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- Outdated forms will not be accepted.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
- 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)			
☐ New Provider	Eff Date:	☐ Deleting Provider	Eff Date:
☐ Add Location	Eff Date:	☐ Deleting Location	Eff Date:
☐ Practice Address Change	Eff Date:	☐ Correspondence Change	Eff Date:
☐ Billing Address Change	Eff Date:	☐ Update Information	Eff Date:
☐ Other	Explanation:		

Practitioner Information

DEA Certificate # (if applicable)	NPI # (Individual)		
First Name	Middle Initial	Last Name	
Suffix	Maiden Name		Title (MD, etc)
Social Security #	☐Male ☐Female		Date of Birth
Provider Direct Email:		Languages Spoken	
Medicare # or UPIN		Medicaid #	
OH License #		CAQH #	
Primary Specialty	List in Directory? ☐ YES ☐ NO	Secondary Specialty	List in Directory? ☐ YES ☐ NO
If you are an OB/GYN, do you perform deliveries? ☐ 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? All ☐ None ☐

Blindness or Visual Impairment	**Yes** ☐	**No** ☐	Physical Disabilities	**Yes** ☐	**No** ☐
Chronic Illness	**Yes** ☐	**No** ☐	Serious Mental Illness	**Yes** ☐	**No** ☐
Co-Occurring Disorders	**Yes** ☐	**No** ☐	Substance Abuse	**Yes** ☐	**No** ☐
Deafness or Hard-of-Hearing	**Yes** ☐	**No** ☐	Are you a Ryan White HIV provider?	**Yes** ☐	**No** ☐
HIV/AIDS	**Yes** ☐	**No** ☐	Are you an Indian provider as defined by CMS?	**Yes** ☐	**No** ☐
Homelessness	**Yes** ☐	**No** ☐	Are you a family planning provider?	**Yes** ☐	**No** ☐
Intellectual and Developmental Disorders	**Yes** ☐	**No** ☐	Other?	**Yes** ☐	**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 ☐ NO	If approved, would you like this location to be listed in the directory? ☐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	Office Name	
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 ☐	Start / End / Closed ☐	Start / End / Closed ☐	Start / End / Closed ☐	Start / End / Closed ☐	Start / End / Closed ☐	Start / End / Closed ☐

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	

Contacts **submission of e-mail addresses and signing of this form authorizes us to contact you via e-mail*

Credentialing 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: