HELP RESOURCES

Practitioner New Practitioner Form

Start Date: Effective date for practitioner

Tax ID: The nine-digit identification number used by the Internal Revenue Service in the administration of tax laws for this practitioner

Last Name: The last name of the individual practitioner as listed on state license where care is being rendered

First Name: The first name of the individual practitioner as listed on state license where care is being rendered

Middle Initial: The middle initial of the individual practitioner as listed on state license where care is being rendered

Credential / Degree: Credential(s) or degree(s), representing education and ability to provide care, awarded to the new practitioner

Date of Birth: Practitioner Date of birth

Gender: Select the appropriate gender for the new practitioner

Practitioner NPI: The unique 10-digit identification number assigned to the new health care practitioner

License Type: The occupational licensure of the practitioner (ex: physician, physical therapist, licensed clinical social worker, etc.)

License Number: The identifying number given on the state license to the physician by the state medical board

License State: State in which the practitioner is licensed to practice

License Expiration Date: The date in which the practitioner's license expires, if not removed

Primary Location: Select this next to the primary location at which the practitioner practices

Facility Name: Name of each clinic, hospital or other facility where practitioner will be seeing members

Address: Physical address associated with each facility location

City: City associated with each facility location

State: State associated with each facility location

Zip: Zip Code associated with each facility location (must include four-digit extension)

Phone: Telephone number associated with each facility location

County: County in which each facility is located

Clinical or Referral / Authorization Fax: Fax number for submission of referrals or authorization documentation for each location

Select PCP and / or Specialist: PCP denotes that members can select the practitioner as their primary care physician

Practitioner Status: Select the status that best describes practitioner from the drop-down menu

Specialty: Select the applicable specialty from the drop-down menu

Taxonomy Code: Code description that most closely describes the practitioner's type / classification / specialization for purpose of rendering health care. If applicable, enter more than one code description in order to adequately describe the type / classification / specialization

List in Network Directory: Should the practitioner be listed in the electronic and paper directories? Select Yes or No

Hospitalist?: Does the practitioner specialize in the care of patients in the hospital setting? Select Yes or No

Billing Name: Complete legal name of organization or corporate entity

Billing Address: Street address associated with billing organization

City: City associated with billing address

State: State associated with billing address

Zip: Zip Code associated with billing address (must include four-digit extension)

Billing NPI: The unique 10-digit identification number for covered health care providers. If practitioner will be submitting charges under more than one NPI, submit a separate New Practitioner Form for each billing NPI

Taxonomy Code: Code description that most closely describes the practitioner's type / classification / specialization for purpose of rendering health care. If applicable, enter more than one code description in order to adequately describe the type / classification / specialization

List all facilities where practitioner has Hospital Admitting Privileges: Hospital(s) where the practitioner has been granted rights to admit patients

Accepting New Patients? Is the practitioner open to new patients? Select yes or no

Spoken Languages: All languages in which the practitioner is fluent

Comments: List any applicable information not requested above

Credentialing Recipient: Name of the contact who should receive credentialing materials

Address: The number and street where credentialing materials should be mailed

City: City associated with credentialing recipient

State: State associated with credentialing recipient

Zip: Zip Code associated with credentialing recipient

Phone: Telephone number associated with the credentialing recipient

Fax: Fax Number associated with the credentialing recipient

Email Address: Email Address associated with the credentialing recipient

Completed by: Name of the individual completing this form. Individual must be authorized to represent the provider office for enrollment with health insurance payers

Email Address: Email address of the individual completing the form

Phone: Telephone number for the individual completing the form