PROVIDER PROFILE INFORMATION FORM

Information listed on this profile sheet will assist in accurately maintaining provider information in the Cedar Network Directory. Please type or print legibly. If more space is needed than provided on the original, attach additional sheets and reference the question being answered. Please refer to the cover letter for a list of the required documents to be submitted with this form.

PHYSICIAN / PROVIDER INFORMATION			
First Name:	MI:	Last Name:	Degree:
Is there any other name under which you have been know? Name(s):			
Address: STREET:			
CITY:		STATE:	ZIP CODE:
Telephone #:	Fax #:	Physician Email:	
Applying as: ☐PCP ☐Specialist ☐Urgent Care	Gender (optional):	Date of Birth (MM/YYYY):	
Primary Specialty:	Subspecialties:		
Social Security #:	Non-English Language(s) Spoken:	CAQH Provider ID #:	
Tax ID #:	Issue Date (MM/YYYY):	Expiration Date (MM/YYYY):	
Tax ID Legal Name:		Driver's License State/Number	

MEDICAL LICENSURE & CERTIFICATIONS		
DEA #:	California State Medical License #:	Expiration Date (MM/YYYY):
Individual NPI #:	Board Certified ☐ Yes ☐ No	
Name of Certifying Board:	Issue Date (MM/YYYY):	Expiration Date (MM/YYYY):
Secondary Specialty:	Board Certified ☐ Yes ☐ No	
Name of Certifying Board:	Issue Date (MM/YYYY):	Expiration Date (MM/YYYY):
Additional Specialty:	Board Certified ☐ Yes ☐ No	
Name of Certifying Board:	Issue Date (MM/YYYY):	Expiration Date (MM/YYYY):

HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS	
Hospital Privileges ☐Yes ☐No	Primary Hospital Admitting Privileges:
Privilege Status ☐active ☐provisional ☐courtesy ☐temporary	
List Other Hospitals Admitting Privileges:	Privilege Status ☐active ☐provisional ☐courtesy ☐temporary

Please e-mail a copy of the form back to ProviderContracts@wgat.com

WESTERN GROWERS ASSURANCE TRUST

OFFICE/PRACTICE INFORMATION		
☐ I am a solo practitioner billing under an individual Tax ID Number ☐ We are a group practice with multiple providers billing under a single Tax ID number. (Please attach a roster)		Accepting **new** members? ☐ Yes ☐ No
Type of Practice (check all that apply): ☐Solo Practice ☐Group Practice ☐Group Specialty Group ☐Group Multi-Specialty ☐Urgent Care		
Practice/Medical Group Name to Appear in Directory:		Group NPI #:
Primary Office Physical Address:		
CITY:	STATE:	ZIP CODE:
Telephone #:	Fax #:	Email:
Website (if applicable):	Non-English Language(s) Spoken by Office Personnel:	
Primary Office Hours of Operations:		
Billing Address: STREET: (if applicable)		
CITY:	STATE:	ZIP CODE:
Email (where correspondence to be sent)	Digital Contact Information (individual and/or facility)	
Supervising Physician Name (if applicable)		
Credentialing Contact Name:	Telephone #:	Email:
Office Manager or Staff Contact Name:	Telephone #:	Email:
Billing Company's Name (if applicable):	Telephone #:	Email:
Secondary Practice Address (if applicable or provide separate list for additional offices)		
CITY:	STATE:	ZIP CODE:
Telephone #:	Fax #	Email:

PROFESSIONAL LIABILITY INSURANCE COVERAGE		
Malpractice Insurance Carrier Name:		
Policy #:	Effective Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)
Telephone #:	Type of Coverage ☐Shared ☐Individual	Length of Time with Carrier

Provider Representative Signature: _____ Date: _____

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