Practitioner Request for Application

Please send an application via:	
Name:	Licensure:
Work Address:	Mailing Address:
City, State, Zip:	City, State, Zip:
Phone Number:	Fax Number:
Email Address:	CAQH Provider ID:
Birth Date (MM/DD/YYYY):	Social Security Number:
Tax Identification Number:	NPI Number:
DEA Number:	Controlled Dangerous Substance Number:
Board Certification (If Applicable):	
Are you fully licensed at the highest level of Independent Practice (Non-MDs Only):	
MDs Only – Did you complete a 3 year residency in psychiatry:	
Is your Graduate school/Residency program accredited:	
Are you a Medicare participating provider:	
Is English your primary language:	
Do you speak any additional languages:	
Are you a United States Citizen:	

To request an application for becoming a contracted provider, please Fax this form to 877-855-9035. If you would like to learn more about becoming a part of our network, you can visit our website at http://valueoptions.com/providers/Network/Military_OneSource.htm or you may call Provider Service Line at (800) 397-1630 during our normal business hours: 8:00am - 8:00pm ET, Monday through Friday. Thanks