



Prescribing Practitioner Information Form All Counties

Facility or Practice Name: Phone:

Administrative Address

Name of Person Completing This Form: Title:

Facility PROMISe Number (9 digits) Date of Submission:

Level of Care	Service Address	Prescribing Practitioner Name and Degree (MD/DO or CRNP)	Prescribing Practitioner License Number	Prescribing Practitioner DEA Number
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If Prescribing Practitioner is associated with more than one program, please list each program for which that prescriber is rendering services.

You can submit this form in one of three ways: 1) Click the Submit by Email button, 2) Click the Print Form button and fax the form to Attention Network Management at 412-454-2177, or 3) Save the form and Email it as an attachment to CCBHProviderSub@upmc.edu