**EZ-NET Provider Portal Access**

**W9 Name (Pay to)**

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

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

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

**PCP or Specialist Specialty Description**

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

**Phone**

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

**Email**

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

**Contact Name**

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

Please email this form to [providerrelations@capitalhealthpartners.com](mailto:providerrelations@capitalhealthpartners.com)