

PROVIDER INFORMATION FORM

- 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 affiliation change
 - » Physician leaving the practice
- Complete all pages of this form in its entirety to begin the process.
- Complete one form per provider.
- 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- Outdated forms will not be accepted.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 will review the application to ensure 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 after the third try, you must resubmit the form.
- Once the committee has reviewed your request, you will be notified in writing of their decision.
- If your application is approved, the credentialing process takes 60-90 days. (Your expediency will streamline this process.)
- If you have already completed your application with CAQH, please ensure 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 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, your panel provider effective date will be after we receive your signed contract. Therefore, you should not schedule or see AultCare patients until that time.
- Please submit this form and supporting documentation to one of the following:
 - » Email: credentialing@aultcare.com
 - » Fax: 330-363-6421
 - » Mail: AultCare | Attn: Network Analysis, Credentialing and Contracting | PO Box 6910 | Canton, OH 44709
- Please submit a copy of your W-9 to providermaintenance@aultcare.com.
- If you have additional questions, please contact AultCare and PrimeTime Network Analysis, Credentialing and Contracting at 330-363-1400 between 8 a.m. – 4:30 p.m. Eastern time, Monday – Friday.

OVERALL REASON FOR REQUEST (Check all that apply)

<input type="checkbox"/> New Provider	Effective Date	
<input type="checkbox"/> Deleting Provider	Effective Date	Reason
Where can medical records be retrieved?		
<input type="checkbox"/> Add Location	Effective Date	<input type="checkbox"/> Deleting Location Effective Date
<input type="checkbox"/> Practice Address Change	Effective Date	<input type="checkbox"/> Correspondence Change Effective Date
<input type="checkbox"/> Billing Address Change	Effective Date	<input type="checkbox"/> Update Information Effective Date
<input type="checkbox"/> Other (please explain)		

PRACTITIONER INFORMATION

DEA Certification Number (if applicable)		NPI Number (individual)	
First Name	Middle Initial	Last Name	
Suffix	Maiden Name	Title (M.D., etc.)	
Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Provider Direct Email		Languages Spoken	
Medicare Number of UPIN			
OH License Number		CAQH Number	
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 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?

Anger Management	<input type="checkbox"/> YES <input type="checkbox"/> NO	LGBTQ	<input type="checkbox"/> YES <input type="checkbox"/> NO
ADD/ADHD	<input type="checkbox"/> YES <input type="checkbox"/> NO	Marriage/Family	<input type="checkbox"/> YES <input type="checkbox"/> NO
Child & Adolescent	<input type="checkbox"/> YES <input type="checkbox"/> NO	OCD	<input type="checkbox"/> YES <input type="checkbox"/> NO
Eating Disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	PTSD/Trauma	<input type="checkbox"/> YES <input type="checkbox"/> NO
Faith-Based Counseling	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sexual Addiction	<input type="checkbox"/> YES <input type="checkbox"/> NO
Grief	<input type="checkbox"/> YES <input type="checkbox"/> NO	Substance Abuse	<input type="checkbox"/> YES <input type="checkbox"/> NO

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 NOIf approved, would you like this location to be listed in the directory? YES NODoes this provider regularly schedule to see patients at this location? YES NODo you provide your patients with the option of e-prescriptions? YES NODoes this location take walk-ins? YES NODoes this location provide extended hours? YES NODo you provide telehealth services at this location? YES NO

Tax ID

Group Name (legal name)

Office Name (for directory purposes)

Street Address

Suite Number

City

State

County

Zip Code

Telephone Number

Fax Number

NPI Group Number (if applicable)

LOCATION DETAIL INFORMATIONIs this location on an accessible transportation route? YES NODo you supply translation services for written material? YES NODo you provide and bill for lab services at this location? YES NODo you provide and bill for diagnostic radiology services at this location? YES NODo 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

Handicap accessible parking spaces, curb ramps or loading zones at building entrance? YES NODoorways wide enough to ensure safe passage by individuals using mobility aids? YES NOWheelchair accessible restrooms with grab bars and accessible lavatories? YES NOASL signage and raised tactile text characters at office, elevator and restroom doors? YES NOMedical equipment accessible to patients using mobility aids? YES NOExam rooms accessible to patients using mobility aids? YES NO

Other

CONTACTS (Submission of email addresses and signing of this form authorizes us to contact you via email)

Correspondence Contact

Phone Number

Email Address

Practice Administrator

Phone Number

Email Address

Correspondence address for mailing purposes Same as office location

Street Address

Suite Number

City

State

Zip Code

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

Street Address

Suite Number

City

State

Zip Code

Printed name of person completing this form _____

Signature of person completing this form _____ **Date** _____

Additional Comments