

Provider Capacity Form



1. Individual Providers

Check here if you are a primary care provider Check here to accept auto assignment (PCPs only)

Check here if you are a behavioral health and/or physical health provider (not a primary care provider)

Provider Name _____ Specialty _____

Provider NPI _____ Tax ID _____ Individual Provider Capacity _____

2. Provider Group

Check here if your group is a primary care office Check here to accept auto assignment (PCP groups only)

Check here if your group is a behavioral health and/or physical health office (not a primary care provider group)

Provider Group Name _____ Specialty _____

Specialty _____

Group NPI _____ Tax ID _____ Provider Group Capacity _____

Note: Group capacity will be evenly dispersed to all providers.

3. Provider Locations (if multiple, please identify)

Check if this is the primary location

Address _____

City _____ State _____ ZIP _____

Check if this is the primary location

Address _____

City _____ State _____ ZIP _____

Check if this is the primary location

Address _____

City _____ State _____ ZIP _____

Check if this is the primary location

Address _____

City _____ State _____ ZIP _____

Check if this is the primary location

Address _____

City _____ State _____ ZIP _____

Please send this form to: **ORProviderService@pacificsource.com**

Questions: Please contact your Provider Service Representative:

ORProviderService@pacificsource.com or **(541) 246-1457**