



**Enrollment Form – Nurse Practitioner as PCP**

**NOTE:** SWH requires each PCP Health Care Practitioner that routinely provides Covered Services to persons age 65 and over represents and warrants that he/she has at least two years’ experience in the care of persons age 65 and over.

**NP Name:** \_\_\_\_\_

Currently SWH credentialed?      yes                      no                      unknown

SWH ID #      \_\_\_\_\_      n/a                      unknown

NP has minimum 2 years experience in geriatric medicine **(required)**:    yes                      no

**Supervising Physician Name:** \_\_\_\_\_

Currently SWH credentialed?      yes                      no                      unknown

SWH ID #      \_\_\_\_\_      n/a                      unknown

NP’s arrangements for admitting patients to hospital: \_\_\_\_\_

\_\_\_\_\_

NP’s Panel will be:  
\_\_\_\_\_ Accepting Patients  
\_\_\_\_\_ Existing Patients

Languages spoken:  
\_\_\_\_\_  
\_\_\_\_\_

Name of Practice: \_\_\_\_\_ Phone: \_\_\_\_\_

Practice Address: \_\_\_\_\_

NP Signature: \_\_\_\_\_ Date: \_\_\_\_\_

FAX completed form to 617-551-4185. Attn: Provider Relations  
Or email to [ProviderRelations@SeniorWholeHealth.com](mailto:ProviderRelations@SeniorWholeHealth.com)