PROVIDER ENROLLMENT FORM

This form should be used by Physician Hospital Organizations/Physician Organizations (PHOs/POs) and individual providers for non-delegated networks and direct agreements.

Instructions

To avoid delays in the credentialing process:

1. Ensure provider information on your CAQH Proview™ profile and in the National Plan and Provider Enumeration System (NPPES) is up to date and accurate. Note: Information in your *Provider Directory Snapshot* may be used in provider directories.
2. Complete all fields below and sign the form.
3. Email completed form along with documents below to providernetwork@hap.org. **Please put "new physician application" in the subject line.**
   - Current W-9 (signed and dated)
   - EIN/IRS letter
   - Collaborative Physician Agreement, if applicable
   - HAP Disclosure of Ownership and Control Interest Form
   - Children's Special Healthcare Services Provider Attestation Form (for HAP CareSource)

PROVIDER INFORMATION (For multiple providers, please attach a roster)		
Name (last, first, middle):		Degree:
☐ Male ☐ Female	Race/Ethnicity:	
NPI #:	Group NPI #:	
Physician's CAQH ID number: (Make sure HAP is added to physician's CAQH Registry)	CHAMPS number: (if applicable)	
Medicare #: (HAP requires participation in Medicare. If you don't participate, stop and resubmit once Medicare # obtained)		
☐ Primary Care Physician	☐ Specialist	☐ Hospital based
Primary specialty:		
Practicing specialty:		

PRIMARY OFFICE INFORMATION (for additional locations, complete next page)			
Practice name:			
Street address:			Suite #:
City:		State:	Zip:
Phone:	Fax:	Email:	
Do you offer telehealth services?	☐ Yes	☐ No	
Please choose one. Employed by:	☐ Health System	☐ Independent Group	
Contract with PHO and/or PO? If yes, please indicate which hospital system or PHO/PO affiliations:	☐ Yes	☐ No	

BILLING INFORMATION			
Pay to name:			
Tax identification number:		Billing NPI:	
Address:			
Phone:	Fax:	Email:	

Additional Office Locations

Attach a separate sheet with the same information if you have more office locations.

Street:
City, ST, Zip:
Phone: Fax: Email:
TIN: Website:
Telehealth services offered: ☐ Yes ☐ No
Hours:

Effective date of addition:

Street:
City, ST, Zip:
Phone: Fax: Email:
TIN: Website:
Telehealth services offered: ☐ Yes ☐ No
Hours:

Effective date of addition:

Street:
City, ST, Zip:
Phone: Fax: Email:
TIN: Website:
Telehealth services offered: ☐ Yes ☐ No
Hours:

Effective date of addition:

Street:
City, ST, Zip:
Phone: Fax: Email:
TIN: Website:
Telehealth services offered: ☐ Yes ☐ No
Hours:

Effective date of addition:

CONSENT AND AUTHORIZATION	
By signing this form, I affirm the information provided is true and accurate to the best of my knowledge. Any incomplete or misstatements could result in denial of credentialing. I authorize HAP to access physician information from the Council of Affordable Quality Healthcare (CAQH) Proview database.	
Signature	
Printed name	Date
Title	
Email	Phone