

## Provider Information Form Instructions

- This form is a request for a provider application. *Completing this form does not constitute approval of membership.* All requests will go before our committee.
- This form may also be used to update provider information including but not limited to the following-
  - Provider name
  - Telephone Number
  - Fax Number
  - Credentialing correspondence information of person to contact for provider updates
  - Office Manager information update
  - Provider accepting or no longer accepting new patients
  - Practice address change
  - Practice office hours
  - Practice affiliation change
  - Physician leaving the practice
- Please complete both pages of this form in its *entirety* and legibly to begin the process.
- Please complete one form per provider.
- Please fill out Page 2 of the form for each location in which the provider is practicing.
- Outdated forms will not be accepted.
- Once your request is received, we review the application to make sure it is complete and includes all required documentation. **All portions of this form are required.**
- If any portion of this form is missing information, we will attempt to contact you once per week, for three weeks. As soon as we receive the outstanding information, we will send the application to the next committee meeting. If we are unable to reach you, you would need to re-request again if interested in the future.
- Once the committee has reviewed your request, you will be notified in writing of their decision.
- If approved for application, the credentialing process takes 60-90 days. (your expediency will streamline this process)
- If you have already completed your application with CAQH, please ensure that you have authorized AultCare to access your data.
- Using CAQH does not grant participation or constitute applying for participation with AultCare.
- Please make sure you include ALL REQUIRED documentation, as we will not process requests that are missing required information.
- Once Credentialing is complete a PEER review is conducted.
- If approved through PEER review, you will go before a committee for approval of contracts.
- If approved for final membership, note that your panel provider effective date will be **after** we receive your signed contract. Therefore, you should not be scheduling or seeing AultCare patients until that time.
- Per the Centers for Medicare and Medicaid Services (CMS), we are now required to verify the information contained in our provider files quarterly. This includes verification of information, such as your address, phone number, office hours, email, and affiliated physicians.
- Please mail, fax (330) 363-6421 or email, [credentialing@aultcare.com](mailto:credentialing@aultcare.com) this form and supporting documentation to:
  - AultCare**
  - Attn: Network Analysis, Credentialing, & Contracting**
  - PO Box 6910**
  - Canton, OH 44709**
- If you have additional questions, you may contact the AultCare and PrimeTime Network Analysis, Credentialing, & Contracting department at 330-363-1400 between the hours of 8:00 am to 4:30 pm EST, Monday through Friday.

**Overall Reason for Request (check all that apply)**

<input type="checkbox"/> New Provider	Eff Date:	<input type="checkbox"/> Deleting Provider	Eff Date:
<input type="checkbox"/> Add Location	Eff Date:	<input type="checkbox"/> Deleting Location	Eff Date:
<input type="checkbox"/> Practice Address Change	Eff Date:	<input type="checkbox"/> Correspondence Change	Eff Date:
<input type="checkbox"/> Billing Address Change	Eff Date:	<input type="checkbox"/> Update Information	Eff Date:
<input type="checkbox"/> Other	Explanation:		

**Practitioner Information**

DEA Certificate # (if applicable)		NPI # (Individual)	
First Name	Middle Initial	Last Name	
Suffix	Maiden Name	Title (MD, etc)	
Social Security #	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Provider Direct Email:		Languages Spoken	
Medicare # or UPIN		Medicaid #	
OH License #		CAQH #	
Primary Specialty	List in Directory? <input type="checkbox"/> YES <input type="checkbox"/> NO	Secondary Specialty	List in Directory? <input type="checkbox"/> YES <input type="checkbox"/> NO

If you are an extender (NP, PA, CNM, CNS), who is your standard care arrangement with? ***\*must submit copy of SCA***

If you are an OB/GYN or CNM, do you perform deliveries?  YES  NO

If you are an Ophthalmologist or Podiatrist, do you perform surgeries?  YES  NO

**Hospital Privileges - At least one HOSPITAL must be an in-network AultCare participating hospital in the vicinity of the practice you are requesting for.**

