



PROVIDER ENROLLMENT FORM

This form should be used by Physician Hospital Organizations/Physician Organizations (PHOs/POs) and individual providers for non-delegated networks and direct agreements.

Instructions

To avoid delays in the credentialing process:

1. Ensure provider information on your CAQH Proview™ profile is up to date and accurate. Note: Information in your *Provider Directory Snapshot* may be used in provider directories.
2. Physician Assistants and Nurse Practitioners must complete a Collaborative Physician Agreements. (A HAP agreement is available at hap.org/providers, then select *Join HAP*).
3. Complete all fields below and sign the form.
4. Email completed form with current W-9 (signed and dated) and any other required documents to providernetwork@hap.org.

PROVIDER INFORMATION (For multiple providers, please attach a roster)			
Name (last, first, middle):			Degree:
Male	Female	Race/Ethnicity:	
NPI #:		Group NPI #:	
Physician's CAQH ID number: (Make sure HAP is added to physician's CAQH Registry)		CHAMPS number: (if applicable)	
Medicare #: (HAP requires participation in Medicare. If you don't participate, stop and resubmit once Medicare # obtained)			
Primary Care Physician		Specialist	Hospital based
Primary specialty:			
Practicing specialty:			

PRIMARY OFFICE INFORMATION (for additional locations, complete next page)			
Practice name:			
Street address:			Suite #:
City:		State:	Zip:
Phone:	Fax:	Email:	
Do you offer telehealth services?	Yes	No	
Please choose one. Employed by:	Health System	Independent Group	
Contract with PHO and/or PO?	Yes	No	
If yes, please indicate which hospital system or PHO/PO affiliations:			

BILLING INFORMATION			
Pay to name:			
Tax identification number:			Billing NPI:
Address:			
Phone:	Fax:	Email:	

Additional Office Locations

Attach a separate sheet with the same information if you have more office locations.

Street:			
City, ST, Zip:			
Phone:	Fax:	Email:	
TIN:		Website:	
Telehealth services offered:	Yes	No	
Hours:			
Effective date of addition:			
Street:			
City, ST, Zip:			
Phone:	Fax:	Email:	
TIN:		Website:	
Telehealth services offered:	Yes	No	
Hours:			
Effective date of addition:			
Street:			
City, ST, Zip:			
Phone:	Fax:	Email:	
TIN:		Website:	
Telehealth services offered:	Yes	No	
Hours:			
Effective date of addition:			
Street:			
City, ST, Zip:			
Phone:	Fax:	Email:	
TIN:		Website:	
Telehealth services offered:	Yes	No	
Hours:			
Effective date of addition:			

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

Email

Phone