Soundpath HEALTH

Add New Provider to Current Provider Participation Agreement

Complete this form to add a **new** provider to your current Provider Participation Agreement. If you are sending multiple records, complete Section I and attach a roster (available at *www.soundpathhealth.com*). Submission of this form is not an automatic approval to the Soundpath Health network. We will contact you for more information or send confirmation of your request. This form should be completed electronically or legibly printed in blue or black ink only. All fields are required. Enter 'NA' for any field that is not applicable.

Section I. Person Completing this Form

Name (Last, First, MI)	Title

Phone No.	Email Address

Signature	Date Signed (MM/DD/YYYY)
X	

Section II. Provider Information

Name of Provider (Last, First, MI) *Do not abbreviate. Include suffix: Jr., Sr., III, etc.*	Group/Practice Name

Effective Date at this practice (MM/DD/YYYY)	Provider/Practice TIN No.	Individual NPI No.	Provider CAQH No.

Type of Practice ☐ Individual ☐ Group	Degree	Specialty

Phone No.	Fax No.	Email Address

Section III. Practice Information

	Primary Practice Information	Secondary Practice Information
Group/Practice Name *(If same as above, mark SAME.)*		
Group/Practice TIN No. *(If same as above, mark SAME.)*		
Group/Practice NPI No.		
Street Address		
City| State| Zip	City State Zip	City State Zip
Effective date at this practice (MM/DD/YYYY)		
Office Phone No.		
Office Fax No.		
Office Email *(Communications go to this email)*		
Billing Name *(As it appears on W-9)*		
Billing Address		
City| State| Zip	City State Zip	City State Zip

Use a separate sheet of paper for additional locations. Please include all requested information. Sign, date, and attach to this application. You may also use the online roster template at www.soundpathhealth.com and attach to this form.

Section IV. Credentialing Contact Information

Contact Name (Last, First, MI)		Title		
Mailing Address		City	State	Zip
Phone No.	Fax No.	Email Address		

Section V. Additional Comments

Mail | Fax | Email	Internal Use Only
Soundpath Health 33820 Weyerhaeuser Way S., Ste. 200 Federal Way, WA 98001 F: 253.517.4362 E: providerrelations@soundpathhealth.com	☐ Date received by PR _____ Initials _____ ☐ Credentialing required? ☐ Y ☐ N Initials _____ ☐ Date received by Prov Data Team _____ Initials _____ ☐ Date QA completed _____ Initials _____ ☐ Internal Contract ID _____ Initials _____