Oklahoma Health Network
Provider Application

Provider Name: _____
Last First Middle

Professional Degree: _____ **OK License No.**_____

Primary Specialty: _____ _____
Subspecialty

Secondary Specialty: _____ _____
Subspecialty

Tax ID No._____ **Medicare No.**_____**NPI No**._____

Group/Clinic (if applicable): NPI No. _____

Office Address: _____
Street Address Bldg/ Suite Number

_____
City State Zip Code

(___)_____(___)_____
Phone Number Fax Number E-mail Address

Billing Address: _____
(if different) Street Address/P.O. Box Bldg/ Suite Number

_____
City State Zip Code

(___)_____(___)_____
Phone Number Fax Number E-mail Address

Mailing Address: _____
(if different) Street Address/P.O. Box Bldg/ Suite Number

_____
City State Zip Code

Office Manager: _____**Clinic/Group Name:** _____

Please list all facilities where you have admitting privileges:

_____ _____
Primary Facility Secondary Facility

_____ _____
(Other) (Other)

Do you admit patients through a hospitalist? **Yes**____ **No**____ If yes, please provide the following information:

Hospitalist Name (Primary): _____ Hospital:_____

Hospitalist Name (Secondary): _____ Hospital:_____

Do you have ownership in a facility to which you refer patients? **Yes**____ **No**____

If yes, please list facilities _____

Form Completed By: _____ *Title:* _____ *Date:*_____