

Additional Practice Form

Arkansas Health Network



Form instructions: Please complete this form to submit supplemental information about additional practice locations that operate under the same Tax ID Number (TIN) as identified on your Network Application. Complete as many pages as needed to accommodate all locations and attach to your Network Application Form. Electronic formats available upon request.

For application questions: Tiffani Butler, 501.442.5523, TButler@stvincenthealth.com
 or Hayden Finley, 870.926.7917, HLFinley@stvincenthealth.com

Section 1 - Individual/Group Practice Details

Important: If there any providers who use a **different** Tax ID or TIN, a separate AHN application must be submitted!

Additional Practice Location # _____

Practice Information (ALL fields are required)			
Legal business name			
"Doing business as" (DBA) name, if different than above			
Tax ID Number (TIN)		Practice/Group NPI	
Primary phone number	Secondary phone number	Fax number	
Practice address (where providers see patients)	City	State	Zip
Mailing address (if different from above)	City	State	Zip
Billing address (if different from above)	City	State	Zip
Practice email	Website (URL) if applicable		
Do you use an electronic medical record (EMR)?	EMR Name	EMR Version	

Practice Contacts <i>Please fill in each of the contact types below. They may be the same person. Check one as the Primary Contact.</i>				
Primary Contact? <input type="checkbox"/>	Executive Director	First name	Middle initial	Last name
		Email address	Phone number	Position or title

Additional Practice Form

Arkansas Health Network



Primary Contact? <input type="checkbox"/>	Practice Manager	First name	Middle initial	Last name
		Email address	Phone number	Position or title
Primary Contact? <input type="checkbox"/>	Credentialing Manager <i>(for roster information updates)</i>	First name	Middle initial	Last name
		Email address	Phone number	Position or title
Primary Contact? <input type="checkbox"/>	Other Contact <i>(Optional)</i>	First name	Middle initial	Last name
		Email address	Phone number	Position or title

Additional Practice Location # _____

Practice Information <i>(ALL fields are required)</i>				
Legal business name				
"Doing business as" (DBA) name, if different than above				
Tax ID Number (TIN)		Practice/Group NPI		
Primary phone number	Secondary phone number		Fax number	
Practice address (where providers see patients)		City	State	Zip
Mailing address (if different from above)		City	State	Zip
Billing address (if different from above)		City	State	Zip
Practice email		Website (URL) if applicable		
Do you use an electronic medical record (EMR)?	EMR Name		EMR Version	

Additional Practice Form

Arkansas Health Network



Practice Contacts <i>Please fill in each of the contact types below. They may be the same person. Check one as the Primary Contact.</i>				
Primary Contact? <input type="checkbox"/>	Executive Director	First name	Middle initial	Last name
		Email address	Phone number	Position or title
Primary Contact? <input type="checkbox"/>	Practice Manager	First name	Middle initial	Last name
		Email address	Phone number	Position or title
Primary Contact? <input type="checkbox"/>	Credentialing Manager <i>(for roster information updates)</i>	First name	Middle initial	Last name
		Email address	Phone number	Position or title
Primary Contact? <input type="checkbox"/>	Other Contact <i>(Optional)</i>	First name	Middle initial	Last name
		Email address	Phone number	Position or title

Additional Practice # _____

Practice Information <i>(ALL fields are required)</i>				
Legal business name				
"Doing business as" (DBA) name, if different than above				
Tax ID Number (TIN)		Practice/Group NPI		
Primary phone number	Secondary phone number	Fax number		
Practice address (where providers see patients)	City	State	Zip	
Mailing address (if different from above)	City	State	Zip	
Billing address (if different from above)	City	State	Zip	
Practice email	Website (URL) if applicable			
Do you use an electronic medical record (EMR)?	EMR Name	EMR Version		

Additional Practice Form

Arkansas Health Network



Practice Contacts <i>Please fill in each of the contact types below. They may be the same person. Check one as the Primary Contact.</i>				
Primary Contact? <input type="checkbox"/>	Executive Director	First name	Middle initial	Last name
		Email address	Phone number	Position or title
Primary Contact? <input type="checkbox"/>	Practice Manager	First name	Middle initial	Last name
		Email address	Phone number	Position or title
Primary Contact? <input type="checkbox"/>	Credentialing Manager <i>(for roster information updates)</i>	First name	Middle initial	Last name
		Email address	Phone number	Position or title
Primary Contact? <input type="checkbox"/>	Other Contact <i>(Optional)</i>	First name	Middle initial	Last name
		Email address	Phone number	Position or title