

## 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- Outdated forms will not be accepted.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](mailto: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](mailto: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)** New Provider      Effective Date Deleting Provider      Effective Date      Reason

Where can medical records be retrieved?

 Add Location      Effective Date       Deleting Location      Effective Date Practice Address Change      Effective Date       Correspondence Change      Effective Date Billing Address Change      Effective Date       Update Information      Effective Date 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       Male     Female      Date of Birth

Provider Direct Email      Languages Spoken

Medicare Number of UPIN

OH License Number      CAQH Number

Primary Specialty      Secondary Specialty  
List in Directory?  YES  NO      List in Directory?  YES  NOIf you are an OB/GYN or CNM, do you perform deliveries?  YES  NOIf 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 INFORMATION**Is 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**