Provider Enrollment Form

Fallon Health Weinberg-PACE

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):	NY License #	NY License Effective Date

If PCP, total # of physician extenders (NP's/PA's)	Total # of assisting residents certified	Are they board In what specialty	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 (9 Digit)	Languages spoken by office staff

Telephone: Fax: Email: Practice Manager name Practice start date

If office handicapped accessible:	Is office located within 1 block of public transportation	Does office provide medical interpreter services: Does office provide language interpreter services:

Provider email

Practice name:

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

Street

City	State	ZIP code (9 Digit)	Languages spoken by office staff

Telephone Fax Email: Practice Manager Name Practice start date

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Practice Name: _____

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

Street

City | State | ZIP Code (9 Digit) | Languages Spoken by office staff

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

If office handicapped accessible:	Is office located within 1 block of public transportation	Does office provide medical interpreter services: Does office provide language interpreter services:

Provider email _____

Payment Information

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

Payment Address

Street

City | State | ZIP Code (9 Digit) | 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 ☐

Practitioner Rights Notification

Information provided in this form will be utilized for the Health Plan's system configuration, as well as for mandatory provider reporting, as required by the State of New York. Providers have the right and to review information submitted on this form and to correct or update information by contacting a health plan(s) directly.

Please save the completed form and submit it to: AskFHW@fallonweinberg.org.