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|---|---|--|
| <input type="checkbox"/> Provider Add/Change Location | <input type="checkbox"/> Provider Termination | <input type="checkbox"/> Facility Based Provider Application |
| <input type="checkbox"/> Group Add/Change Location    | <input type="checkbox"/> Group Termination    |  |

Provider Information			
Provider Name and Title		<b>Race (optional)</b> <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to disclose	
Social Security No.		<b>Ethnicity (optional)</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Prefer not to disclose	
Languages spoken other than English		<b>Gender Identity (optional)</b> <input type="checkbox"/> Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what % of provider's time is spent at Group listed below: _____			
Location Information			
<input type="checkbox"/> Add Location <input type="checkbox"/> Term Location <input type="checkbox"/> Term Provider from Tax ID Effective Date at Practice Location _____			
Location Name		Location Address: Street, City, State & Zip	
Entity Legal Name		<b>On average, how soon can a new patient get an appointment?</b> <input type="checkbox"/> Within 48 hours <input type="checkbox"/> Within 2 weeks <input type="checkbox"/> 2-4 weeks <input type="checkbox"/> 4-6 weeks <input type="checkbox"/> Beyond 6 weeks	
Location Phone		Location Fax	
Tax ID		Type 2 Organizational NPI	
Is your practice handicapped accessible? <input type="checkbox"/> Yes <input type="checkbox"/> 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)			
Monday	Tuesday	Wednesday	Thursday
Friday	Saturday	Sunday	
From _____ To _____	From _____ To _____	From _____ To _____	From _____ To _____
<b>Practitioner Information at this Location:</b> Are you a PCP at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you provide Telehealth services at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, which modalities: <input type="checkbox"/> Video <input type="checkbox"/> Phone <input type="checkbox"/> Clinic to Clinic Video Do you practice Urgent Care at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you SAMHSA certified for Medication-Assisted Treatment (MAT)? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you see members by appointment at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you offer Interpretation Services? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Patient Parameter: Min Age _____ Max Age _____		Date of last Cultural Sensitivity Training: _____	
<b>Accepting new patients in the following lines of business:</b> Commercial Payers <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Advantage <input type="checkbox"/> Yes <input type="checkbox"/> No Do you opt out of Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No Start Date: _____ End Date: _____ Accepting Medicare/Medicaid Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No Do you opt out of Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No Start Date: _____ End Date: _____			
Completed By (Required)			
Completed By		email	
Title		Phone	