



Date:

Office Information (All Fields are Required)

Name: _____
 Address: _____

 City: _____ State: _____ Zip: _____
 Phone: (____) _____ Fax: _____
 Practice NPI: _____

Site Admin Info (All Fields are Required)

First Name: _____ Last Name: _____
 Job Title: _____ DOB: _____
 Direct Phone: (____) _____ Primary Email: _____
***First and Last Name Must Match the Name on Your Government ID**

Provider Info (All Fields are Required)

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: _____

To submit this form, please save a copy for your records and attach it to an email addressed to TGHIMG-ProviderSupport@tgh.org