# *Provider Enrollment Form*

Fallon Health Weinberg-HMO SNP  Fallon Health Weinberg-MLTC  Fallon Health Weinberg-PACE

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|  |  |  |
| **DATE** | **COMPLETED BY** | **TELEPHONE/EMAIL OF PERSON COMPLETING FORM** |

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| Provider Information |

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|  | | |  |  | | |  | |  | |  | | M  F |
| Provider First Name | | | Middle Initial | Provider Last Name | | | Degree/Title | | Social Security  Number | | Date of Birth | | Gender |
| 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       Are they board certified       In what specialty | | | | | | | DEA #: | |
| PCP  Specialist  Both  Hospitalist Only | |  | | |  | | |  | | | |  | |
| Provider Category Primary Hospital Secondary Hospital Staff Position If no hospital affiliation, provide admitting  Affiliation Affiliation admitting arrangements and MD name | | | | | | | | | | | | | | |
| 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. | | | | | | | | | | | | | | |

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| 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.***

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| Practice Name: |  |

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| --- | --- | --- | --- | --- |
| **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: |  | | | | | | |

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| --- | --- | --- | --- | --- |
| **Address** | Primary Address  Mailing Address  Credentialing Address  Additional Practice | | | |
|  |
| Street | | | | |
|  | |  |  |  |
| City | | State | ZIP Code (9 Digit) | Languages Spoken by office staff |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| 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 |  | | | | | | |

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| --- | --- |
| Practice Name: |  |

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| --- | --- | --- | --- | --- |
| **Address** | Primary Address  Mailing Address  Credentialing Address  Additional Practice | | | |
|  |
| Street | | | | |
|  | |  |  |  |
| City | | State | ZIP Code (9 Digit) | Languages Spoken by office staff |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| 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 |  | | | | | | |

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| Payment Information |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Payee Name: |  | | | |  | |  |
|  | | | | | Tax Identification Number | | Group NPI # |
| Payment Address | |  | | | | | |
|  | | Street | | | | | |
|  | | |  |  | |  | |
| City | | | State | ZIP Code (9 Digit) | | Email | |

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| --- | --- | --- |
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| Telephone | Fax | Contact Name |

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| Optional Practice Information |

Office Hours:

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| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| 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** |
|  |  |  |  |
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Handicap Access: Yes  No

Practice Type: Solo  Partnership  Single  Specialty Group  Multi-Specialty Group  Concierge Model  Other:

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| 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 |
| Describe the steps you take to monitor for and prevent discriminatory practices:   |  | | --- | | 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.**