

- Provider Add/Change Location
- Group Add/Change Location

- Provider Termination
- Group Termination

- Facility Based Provider Application

<b>Provider Information</b>			
Provider Name and Title			
Social Security No.	Foreign Languages spoken by Provider	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Individual NPI	State License # (attach copy)	DEA No. (attach copy)	PTAN
Which primary specialty are you practicing at this location?	Additional Specialties	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:			
<b>Location Information</b>			
<input type="checkbox"/> Add Location		<input type="checkbox"/> Term Location	
Effective Date at Practice Location _____			
Location Name		Location Address: Street, City, State & Zip	
Entity Legal Name	Location Phone	Location Fax	
Tax ID		Type 2 Organizational NPI	
Is your practice handicapped accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this your primary practice location? <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	
<b>If changing locations, indicate what address should be eliminated:</b>			
Credentialing Contact		Credentialing Contact email Address	
<b>Clinic Hours of Operation for this Location (not provider specific)</b>			
Monday	Tuesday	Wednesday	Thursday
Friday	Saturday	Sunday	
From _____ To _____	From _____ To _____	From _____ To _____	From _____ To _____
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	
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	
<b>Patient Parameter:</b> <input type="checkbox"/> Male only <input type="checkbox"/> Female only <input type="checkbox"/> Both      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: _____	
<b>Completed By (Required)</b>			
Completed By		email	
Title		Phone	

Submit via email to [SLHealthPartners@slhs.org](mailto:SLHealthPartners@slhs.org)