

☐ Provider Add/Change Location
☐ Group Add/Change Location

☐ Provider Termination
☐ Group Termination

☐ Facility Based Provider Application

Provider Information																			
Provider Name and Title		Race ☐ American Indian ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Prefer not to disclose		Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to disclose															
Social Security No.	Languages spoken other than English		Gender Identity ☐ Male ☐ Non-binary ☐ Female ☐ Transgender ☐ Prefer not to disclose		Date of Birth														
Individual NPI		State License # (attach copy)		DEA No. (attach copy)	PTAN														
Which primary specialty are you practicing at this location?		Provider Email		Facility Privilege(s) or Admit Plan															
Does above provider practice at another Group/Tax ID? ☐ Yes ☐ No If Yes, what % of provider's time is spent at Group listed below: _____																			
Location Information ☐ Add Location ☐ Term Location ☐ Term Provider from Tax ID Effective Date at Practice Location _____																			
Location Name		Location Address: Street, City, State & Zip																	
Entity Legal Name		Location Phone	Location Fax	On average, how soon can a new patient get an appointment? ☐ Within 48 hours ☐ Within 2 weeks ☐ 2-4 weeks ☐ 4-6 weeks ☐ Beyond 6 weeks															
Tax ID			Type 2 Organizational NPI																
Is your practice handicapped accessible? ☐ Yes ☐ No																			
Notice Address (if different from billing or location address)			Billing address (if different than service address)																
Billing Phone			Billing Fax																
If changing locations, indicate what address should be eliminated:																			
Credentialing Contact			Credentialing Contact email Address																
Clinic Hours of Operation for this Location (not provider specific) <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Monday</td> <td style="text-align: center;">Tuesday</td> <td style="text-align: center;">Wednesday</td> <td style="text-align: center;">Thursday</td> <td style="text-align: center;">Friday</td> <td style="text-align: center;">Saturday</td> <td style="text-align: center;">Sunday</td> </tr> <tr> <td>From _____ To _____</td> <td>From _____ To _____</td> <td>From _____ To _____</td> <td>From _____ To _____</td> <td>From _____ To _____</td> <td>From _____ To _____</td> <td>From _____ To _____</td> </tr> </table>						Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	From _____ To _____	From _____ To _____	From _____ To _____	From _____ To _____	From _____ To _____	From _____ To _____	From _____ To _____
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday													
From _____ To _____	From _____ To _____	From _____ To _____	From _____ To _____	From _____ To _____	From _____ To _____	From _____ To _____													
Practitioner Information at this Location: Are you a PCP at this location? ☐ Yes ☐ No Do you provide Telehealth services at this location? ☐ Yes ☐ No Do you practice Urgent Care at this location? ☐ Yes ☐ No Are you SAMHSA certified for Medication-Assisted Treatment (MAT)? ☐ Yes ☐ No Do you see members by appointment at this location? ☐ Yes ☐ No Do you offer Interpretation Services? ☐ Yes ☐ No																			
Patient Parameter: Min Age _____ Max Age _____ Date of last Cultural Sensitivity Training: _____																			
Accepting new patients in the following lines of business: Commercial Payers ☐ Yes ☐ No Medicare Advantage ☐ Yes ☐ No Do you opt out of Medicare: ☐ Yes ☐ No Start Date: _____ End Date: _____ Accepting Medicare/Medicaid Insurance: ☐ Yes ☐ No Do you opt out of Medicaid: ☐ Yes ☐ No Start Date: _____ End Date: _____																			
Completed By (Required)																			
Completed By			email																
Title			Phone																