University of South Florida College of Medicine
Provider Billing Information Request

Please complete the provider enrollment sheet when a Clinical Provider Application is provided to a prospective candidate and email it to providerenrollment@health.usf.edu.

Anticipated Start Date: _____

Department: _____ Division:_____

Applicant Name: _____
First Middle Last Degree

Employment Type:

☐ Full-time Clinical Faculty ☐ Professional Services Agreement ☐ Other _____

Cost Center:_____

Practice Locations:
Please check all that apply

☐ USF Health Morsani Center
☐ USF Health South Tampa Center
☐ Other Outpatient Site; please specify:_____
☐ Tampa General Hospital
☐ Florida Hospital
☐ H. Lee Moffitt Cancer Center
☐ All Children's Hospital
☐ Other Hospital; please specify:_____

Department Contact: _____ Contact Phone: _____