PRACTITIONER ENROLLMENT FORM
MICHIGAN ASSOCIATION OF HEALTH PLANS (MAHP)

IMPORTANT INSTRUCTIONS FOR COMPLETING THIS FORM:

1. Form must be typed and digitally signed. Handwritten forms will not be accepted.
2. Users will need to download the form, complete the required data fields, save, and upload the form without printing the document.

*** DENOTES REQUIRED FIELDS**

SELECT THE HEALTH PLAN(S) YOU WISH TO JOIN*

- ☐ Aetna Better Health of Michigan
- ☐ Blue Cross Complete
- ☐ Health Alliance Plan/HAP CareSource
- ☐ McLaren Health Plan
- ☐ Meridian Health Plan of Michigan
- ☐ Molina Healthcare of Michigan
- ☐ Paramount Care of Michigan
- ☐ Priority Health
- ☐ United Healthcare Community Plan
- ☐ Upper Peninsula Health Plan

PERSONAL INFORMATION

COMPLETE FORM IN FULL. ATTACH ADDITIONAL SHEETS IF THERE IS INSUFFICIENT SPACE.

Last Name*	First Name*	Middle Initial (if applicable)	Degree/Credential*

Gender*

- ◯ Male
- ◯ Female
- ◯ Other

Race/Ethnicity

- ☐ White/Caucasian
- ☐ Black or African American
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Hispanic or Latino
- ☐ Asian
- ☐ Choose not to disclose
- ☐ Other

LICENSURE & REGISTRATION

Lines of Business* (HMO, PPO, Medicaid, etc.)	Does the provider participate in Medicare?*	Is provider Hospital Based Only?*
Effective Date of Licensure*	National Provider Identifier (NPI)*	CHAMPS Number*
Medicare ID*	Medicaid ID*	CAQH ID*
State License (if applicable)	Issuing State	Expiration Date
State License (#2)	Issuing State	Expiration Date
State License (#3)	Issuing State	Expiration Date

Health Plans do not discriminate against or base credentialing decisions on an applicant's race, ethnicity, or language, providing that information is optional.

CLIA Certificate (if applicable, provide a copy of the certificate)	CLIA Certificate Expiration Date (if applicable, provide a copy of the certificate)	
X-Ray License (if applicable)	X-Ray License Expiration Date (if applicable)	
DEA Controlled Substance License (if applicable) ◯ Yes ◯ No ◯ N/A	PSYPACT Approved (if applicable) ◯ Yes ◯ No ◯ N/A	PSYPACT Number

SPECIALTY INFORMATION

Specialty #1*		Taxonomy*	List Specialty in Directory*	
Board Certified ◯ Yes ◯ No	Board Lifetime Cert. ◯ Yes ◯ No	Board Certification Name (if applicable)	Board Certificate Number	Expiration Date

Specialty #2		Taxonomy	List Specialty in Directory	
Board Certified ◯ Yes ◯ No	Board Lifetime Cert. ◯ Yes ◯ No	Board Certification Name (if applicable)	Board Certificate Number	Expiration Date

Specialty #3		Taxonomy	List Specialty in Directory	
Board Certified ◯ Yes ◯ No	Board Lifetime Cert. ◯ Yes ◯ No	Board Certification Name (if applicable)	Board Certificate Number	Expiration Date

Specialty #4		Taxonomy	List Specialty in Directory	
Board Certified ◯ Yes ◯ No	Board Lifetime Cert. ◯ Yes ◯ No	Board Certification Name (if applicable)	Board Certificate Number	Expiration Date

Collaborating/Supervising Provider Last Name (if applicable)	Collaborating/Supervising Provider First Name (if applicable)	Collaborating/Supervising Provider Middle Name (if applicable)
Collaborating and/or Supervising Provider Degree (if applicable)	Collaborating and/or Supervising Provider License Number (if applicable)	
Collaborating and/or Supervising Provider License Issue State (if applicable)	Collaborating and/or Supervising Provider NPI (if applicable)	

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PRACTICE INFORMATION

Specialized Training and Experience in Treating (if applicable)		Hospital Affiliations (if applicable)
☐ Blind/Visually Impaired	☐ Serious Mental Illness	
☐ Deaf/Hard-of-hearing	☐ American Sign Language	
☐ Homelessness	☐ HIV/AIDS	
☐ Physical Disabilities	☐ Chronic Illness	Hospital Affiliation Appointment Type (if applicable)
☐ LGBTQ+	☐ Child Welfare	
☐ Trauma	☐ Co-occuring Disorders	
	☐ Cognitive Disabled	Hospital Affiliation Appointment Date (if applicable)

