HCAS Provider Enrollment Form

Please Fax only first 2 pages of this form to the health plan

DATE	COMPLETED BY	TELEPHONE/EMAIL OF PERSON COMPLETING FORM

Provider Information

Provider First Name	Middle Initial	Provider Last Name	Degree/Title	Social Security Number	Date of Birth	Gender
						M ☐ F ☐

Provider Email Address: Languages spoken:

Specialty: Board Certified? Yes ☐ No ☐ If you are not certified, are you eligible? Yes ☐ No ☐ If yes, exam date:

Sub Specialty: Board Certified? Yes ☐ No ☐ If you are not certified, are you eligible? Yes ☐ No ☐ If yes, exam date:

CAQH ID:	National Provider Identifier (NPI):	License #:	DEA #:

Provider Category	Primary Hospital Affiliation	Secondary Hospital Affiliation	Staff Position	If no hospital affiliation, provide admitting arrangements and MD name
PCP ☐ Specialist ☐ Both ☐ Hospitalist Only ☐				

Nurse Practitioner Board Certificate number : Provide collaborating MD For all NP's, PA's and APRN's:

Some emergency medicine, radiologists, anesthesiologists, or pathologists who practice exclusively within a facility and who do not receive direct referrals may qualify for an abbreviated process. Please check here if you meet the criteria. ☐

Practice Information

Please check box to indicate address type. Please complete a separate page for all new enrollees in the group. Use a separate page to list additional addresses.

Practice Name: _____

Address Primary Address ☐ Mailing Address ☐ Credentialing Address ☐ Additional Practice ☐

Street

City	State	ZIP Code	Languages Spoken by office staff

Telephone: Fax: Email: Practice Manager Name: Practice Start Date:

Provider email:

Practice Name: _____

Address Primary Address ☐ Mailing Address ☐ Credentialing Address ☐ Additional Practice ☐

Street

City	State	ZIP Code	Languages Spoken by office staff

Telephone: Fax: Email: Practice Manager Name: Practice Start Date:

Practice Name: _____

Address Primary Address ☐ Mailing Address ☐ Credentialing Address ☐ Additional Practice ☐

Street

City	State	ZIP Code	Languages Spoken by office staff

Telephone: Fax: Email: Practice Manager Name: Practice Start Date:

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Payment Information

Payee Name: _____ Tax Identification Number _____ Group NPI # _____

Payment Address _____ Street

_____ City _____ State _____ ZIP Code _____ Email

_____ Telephone _____ Fax _____ Contact Name

Optional Practice Information

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Average Waiting Time to Schedule:

Initial Visit	Routine Physical	Urgent Visit

Your Practice must provide 24-hour coverage. Do you have 24-hour coverage? **Yes** ☐ **No** ☐

Please list Covering Providers or Group (attach additional sheet if necessary):

Name	Specialty	Provider Type	Phone Number

Handicap Access: Yes ☐ No ☐

Practice Type: Solo ☐ Partnership ☐ Single ☐ Specialty Group ☐ Multi-Specialty Group ☐ Concierge Model ☐ Other:

Other Provider Information

Is the provider accepting new patients? Yes ☐ No ☐

Does the provider participate in and meet the conditions of participation in Medicare? Yes ☐ No ☐

Does the provider have a current, valid and active Medicare participating PTAN number? Yes ☐ No ☐

If yes, please indicate participating PTAN number:

Please indicate Medicaid number:

Please list any practice restrictions for the provider:

What age groups do you treat?

Does your organization make decisions to treat patients based solely on a patient's race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient? Yes ☐ No ☐

Describe the steps you take to monitor for and prevent discriminatory practices:

Practitioner Rights Notification

Providers have the right to review information submitted on this form and to correct or update information by contacting a health plan(s) directly.

Additional Documents to Submit: Please see *Health Plan Contracting and Enrollment Required Documents List* located on the Resources page of **www.hcasma.org**

Revised 3/2013