Hospital Name	Status/Type of Privileges	Effective Date

**Does the provider have specialized training and experience in treating the following? All  None**

Blindness or Visual Impairment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Physical Disabilities	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chronic Illness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Serious Mental Illness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Co-Occurring Disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Substance Abuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Deafness or Hard-of-Hearing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you a Ryan White HIV provider?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
HIV/AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you an Indian provider as defined by CMS?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Homelessness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you a family planning provider?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Intellectual and Developmental Disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Additional Comments:**

**Office Information (please make additional copies and complete information for each location)**

ADD Location     DELETE Location    Effective date with this location \_\_\_\_\_ Location \_\_\_\_ of \_\_\_\_

Is this a Multiple Provider Practice?  YES  NO    If yes, include names of other providers \_\_\_\_\_

Are you accepting new patients at this location?  YES  NO    If approved, would you like this location to be listed in the directory?  YES  NO    Does this provider regularly schedule to see patients at this location?  YES  NO

Do you provide your patients with the option of E-prescriptions?  YES  NO    Does this location take walk-ins?  YES  NO    Does this location provide extended hours?  YES  NO

Tax ID \_\_\_\_\_    Group Name (Legal Name) \_\_\_\_\_  
Office Name (For Directory Purposes) \_\_\_\_\_

Street Address \_\_\_\_\_    Suite # \_\_\_\_\_

City \_\_\_\_\_    State \_\_\_\_\_    County \_\_\_\_\_    Zip \_\_\_\_\_

Telephone # \_\_\_\_\_    Fax # \_\_\_\_\_    NPI group # (if applicable) \_\_\_\_\_

BUSINESS HOURS FOR LOCATION (List start & end times)	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Start _____ End _____ Closed <input type="checkbox"/>	Start _____ End _____ Closed <input type="checkbox"/>	Start _____ End _____ Closed <input type="checkbox"/>	Start _____ End _____ Closed <input type="checkbox"/>	Start _____ End _____ Closed <input type="checkbox"/>	Start _____ End _____ Closed <input type="checkbox"/>	Start _____ End _____ Closed <input type="checkbox"/>

**Location Detail Information All  None**

Is this location on an accessible transportation route?  YES  NO    Do you supply translation services for written material?  YES  NO    Do you provide and bill for lab services at this location?  YES  NO

Do you provide and bill for diagnostic radiology services at this location?  YES  NO    Do you provide and bill for mammography services at this location?  YES  NO    Other \_\_\_\_\_

**Please specify which of the following accessibility options you have for individuals with physical disabilities All  None**

Handicap accessible parking spaces, curb ramps, or loading zones at building entrance  YES  NO    Doorways wide enough to ensure safe passage by individuals using mobility aids  YES  NO    Wheelchair accessible restrooms with grab bars and accessible lavatories  YES  NO

ASL signage and raised tactile text characters at office, elevator, and restroom doors  YES  NO    Medical equipment accessible to patients using mobility aids  YES  NO    Exam rooms accessible to patients using mobility aids  YES  NO

Other ECP? (Essential Community Provider)  YES  NO (explain) \_\_\_\_\_    Are you an FQHC (Federal Qualified Health Center) provider?  YES  NO    Other \_\_\_\_\_

**Contacts \*submission of e-mail addresses and signing of this form authorizes us to contact you via e-mail**

Correspondence Contact \_\_\_\_\_    Phone # \_\_\_\_\_    Email Address \_\_\_\_\_

Practice Administrator \_\_\_\_\_    Phone # \_\_\_\_\_    Email Address \_\_\_\_\_

**Correspondence address for mailing purposes:  Same as office location**

Street Address \_\_\_\_\_    Suite # \_\_\_\_\_    City \_\_\_\_\_    State \_\_\_\_\_    Zip \_\_\_\_\_

**Billing address for remit purposes:  Same as office location     Same as correspondence address**

Street Address \_\_\_\_\_    Suite # \_\_\_\_\_    City \_\_\_\_\_    State \_\_\_\_\_    Zip \_\_\_\_\_

Printed Name of Person completing this form \_\_\_\_\_

Signature of Person completing this form \_\_\_\_\_ Date \_\_\_\_\_

**Additional Comments:**  
\_\_\_\_\_