

I have enclosed the following:

- Signed Memorandum of Agreements (last page is fine)
- Completed W-9 (page 1)
- Completed Provider Information Update Form (below)
- A copy of your Liability Insurance certificate
- A copy of your Workers Compensation Insurance certificate

Mail: Women's Health Check Program, 450 W. State St., 4th floor, P.O. Box 83720, Boise, ID 83720-0036;

Scan: WHC@dhw.idaho.gov **Fax:** 208-334-0657

Provider Information Update Form

Clinic Name: _____

Contact person(s): _____

TIN#: _____

Address: _____

Phone: _____

Fax: _____

Email: _____



IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

