COMMERCIAL LOB

Provider First and Last Name: **Title:** **License Number:** **OR** **Ancillary/Group Name (*to be credentialed*):** ***If facility: please attach emergency plan including generator usage**	
Provider's Email Address	
Credentialing Contact Person	
Credentialing Email Address	
Phone Number	
Individual Provider NPI #	
Group NPI #	
Medicaid Provider ID (Optional)	
TAX I.D / W-9	
Group Name:	
Specialty	
***Other Services* Provided**	
Service Area: **(please list** **county)**	
Line of business you are interested in:	**Check:** Commercial Plan ☐
Are you part of a contracted provider group with CCP? No ☐ Yes ☐	
Please submit this form as well as any additional documentation via email to: **credentialingdept@ccpcares.org**	