**EZ-NET Provider Portal Access**

**W9 Name (Pay to)**

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| Click or tap here to enter text. |

**First Name** **Last Name**

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|  | Click or tap here to enter text. |

**PCP or Specialist Specialty Description**

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| Click or tap here to enter text. | Click or tap here to enter text. |

**Phone**

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| Click or tap here to enter text. |

**Email**

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| Click or tap here to enter text. |

**Contact Name**

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| Click or tap here to enter text. |

Please email this form to providerrelations@capitalhealthpartners.com