

PLEASE FILL OUT THIS FORM IN ITS ENTIRETY



**CULINARY HEALTH FUND ADMINISTRATIVE SERVICES LLC  
PROVIDER ADDRESS INFORMATION**

**PRACTICE NAME:** \_\_\_\_\_  
**CORRESPONDENCE MAILING ADDRESS:**

ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

CONTACT/E-MAIL \_\_\_\_\_

**BILLING ADDRESS:**

ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

CONTACT/E-MAIL \_\_\_\_\_

**CREDENTIALING ADDRESS:**

ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

CONTACT/E-MAIL \_\_\_\_\_

**TAX IDENTIFICATION NUMBER:** \_\_\_\_\_  
**SITE LOCATION ADDRESS:**

[1] ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

CONTACT/E-MAIL \_\_\_\_\_

[2] ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

CONTACT/E-MAIL \_\_\_\_\_

[3] ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

CONTACT/E-MAIL \_\_\_\_\_

*If more than 3 sites please attach complete roster including site/providers.*  
 Site roster attached.

**PROVIDER NAME**                      **SPECIALTY**                      **LOCATION NO. Ex.: [2] or all.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*If more providers please attach complete roster including site/providers.*  Site roster attached

Effective Date: \_\_\_\_\_

**Culinary Health Fund**  
1901 Las Vegas Blvd., South Suite #101  
Las Vegas, Nevada 89104  
Or Via Fax at: 702-892-7365

or  
Email: [contractsandcred@culinaryhealthfund.org](mailto:contractsandcred@culinaryhealthfund.org)