

CONTACT FORM
Employees Group Insurance Division

NAME OF PRACTITIONER OR GROUP

Business name

GENERAL INFORMATION

| | | |
|---------------------------|--|----------------------------------|
| Tax ID number | | Medicare number (if applicable) |
| NPI type I (individual) | | NPI type II (organization) |
| Website (for publication) | | Practice email (for publication) |

CONTACT INFORMATION

| | | |
|-------|-----------|---------|
| Name | | Company |
| Phone | Extension | Email |

Contact information will be utilized for all legal and contractual notices as defined in sections 12.2 of the provider contract and 11.1 of the IHO and facility contracts. A contact email address must be included. All notices will be sent electronically.

CREDENTIALING CONTACT INFORMATION

| | | |
|-------|-----------|---------|
| Name | | Company |
| Phone | Extension | Email |

The credentialing contact listed will have direct access to the provider contracting portal to make any necessary updates and changes.

ADDITIONAL CONTACT INFORMATION

| | | |
|-------|-----------|---------|
| Name | | Company |
| Phone | Extension | Email |

The additional contact listed will have direct access to the provider contracting portal to make any necessary updates and changes.

SIGNATURE AND DATE

| | |
|----------------------|------|
| Authorized signature | Date |
|----------------------|------|

RETURN TO EGID BY EMAIL

Email: EGID.NetworkManagement@omes.ok.gov