560 East 200 South
Salt Lake City, UT 84102
801-366-7555 | 800-765-7347
www.pehp.org

PROVIDER PROFILE FORM

PEHP is updating its main operating system that processes claims and stores provider information. The new system allows us to input more provider data, which will help us keep our provider directory up to date and help us better communicate with you and your patients. Please complete and return this form as soon as possible. If you need more space, please feel free to attach additional sheets.

If you have any questions, please contact a PEHP Provider Specialist at 801-366-7555 or 800-765-7347.

Individual Provider Profile Information

I. IDENTIFYING PROVIDER INFORMATION			
Last Name:		First:	Middle:
Home Mailing Address:		City:	
		State:	Zip:
Home Phone Number: ( )		E-mail Address:	
Birth Date: (mm/dd/yyyy)		Citizenship:	
Birth City:	Birth County:	Birth State:	Birth Country:
Social Security #:		Gender:	
NPI #:		Credentials:	
Primary Specialty:			
Secondary Specialty:			

II. PRACTICE INFORMATION		
If more than one office location, please complete this form for each location		
Practice Name/Group Practice Name:	Primary Practice ☐	Other Office Practice ☐
Location NPI #:	Department:	
Tax ID #:	Name Affiliated with Tax ID #:	
Taxonomy Code:		
Practicing Specialties:	Subspecialties:	
List Languages Fluently Spoken by Physician:	List Languages Fluently Spoken by Staff:	

Contact Name:		
Office Address:		
City:	State:	Zip:
Phone Number: ( )	Fax Number: ( )	
Email Address:		
Billing Address: Same as Office Address ☐		
Contact Name:		
Address:		
City:	State:	Zip:
Phone Number: ( )	Fax Number: ( )	
Email Address:		
Communication Contact(s):		
Contact Name:		
Scope of Items that should be sent to this contact:		
Address:		
City:	State:	Zip:
Phone Number: ( )	Fax Number: ( )	
Email Address:		
Contact Name:		
Scope of Items that should be sent to this contact:		
Address:		
City:	State:	Zip:
Phone Number: ( )	Fax Number: ( )	
Email Address:		
Contact Name:		
Scope of Items that should be sent to this contact:		
Address:		
City:	State:	Zip:
Phone Number: ( )	Fax Number: ( )	
Email Address:		

Is your practice limited to certain ages? Yes ☐ No ☐	Age Limitation:	
Office Hours	From	To
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
Holidays		

III. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS		
Please list all institutions where you have current affiliations This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheets. Attach additional sheets if necessary		
Name of primary Admitting Hospital/Institution:		
Mailing Address of Primary Admitting Hospital:		
City:	State:	Zip:
Staff Status: (Active, provisional, courtesy, temp, etc.)	Department:	Appointment Date (mm/yy): From: To:
Name of Other Hospital/Institution:		
Mailing Address of Other Hospital/Institution:		
City:	State:	Zip:
Staff Status: (Active, provisional, courtesy, temp, etc.)	Department:	Appointment Date (mm/yy): From: To:
Name of Other Hospital/Institution:		
Mailing Address of Other Hospital/Institution:		
City:	State:	Zip:
Staff Status: (Active, provisional, courtesy, temp, etc.)	Department:	Appointment Date (mm/yy): From: To:
If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care):		

Mental Health Individual Provider Sub-Specialties

Please check all that apply:

Sub-Specialty:

- ☐ ADD/ADHD
- ☐ Adjustment Disorder
- ☐ Anxiety Disorder
- ☐ Cognitive Disorder
- ☐ Dissociative Disorders
- ☐ Eating Disorder
- ☐ Impulse-Control Disorder
- ☐ Mood Disorder
- ☐ Personality Disorder
- ☐ Psychotic Disorders
- ☐ Sexual/Gender Identity Disorder
- ☐ Substance Abuse Related Disorders

Age of Patient you treat:

☐ Child (0-12) ☐ Adolescent (13-18) ☐ Adult (19+)