TGH EpicLink New Office Request Form

TGH IMAGING

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. This form must be typed before it will be accepted.

FORM #: E379, 03/24