TGH EpicLink New Office Request Form

TGH | IMAGING

Date: _____

Office Information

Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: ( ) _____ Fax: _____

Practice NPI: _____

Site Admin Info (All Fields are Required)

First Name: _____ Last Name: _____ Middle Initial: _____

SSN (last 4 digits): _____ DOB: _____

Job Title: _____ Birth City: _____ Birth State: _____

Direct Phone: ( ) _____ Primary Email: _____

Provider Info

First Name: _____ Last Name: _____ Middle Initial: _____

Provider NPI: _____ Specialty: _____

License Number: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Provider NPI: _____ Specialty: _____

License Number: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Provider NPI: _____ Specialty: _____

License Number: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Provider NPI: _____ Specialty: _____

License Number: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Provider NPI: _____ Specialty: _____

License Number: _____

By selecting submit, Adobe will attempt to open your email client and send the completed form to the TGH Imaging provider support email address. If this does not work, please save a copy of the form, and email it to TGHIMG-ProviderSupport@tgh.org This form must be typed before it will be accepted.

Submit