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Please return this Group Add Request form along with a completed Nevada Standard Credentialing Application. Make certain all signature dates and attached documents are current. Providers may NOT see/treat Culinary Health Fund patients prior to receiving an effective date from the Credentialing Committee.

**GROUP ADD REQUEST**

Name of Group: \_\_\_\_\_

Tax ID # \_\_\_\_\_

Name of Provider being added: \_\_\_\_\_

Provider type (please circle one):

MD / DO / PAC / APRN / RBT / BCBA / DPM / CRNA / RD / AUD / OMD / PT / OT / ST

Provider's NPI # \_\_\_\_\_

Specialty of Provider being added: \_\_\_\_\_

If adding APRN, will he/she perform First Assist services?	Yes	No
Certification date: _____ Number: _____		

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

Hospital-Based Provider? (Please circle one)      Yes      No

Practice Location(s) \_\_\_\_\_  
(attach separate sheet if necessary) \_\_\_\_\_

Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Please fax back to: 702-892-7365 or e-mail to [contractsandcred@culinaryhealthfund.org](mailto:contractsandcred@culinaryhealthfund.org)