pending		
Requested Contract Primary Specialty:		Requested Contract Secondary Specialty:	
Requested Line of Business:	<input type="checkbox"/> Medicare Medicare #:	<input type="checkbox"/> TriWest	<input type="checkbox"/> Medi-Cal MediCal #:
	<input type="checkbox"/> Cal MediConnect	<input type="checkbox"/> Others	
Credentialing Mailing Address:			
Credentialing Contact Name:			
Credentialing Contact Email:			
Credentialing Contact Phone:			
Physical Location(s) (as it will appear on directory. If it is the same as above, type "Same as Above"):			