

Provider Profile Contact Information Request

Please complete the information below to assist with future provider related questions:

Clinic/Group Name: _____

Main Contact Person: _____ **Title:** _____

Phone: _____ **Fax:** _____

Email: _____

Credentialing Contact: _____ **Title:** _____

Phone: _____ **Fax:** _____

Email: _____

Billing Contact: _____ **Title:** _____

Phone: _____ **Fax:** _____

Email: _____

Medical Records Contact: _____ **Title:** _____

Phone: _____ **Fax:** _____

Email: _____

When complete, please send this correspondence to: providerMD@CareFirst.com

Fax: 410-779-9389