SummaCare Provider Office Application Form

Please complete one form per practice. Use additional sheets as necessary. Submitting this application request form does not constitute in-network status with the SummaCare network. SummaCare will notify you of either the acceptance or decline of your application.

Date of Request _____

Practice Name: _____

Solo Practice ☐ Group Practice ☐

Please list all providers in this practice. (You may attach an additional sheet if necessary)

Name	Degree	Specialty	Individual NPI #	CAQH #	Hospital Privileges

Primary Practice Location: _____

City _____ State ___ Zip _____ County _____

Phone _____ Fax _____

Email Address: _____

Secondary Practice Location: _____

City _____ State ___ Zip _____ County _____

Phone _____ Fax _____

Additional Practice Location: _____

City _____ State ___ Zip _____ County _____

Phone _____ Fax _____

Remit/Corporate Name: _____

Remit Address: _____

City _____ State ___ Zip _____ County _____

Phone _____ Fax _____

Practice Tax ID #: _____ Group NPI #: _____

Contracting/Credentialing Contact Information:

Name: _____ Title: _____ Email: _____

Address: _____ Phone: _____

_____ Fax: _____

Correspondence Address: (if different than primary location)

Name: _____ Email: _____

Address: _____ Phone: _____

_____ Fax: _____

Submit completed forms to: **Fax:** 330-996-8801 **Email:** sccontracting@summacare.com
Mail: Attn: Contracting, P.O. Box 3620, Akron, OH 44309-3620