Culinary Health Fund
Administrative Services, LLC

PLEASE FILL OUT THIS FORM IN ITS ENTIRETY

CULINARY HEALTH FUND ADMINISTRATIVE SERVICES LLC
PROVIDER ADDRESS INFORMATION

PRACTICE NAME:_____ **TAX IDENTIFICATION NUMBER:**_____

CORRESPONDENCE MAILING ADDRESS:

ADDRESS _____

_____

PHONE _____FAX _____

CONTACT/E-MAIL _____

○NEW ○REMOVE Effective Date_____

SITE LOCATION ADDRESS:

[1] ADDRESS _____

_____

PHONE _____FAX _____

CONTACT/E-MAIL _____

○NEW ○REMOVE Effective Date_____

BILLING ADDRESS:

ADDRESS _____

_____

PHONE _____FAX _____

CONTACT/E-MAIL _____

○NEW ○REMOVE Effective Date_____

[2] ADDRESS _____

_____

PHONE _____FAX _____

CONTACT/E-MAIL _____

○NEW ○REMOVE Effective Date_____

CREDENTIALING ADDRESS:

ADDRESS _____

_____

PHONE _____FAX _____

CONTACT/E-MAIL _____

○NEW ○REMOVE Effective Date_____

[3] ADDRESS _____

_____

PHONE _____FAX _____

CONTACT/E-MAIL _____

○NEW ○REMOVE Effective Date_____

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

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

Culinary Health Fund
Via Fax at:702-892-7365
or Email:
demographics@culinaryhealthfund.org

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