MHS Practitioner Enrollment Form

This form is used to enroll practitioners in Ambetter or Allwell Only. If Medicaid is requested, the IHCP form should be used for all programs. **Only submit one form!**

Please select the programs for which this form applies: □Ambetter □AllWell

PRACTITIONER DATA

CAQH Number:		
Practitioner First Name: MI: Last Name:		
Degree: □MD □DO □DMD □DPM □CRNA □NP □CNM □Other:		
Date of Birth:	Gender: □Male □Female	NPI:
Enrolling as: □PMP with Panel □NP Supporting a Specialty □Physician Specialist □Certified Mid-Wife □NP Supporting a PMP □Behavioral Health □Other _____		
Primary Taxonomy: _____	Secondary Taxonomy:_____	NP - Specialty supp:_____
Are You: □A Locum Tenem?	□Hospital-Based Physician?	□Hospitalist?
The National Committee for Quality Assurance (NCQA) requires that health plans assess the cultural, ethnic, racial, and linguistic needs of members of the practitioners in the network. Please provide the following information:		
Ethnicity: □Asian □African-American/Black □Caucasian/White □Hispanic/Latino □Native American □ Pacific Islander □ Other (please specify)_____		
Practitioner Email:	Fax:	Phone:
Maximum membership (panel size) accepted (PMPs only): Ambetter _____ Allwell_____		
Age Restrictions: Minimum Age Years _____	Maximum Age Years _____	
OB (Family Practitioners) □ Yes □ No		
Hospital Privileges □ Yes □ No		
Hospital:	Address:	
Hospital:	Address:	
Hospital:	Address:	

If you do not have hospital privileges, state relationship privileges:

Relationship Privileges □ Yes □ No		
Physician:	Hospital:	Address:

Any primary care provider (PCP) that renders OB services must have delivery privileges and/or relationship privileges to deliver.

Delivery Privileges □ Yes □ No

Hospital:_____ Address:_____

If you do not have delivery privileges, state relationship privileges:

Relationship Privileges □ Yes □ No		
Physician:	Hospital:	Address:

Indicate the type of practice associated with this enrollment:

□ Individual □ Group □FQHC □ RHC □ CMHC □ Urgent Care □ Health Depart. □ Medical

If you are a facility based practitioner (i.e. diagnostic radiology, pathology, anesthesiology, etc) or a Midlevel that does not hold a panel, MHS only requires a primary address per each Group NPI. MHS will not load additional addresses for these type practitioners.

PRIMARY PRACTICE INFORMATION									
Practice Group Name:									
Group Website:_____									
Service Location Address (include ZIP+4):									
Primary Phone:					Primary Fax:				
Office Contact:				Office Contact Email:					
County:				Group NPI:					
Taxonomies:									
Location Office Hours:	Mon	Tues	Wed	Thurs	Fri	Sat	Sun		
Is this office: Handicap accessible? □ Yes □ No On a bus route? □ Yes □ No									
Our office is fluent in the following languages other than English: _____									

PAY-TO INFORMATION		
Billing Name:		TIN:
Billing (Pay-To) Address:		
Billing Phone:	Billing Contact Name:	Billing Contact Email:

MAILING ADDRESS
Mailing Address Same as Primary Practice Address? □ Yes □ No
Mailing Address:

*Please only list addresses where you routinely see patients. Additional addresses, for each group NPI, are for directory purposes and not necessary for claims payments.

OTHER PRACTICE LOCATIONS

Please list additional practice locations in which you will see Ambetter & Allwell members

Practice Group Name:									
Does this location use Nurse Practitioners or Physician Assistants? □ NP □ PA □ N/A									
Service Location Address (include ZIP+4):									
Primary Phone:					Primary Fax:				
Office Contact:					Office Contact Email:				
County:									
Group NPI:					Taxonomies:				
Location Office Hours:	Mon	Tues	Wed	Thurs	Fri	Sat	Sun		
Is this office: Handicap accessible? □ Yes □ No On a bus route? □ Yes □ No									

Does this site: **Offer weekend hours?** □ Yes □ No **Evening Hours?** □ Yes □ No **Serve Children w/ Special Needs?** □ Yes □ No

