

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- Outdated forms will not be accepted.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 this form and supporting documentation to:
AultCare
Attn: Network Analysis, Credentialing, & Contracting
PO Box 6910
Canton, OH 44709
- Please submit a copy of your W9 to ProviderMaintenance@aultcare.com
- 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: | Reason: | Where can Medical Records be retrieved? | | |
| <input type="checkbox"/> Practice Address Change | Eff Date: | <input type="checkbox"/> Deleting Location | Eff Date: | | |
| <input type="checkbox"/> Billing Address Change | Eff Date: | <input type="checkbox"/> Correspondence Change | Eff Date: | | |
| <input type="checkbox"/> Other | Explanation: | <input type="checkbox"/> Update Information | Eff Date: | | |
| 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? <i>*must submit copy of SCA</i> | | | | | |
| If you are an OB/GYN or CNM, do you perform deliveries? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| If you are an Ophthalmologist or Podiatrist, do you perform surgeries? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> None <input type="checkbox"/> | | | | | |
| 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:

