Insert Letterhead Here

Please provide the name of your practice

Date 11/6/23 **CAQH ID:**

Southern New England Healthcare Organization
200 Day Hill Road
Windsor, CT 06095

Attn: Southern New England Healthcare Organization Credentialing

Re: **New Provider for:**

TIN: **Group NPI:**

Name:

Effective with our group: **NPI:** **Individual PTAN:**

To Whom It May Concern:

Attached is the Credentialing application for who will be joining , **effective,** _____ with the specialty in _____*****. *If you could please see that all payments and correspondence are sent to the following addresses:*

Payment Address: **Address** _____

Phone: _____ **Fax:** _____

Primary Practice: **Address:** _____ **Secondary:** **Address:** _____

_____ _____

Phone: _____ **Phone:** _____

Fax: _____ **Fax:** _____

List in directory? ◯ **Yes or No** ◯ **List in directory?** ◯ **Yes or No** ◯

Accepting patients? ◯ **Yes or No** ◯ **Accepting patients?** ◯ **Yes or No** ◯

All checks should be made payable to the group under the tax identification number:

If you should have any questions or need additional information, please feel free to contact me at

Thank you,

Name

Title

***If practicing multiple specialties, please list which is the primary, secondary and any additional**

Once completed, please remember to save the form, then send an encrypted email to the SoNE Credentialing team for processing at CredentialingTeam@SoneHealthcare.com
For additional provider locations, please fill out second page.

Additional:

Address: ______________________________
____
Phone: ______________________________
Fax: ______________________________
List in directory? ◯ **Yes or No** ◯
Accepting patients? ◯ **Yes or No** ◯

Address: ______________________________
____
Phone: ______________________________
Fax: ______________________________
List in directory? ◯ **Yes or No** ◯
Accepting patients? ◯ **Yes or No** ◯

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Address: ______________________________
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Phone: ______________________________
Fax: ______________________________
List in directory? ◯ **Yes or No** ◯
Accepting patients? ◯ **Yes or No** ◯

Address: ______________________________
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Phone: ______________________________
Fax: ______________________________
List in directory? ◯ **Yes or No** ◯
Accepting patients? ◯ **Yes or No** ◯

Address: ______________________________
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Accepting patients? ◯ **Yes or No** ◯

Address: ______________________________
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Accepting patients? ◯ **Yes or No** ◯

Address: ______________________________
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Accepting patients? ◯ **Yes or No** ◯

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Accepting patients? ◯ **Yes or No** ◯