**Attn: Janelle Jensen**

500 Cummings Center, Suite 6500

Beverly, MA 01915

Phone: 978-236-1760

Fax: 978-236-1777

Janelle.N.Jensen@lahey.org

**NORTHEAST PHO PROVIDER DATA FORM**

**Provider Contact Information**

**Provider Clinical Information**

**Primary Practice Information**

**Secondary Practice Information**

|  |  |
| --- | --- |
|   |   |
| Last name: |   |
| First name: |   |
| Middle initial: |   |
| Preferred contact phone #: |   |
| Preferred email address: |   |
|  |  |
| Preferred email address: |   |

|  |  |
| --- | --- |
| Direct Secure Messaging Address within EMR system: |   |
| Primary specialty: |   |
| Board Certified: |  **[ ]**Yes **[ ]**No **[ ]**Eligible  If Eligible, date scheduled to take exam(s) or when you will be eligible  to apply:  |
|  Ages treated: |   |
| Clinical special interests:  |   |

|  |  |
| --- | --- |
|   |   |
| Primary practice name: |   |
| Primary practice address: |   |
| Start date with practice: |   |

|  |  |
| --- | --- |
|   |   |
| Secondary practice name (ifapplicable): |   |
| Secondary practice address (ifapplicable): |   |



|  |  |
| --- | --- |
|   | **Enrollment Contact** |
| Name: |   |
| Phone #: |   |
| Email: |   |

**Work Week Information**

**Affiliation & Ownership Information**

**Please initial to acknowledge:**

Surgeries, admissions, outpatient testing will be done for NEPHO patients at Northeast Hospital

Corporation (please initial)

**Please submit the following along with this form:**

* CV showing month & year of work history
* CAQH Summary report

**Send to the attention of Janelle Jensen:
Email** **Janelle.N.Jensen@lahey.org** **Or fax 978-236-1777**

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Monday -

Tuesday -

Wednesday -

Thursday -

Friday -

Saturday -

Sunday -

|  |  |
| --- | --- |
|   |   |
| Days & hours provider will be seeingpatients |   |
|   |   |
|   |   |
|   |   |
|   |   |
|   |   |
|   |   |

|  |  |
| --- | --- |
|   | **Hospital Information** |
| Privilege date at Beverly Hospital: |   |
| Note privileges as applicable: Anticipated, Temps or Active |   |

|  |  |
| --- | --- |
|   |   |
| List all provider networks (hospitals) you are affiliated with (includingLahey, if applicable): |   |
| Will NEPHO be your primary or secondary network affiliation? |   |
| List all ownership interests in any outpatient facility (e.g. surgery, lab,imaging, etc): |   |