

<p><b>*Full Name</b> (as it appears on your medical license):</p> <p>Degree: _____ License #: _____</p>	<p><b>CAQH #</b> (Profile must be current, and SCCIPA must be granted access to view):</p>
<p><b>Primary Office Address:</b></p>	<p><b>Phone:</b></p> <p><b>Fax:</b></p>
<p><b>Secondary Office Address:</b></p>	<p><b>Phone:</b></p> <p><b>Fax:</b></p>
<p><b>Individual NPI:</b></p> <p>_____</p> <p><b>Organizational NPI:</b></p> <p>_____</p>	<p><b>Practice Name:</b></p> <p>_____</p> <p><b>Tax ID:</b></p> <p>_____</p>
<p><b>Mid Level Title:</b></p>	
<p><b>Supervising Physician (Required):</b></p>	
<p><b>Additional Notes:</b></p>	
<p><b>Please add me to SCCIPA.</b></p> <p><b>Signature:</b> _____ <b>Date:</b> _____ <b>Phone:</b> _____</p> <p><b>Email:</b> _____ <b>Office Manager Name:</b> _____</p> <p><b>Required Attachments:</b></p> <p><b>Curriculum Vitae</b></p> <p><b>Current W9</b></p>	

Application Fees Waived

For Office Use: Receipt Date \_\_\_\_\_