Attention: Provider Services
910 Douglas Pike
Smithfield, RI 02917
Phone: 1-401-459-6020 or 1-800-459-6019
Fax: 1-401-709-7066

New Practitioner Education Form

Please complete this form and return via fax or mail to Neighborhood Provider Services. Address information above.

Date: _____ **Number of pages (including this cover sheet):** _____

Provider Group Name: _____ **Site Liaison/Contact Name:** _____

Phone Number: _____ **Fax Number:** _____

A. Practitioner Demographic Information		
Practitioner Name:		
Title (MD, NP, etc.):	Specialty:	Sub-Specialty(s):
Start Date:	Neighborhood ID # (if available):	
If the practitioner is not currently credentialed with Neighborhood, please complete Box D.		
B. Previous Practice Information (if available)		
Provider Group Name:		
Phone Number:	Contact Name:	
End Date:		
C. Billing Information		
Billing Name:		
Billing Address:		
Phone Number:	Fax Number:	
Contact Name:		Please attach a copy of the W-9 form.
D. Credentialing Information		
Please circle one:		
Has the incoming practitioner submitted an application **to** Neighborhood to date?	YES	NO
Date submitted: _____		
Would you like us to send you a Neighborhood Practitioner Application?	YES	NO