PROVIDER ENROLLMENT FORM

To avoid delays in the credentialing process:

- **Ensure physician information on your CAQH Proview™ profile is updated and accurate. (Note: Information you have in your *Provider Directory Snapshot* may be used in provider directories)**
- **Physician Assistants and Nurse Practitioners must send Collaborative Physician Agreements**
- **Complete all information below and sign the form**
- **Email completed form with W-9 to providernetwork@hap.org**

PHYSICIAN INFORMATION (For multiple providers, please attach a roster)

Name (last, first, middle): **Degree:**

☐ Male ☐ Female | **Race/ Ethnicity:** | **NPI number:** **Group NPI Number:**

Physician's CAQH ID number:
(Make sure HAP is added to physician's CAQH Registry)

CHAMPS number:
(if applicable)

Primary specialty:

Practicing specialty:

HAP requires participation in Medicare. Do you participate? ☐ Yes ☐ Pending ☐ No*
*If no, stop and resubmit once Medicare # obtained

PRIMARY OFFICE INFORMATION (for additional locations, attach a separate sheet)

Practice name:

Street address: **Suite #:**

City: **State:** **Zip:**

Phone: **Fax:** **Email:**

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.

Please check all that apply.

Any specialized training/experience

☐ Blindness/visual impairment ☐ Co-occurring disorders ☐ Homelessness ☐ Serious mental illness
☐ Child welfare ☐ Deafness or hard of hearing ☐ Other areas of specialty ☐ Substance abuse
☐ Chronic illness ☐ HIV/AIDS ☐ Physical disability ☐ Trauma
☐ None of these

Accommodations for individuals with disabilities

☐ Accessible exam rooms ☐ Grab bars ☐ Scales ☐ Wide entry
☐ Bathroom/stalls ☐ Lifts ☐ Wheelchair access ☐ Other accessible equipment

BILLING INFORMATION

Bill to name:

Tax identification number:

Billing NPI:

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:_____ Date:_____

Printed name: _____

Title:_____