

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](mailto:TGHIMG-ProviderSupport@tgh.org) This form must be typed before it will be accepted.

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