

Atrium Health – Carolinas Gastro Centers

New Provider Information Form (PIF)

Date of Submission: Click or tap to enter a date. **[ ]  Physician** **[ ]  Allied Health Provider**

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| Provider Information |
| **Full Legal Name:** **Title:**  **M** [ ]  **F**[ ]  | SSN:  | DOB:  | NPI:  |
| Current Home Address:  | City, State, Zip:  |
| Phone:  | Alternate Phone:  | Preferred Email: Alternate Email**:** |
| **Practicing** Specialty:  |
| Practice Information |
| Primary Practice:  |
| Practice Address:  | City, State, Zip:  |
| Practice Phone: SecureFax: | Clinical Start Date:        |
| Practice Manager/Contact:  |
| Privilege Information |
| **Primary Privileges location (if more than one location checked):** **Start Date:       Canopy Date:****Course Type:** **[ ]  Acute (Hospital)****[ ]  Anesthesia**  |
| Privilege Locations**: [ ]  John J Delaney Ste/ 120** **[ ]  1001 Blythe Blvd, Ste 400**   |
| Training Status (PHYSICIAN ONLY) |
| **[ ]** From Residency/Fellowship | **Incoming Fellow** |  |
| Additional Comments |
| **Notes/Comments:****NC State Medical License:** **North Carolina License:** **NC Approval to Practice:** **Sponsoring Physician (for ACPs only):**  | **License – SC:** **DEA – NC:** **DEA – SC:** **Taxonomy:** |

Please complete electronically and forward the completed PIF along with the provider’s current CV **to** MSSproviderREQ@atriumhealth.org