Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

Provider Information Form (PIF)

Once you have completed this entire form please email it to: **SWHPEXPEDITES@BSWHealth.org**. If a field is not applicable please put N/A.

DATE: _____

GROUP INFORMATION (Please list group-level information below & individual provider information on pages 2 – 3.)		
Legal Name:		
DBA (*if applicable*):		
Billing Tax ID:	Group NPI:	Group TPI:

CONTACT PERSON	
Name:	Email:
Phone #:	Fax #:

GROUP HOURS OF OPERATION (To be listed in directory)

☐ Mon – Fri, 8a – 5p
☐ 24 hours/ 7 days/week

If different, please list below.

Mon:	Tues:	Wed:	Thurs:	Fri:	Sat:	Sun:

Practice Limitations: None ☐ Male only ☐ Female only ☐ Ages 0 to 99 ☐ Other(please specify): _____

MAILING ADDRESS

Is Mailing Address the same for all providers in your group? Yes ☐ No ☐ (if not make note on individual section)

Contact Name:		
Mailing Address:		
City:	State:	Zip + 4 Digits:
Phone #:	Fax #:	

BILLING ADDRESS (It is assumed this is the same for all providers in your group)

Billing Address:		
City:	State:	Zip + 4 Digits:
Phone #:	Fax #:	

CREDENTIALING ADDRESS (It is assumed this is the same for all providers in your group)

Contact Name:	Email:	
Credential Address:		
City:	State:	Zip + 4 Digits:
Phone #:	Fax #:	

INDIVIDUAL PROVIDER INFORMATION

(*Please complete for each individual provider in the group. If you need to list additional providers, please make a copy of this form.)*

Last Name:		First Name:	Middle Initial:
Degree Type:	Ethnicity:	Gender: Male ☐ Female ☐	DOB: __ __ / __ __ / __ __
PCP? Yes ☐ **(If yes, you cannot be hospital based)** No ☐		Hospital Based? Yes ☐ No ☐	

Please list where you have **In-Network*** Admitting Privileges:

*Please refer to https://portal.swhp.org/#/search to verify if your privileges are in SWHP's Network

Languages Spoken, other than English: Spanish ☐ Other (please specify): _____

Primary Specialty:	Secondary Specialty:
List in Directories Yes ☐ No ☐	List in Directories Yes ☐ No ☐
Primary Taxonomy #:	Secondary Taxonomy #:
Board Certified in Primary Specialty? Yes ☐ No* ☐	Board Certified in Secondary Specialty? Yes ☐ No ☐

*If not board certified or board eligible, will be required to complete 50 CME hours per year. Board Exception form MUST be completed prior to credentialing information submission.

NPI #:	DEA #:
Social Security #:	TX Health Steps # (EPSDT):

*CAQH#:

*Please add Scott & White Health Plan as an authorized plan for CAQH & ensure information updated

TPI/Medicaid #:	License #:	Medicare #:

Insurance Amounts: $_____ (per occurrence) / $_____ (aggregate)

MIDLEVELS ONLY

Supervising Physician Name and NPI: _____

Supervising Physician Specialty: (SWHP requires to be same specialty as midlevel) _____

Are midlevel protocols available upon request? Yes ☐ No ☐

Please notify SWHP should your Supervising Physician change.

PRIMARY PRACTICE LOCATION

Contact name:		
Street Address:		
City:	State:	Zip + 4 Digits:
Phone #:	Fax #:	

ADDITIONAL SERVICE LOCATIONS (*If you need to list additional locations, please make a copy of this page.*)

Street Address:		
City:	State:	Zip + 4 Digits:
Phone #:	Fax #:	
TPI/Medicaid #:	NPI #:	
Alternate Address Information		
Street Address:		
City:	State:	Zip + 4 Digits:
Phone #:	Fax #:	
TPI/Medicaid #:	NPI #:	
Alternate Address Information		
Street Address:		
City:	State:	Zip + 4 Digits:
Phone #:	Fax #:	
TPI/Medicaid #:	NPI #:	
Alternate Address Information		
Street Address:		
City:	State:	Zip + 4 Digits:
Phone #:	Fax #:	
TPI/Medicaid #:	NPI #:	
Alternate Address Information		
Street Address:		
City:	State:	Zip + 4 Digits:
Phone #:	Fax #:	
TPI/Medicaid #:	NPI #:	
Alternate Address Information		
Street Address:		
City:	State:	Zip + 4 Digits:
Phone #:	Fax #:	
TPI/Medicaid #:	NPI #:	
Alternate Address Information		
Street Address:		
City:	State:	Zip + 4 Digits:
Phone #:	Fax #:	
TPI/Medicaid #:	NPI #:	