GROUP PRACTICE INFORMATION

Legal Business Name*	Medical Group Practice Name*
Group Billing NPI*	Group Taxonomy*
Effective Date in Group*	Group Type* ☐ PO ☐ PHO ☐ Independent Group ☐ Other
Group Tax ID Number (TIN)*	PO/PHO Name*

PRACTICING LOCATIONS

Scope of Practice*

☐ PCP ☐ OBGYN ☐ Specialist ☐ BH ☐ Hospital Based Only ☐ Other _____

Is this your Primary Location?* ◯ Yes ◯ No		Practicing Location Name*		
Practicing Location Billing NPI*		Start Date at Location		
Address Line 1*	Address Line 2*	City*	State*	Zip Code*
Tax ID Number (TIN)*	Location Phone*	Location Fax*		
Direct appointments at this location?* ◯ Yes ◯ No	Appointment Phone (if different than Location Phone)	Provider Fax (if different than Location Fax)		
Do you practice at this location at least 20 hours a week?* ◯ Yes ◯ No		Do you practice at a nonstandard practice location?* (residence, church, etc.) ◯ Yes ◯ No		

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Accepting Patients at this Location* ◯ Accepting New ◯ Not Acccepting ◯ Exsiting Patients Only ◯ Covering Only	Include Location in Directory* ◯ Yes ◯ No	Gender Limitations*
Accepts Minimum Patient Age*	Accepts Maximum Patient Age*	
Do you accept auto-assigned members?* ◯ Yes ◯ No	Do you accept CSHCS members?* ◯ Yes ◯ No	
Do you E-Prescribe?* ◯ Yes ◯ No	What counties do you serve?*	
Practice Capacity Minimum Enrollees* ◯ Yes ◯ No Mimimum ◯ Maximum _____		
Practice Email*	Practice Website (if applicable)	
Non-English Languages Spoken at Location	Location Offers American Sign Language* ◯ Yes ◯ No ◯ N/A	
Telecommunication Device for Deaf (TDD) Number	Text Telephone (TTY) Number	
Offer Telehealth* ◯ Yes ◯ No ◯ N/A	Virtual Only* ◯ Yes ◯ No	Patient Center Medical Home Certified* ◯ Yes ◯ No ◯ N/A

Group Hours (if applicable)

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
After-hours Coverage	☐	☐	☐	☐	☐	☐	☐

Practice Limitation (if applicable)	Primary Location Service
Access to Public Transportation* ◯ Yes ◯ No ◯ N/A	Language Line Available* ◯ Yes ◯ No ◯ N/A

Physical Accessibility*

☐ Parking ☐ Exam Room ☐ Portable Lifts ☐ Restrooms ☐ Text Telephone (TTY)
☐ Office ADA Accessible ☐ Exam Table Scales ☐ Medical Equipment ☐ Grab Bars ☐ Non ADA Accessibility

ADA Compliance* ◯ Yes ◯ No ◯ N/A	Completion of Cultural Competency* ◯ Yes ◯ No ◯ N/A
Completion of Annual FWA Training* ◯ Yes ◯ No ◯ N/A	CSHCS Attestation* ◯ Yes ◯ No ◯ N/A

Completion of the Model Of Care Training (if applicable)
◯ Yes ◯ No ◯ N/A

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Qualified Onsite Medical Interpreter Available* ◯ Yes ◯ No ◯ N/A	Call Ahead for Onsite Interpreter* ◯ Yes ◯ No ◯ N/A
Documents Available in Languages Other than English* ◯ Yes ◯ No ◯ N/A	Vaccines for Children Program Participant* ◯ Yes ◯ No ◯ N/A
Electronic Medical Records* ◯ Yes ◯ No ◯ N/A	Electronic Medical Records Software*

BILLING AND TAX INFORMATION

W-9 IS REQUIRED WITH ENROLLMENT FORM

Legal Business Name as it Appears on W-9*		Tax ID Type* ◯ EIN ◯ SSN, as listed on the W-9 form		
Remittance Address 1*	Remittance Address 2*	Remittance City*	Rem. State*	Rem. Zip Code*
Phone Number*	Fax Number*	Billing Contact Person*	Billing Contact's Email*	

CREDENTIALING CONTACT INFORMATION

First Name*	Last Name*	
Phone Number*	Fax Number*	Email*

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STANDARD AUTHORIZATION, ATTESTATION AND RELEASE

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowleTe that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowleTe that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowleTe and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowleTe that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowleTe and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowleTe that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowleTe that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

Title*

Date Signed*