



NEW PRACTITIONER INFORMATION SHEET

ALL PRACTITIONERS MUST BE FULLY CREDENTIALLED WITH TLC

Last: _____ First: _____ MI: ____ Degree _____
DOB: _____ SSN: _____ Specialty: _____
Board Certification (if applicable): _____ Type 1 NPI: _____
Starting Date: _____ Female ____ Male ____
DEA: _____ State: ____ Expiration Date: _____
License Number: _____ State: ____ Expiration Date: ____ Medicaid ID: _____ State: ____
Primary Language Spoken: _____ Secondary Language Spoken: _____
Professional Liability Insurance Company: _____

Practice Address:

Group Name: _____
Address: _____ City: _____ State: ____ Zip: _____
County: _____ Phone: _____ Fax: _____
Type 2 NPI: _____
Directory Suppress? Yes ____ No ____
Practicing Specialty at this site: _____ Primary Site? Yes ____ No ____
Cultural Competency (CC): Yes/No _____ American Disability Compliant (ADA): Yes/No _____
Website: Yes/No. If yes, what is it? _____

Remittance Address:

Group Name: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
Federal Tax ID Number: _____

Credentialing Contact Information:

Credentialing Contact Person: _____
Phone: _____ Fax: _____
Credentialing Contact E-mail Address: _____
Signature/Position of Credentialing Contact Person: _____

Please attach a list of all satellite and / or outreach locations complete with practice address, phone numbers and remittance address.

Please mail, fax or email correspondence to: TLC Advantage, LLC, PO Box 89410, Sioux Falls, SD 57109-9410

Email: TLCProviderRelations@tlcadvantage.com

Fax: 605-361-1123

A PREFERRED PROVIDER ORGANIZATION