**Attn: Janelle Jensen**

500 Cummings Center, Suite 6500

Beverly, MA 01915

Phone: 978-236-1760

Fax: 978-236-1777

[Janelle.N.Jensen@lahey.org](mailto: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 (if  applicable): |  |
| Secondary practice address (if  applicable): |  |



|  |  |
| --- | --- |
|  | **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**](mailto: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 seeing  patients |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

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

|  |  |
| --- | --- |
|  |  |
| List all provider networks (hospitals) you are affiliated with (including  Lahey, 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): |  |