Our office is fluent in the following languages other than English: _____

Practice Group Name:									
Does this location use Nurse Practitioners or Physician Assistants? □ NP □ PA □ N/A									
Service Location Address (include ZIP+4):									
Primary Phone:					Primary Fax:				
Office Contact:					Office Contact Email:				
County:									
Group NPI:					Taxonomies:				
Location Office	Mon	Tues	Wed	Thurs	Fri	Sat	Sun		
Is this office: Handicap accessible? □ Yes □ No On a bus route? □ Yes □ No									

Does this site: **Offer weekend hours?** □ Yes □ No **Evening Hours?** □ Yes □ No **Serve Children w/ Special Needs?** □ Yes □ No

Our office is fluent in the following languages other than English: _____

Practice Group Name:									
Does this location use Nurse Practitioners or Physician Assistants? □ NP □ PA □ N/A									
Service Location Address (include ZIP+4):									
Primary Phone:					Primary Fax:				
Office Contact:					Office Contact Email:				
County:									
Group NPI:					Taxonomies:				
Location Office	Mon	Tues	Wed	Thurs	Fri	Sat	Sun		
Is this office: Handicap accessible? □ Yes □ No On a bus route? □ Yes □ No									

Does this site: **Offer weekend hours?** □ Yes □ No **Evening Hours?** □ Yes □ No **Serve Children w/ Special Needs?** □ Yes □ No

Our office is fluent in the following languages other than English: _____

ATTESTATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Managed Health Services (MHS), its representatives, agents, or designees, to obtain from any source, information and/or documents regarding my professional credentials and qualification related to this application for new or continued network provider privileges (hereinafter referred to as "Credentialing Information").

I understand and agree that acceptance of this application does not constitute approval or acceptance of participating provider status for any MHS contracted network, and grants me no rights or privileges or participation until such time as I receive an actual written notice of acceptance and participating provider status. termination of my request for application is not an adverse action within the reporting requirements of the National Practitioner Data Bank and does not entitle me to any appeal or hearing.

I understand that MHS will conduct an independent verification of this Credentialing Information and such information will be used to evaluate my credentials according to MHS standards. I hereby consent to the release of Credentialing information to MHS, its agents, representatives, or designees. This authorization to release Credentialing Information shall include, but not be limited to, sources such as the medical staff office and/or Chief(s) of clinical departments of any hospital or facility with which I have at any time been affiliated, all National Practitioner Data Bank and/or Peer Review Committee information and reports, including utilization review information, and information from professional boards, state regulatory and licensing agencies, professional societies, accrediting agencies, and any companies from which I have obtained professional liability insurance. I hereby release all third party sources of Credentialing Information from any and all liability related to the release of such information that is provided in good faith without malice.

I hereby release and hold harmless from any and all liability all members of MHS, the Board of Directors, its officers, agents, peer review committee members and employees, for all activities executed in good faith and without malice regarding the evaluation of my credentials and qualifications or the denial or termination of participating provider status in any MHS contracted network.

A photocopy of this authorization will serve as an original. I understand that MHS, the Credentialing Committee, and/or their designees will utilize this information only in connection with my application for credentialing or re-credentialing purposes. I understand MHS, its Credentialing Committee, and their designees will treat this information as confidential.

The undersigned certifies and attests that the forgoing is truthful, correct and complete in all respects, and the undersigned further understand the intentional submission or false or misleading information or the withholding of relevant information is grounds for denial or immediate termination from MHS provider networks. The undersigned hereby agrees to report to MHS any changes in the above information within 30 days of change.

Printed Name: _____ Title: _____

Signature: _____ Date: _____

During the credentialing and re-credentialing process, MHS will obtain information from various outside sources (e.g., state licensing agencies, National Practitioner Data Bank) to evaluate your application. You have the right to review any primary source information that MHS collects during this process. The rights do not include information obtained as references, recommendations or other information that is peer review protected.

Should you believe any of the information used in the credentialing and re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by you, as the practitioner, you will have the right to correct any information and submit your comments and explanations for any other factual information.

Please keep a copy for your records.