Arkansas Health Network



<u>Form instructions:</u> 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, <a href="https://https

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	han above	e					
Practice Specialty							
Tax ID Number (TIN)			Practice/Group NPI				
Primary phone number	Seconda	Secondary phone number Fax r		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	9				
Do you use an electronic medical record (EMR)? EMR Na			me		EMR Version		

Arkansas Health Network



riactice	e Contacts Fleuse Jili III euch	of the contact types below. They ma	y be the sume person. C	HECK OH	e as the Filliary Contact.			
Primary Contact? Executive Director		First name	Middle initial	Last r	name			
	Executive Director	Email address	Phone number		Position or title			
Primary Contact? Practice Manager		First name	Middle initial	Last r	name			
	Email address	Phone number	_	Position or title				
Primary Contact? Credentialing Manager	First name	Middle initial	Last r	name				
	(for roster information updates)	Email address	Phone number		Position or title			
Primary Contact? Other Contact (Optional)		First name	Middle initial	Last r	name			
		Email address	Phone number		Position or title			
Insuran	nce Credentialing	<u>, </u>						
		If YES:						
Cigna Credentialing	☐ In Process	Estimated date of comp	oletion:					
☐ Yes ☐ No		☐ Completed	Effective Date:	Comple Date:	leted Notification			
		If YES:						
BCBS Credentialing Yes No		☐ In Process	Estimated date of completion:					
		☐ Completed	Effective Date:	Compl Date:	leted Notification			
Centene/QualChoice Credentialing ☐ Yes ☐ No		If YES:						
		☐ In Process	Estimated date of comp	timated date of completion:				
		☐ Completed	Effective Date:	Comple Date:	leted Notification			
		If YES:						
Aetna Credentialing ☐ Yes ☐ No		☐ In Process	Estimated date of comp	timated date of completion:				
		☐ Completed	Effective Date:	Comple Date:	pleted Notification :			
_		If YES:						
UMR/UH	C Credentialing	☐ In Process	Estimated date of comp					
☐ Yes	□ No		Effective Date:	Comple	eted Notification			

□ Completed

Effective Date:

Completed Notification

Date:

Practice Information (ALL fields are required)

Arkansas Health Network



Additional Practice Location #____

Legal business name										
"Doing bu	isiness as" (DBA) name, if differe	ent than abov	/e							
Practice S	pecialty			ı						
Tax ID Nu	mber (TIN)			Practice/Grou	rup NPI					
Primary p	hone number	Second	ary phone	number Fax num			nber	ıber		
Practice a	ddress (where providers see pat	cients)		City			State		Zip	
Mailing ac	ddress (if different from above)			City			State		Zip	
Billing add	dress (if different from above)			City			State		Zip	
Practice email Website (UR				Website (URL)	L) if applicable					
Do you use an electronic medical record (EMR)? EMR Nai			me	ne EMR Version						
Practice Contacts Please fill in each of the contact types below. They may be the same person.					erson. Ch	eck one	e as the	Primary Contact.		
Primary Contact?	Executive Director	First name			Middle initi	le initial La:		name		
	Executive Director		ess	Phone number				Position or title		
Primary Contact?	Describes Management	First name			Middle initial		Last name			
Practice Manager Email address			Phone number			Position or title				
Primary Contact? Credentialing Manager		First name			Middle initial		Last name			
	(for roster information undates)			Phone number		Position or title		on or title		
Primary Contact?	Other Contact	First name			Middle initi	le initial Last na		ame		
	(Optional)	Email addr	ess		Phone num	nber		Positio	on or title	

If YES:

Arkansas Health Network

Insurance Credentialing



Cigna Credentialing	☐ In Process	Estimated date of completion:					
☐ Yes ☐ No	☐ Completed				Completed No	otification	
	If YES:						
BCBS Credentialing	☐ In Process		Estimated date of completion:				
☐ Yes ☐ No	☐ Completed		Effective Date: Completed Notification Date:			otification	
	If YES:						
Centene/QualChoice Credentialing	☐ In Process		Estimated date of completion:				
☐ Yes ☐ No	☐ Completed		Effective Date:		Completed Notification Date:		
	If YES:						
Aetna Credentialing	☐ In Process		Estimated date of completion:				
☐ Yes ☐ No ☐ Completed			Effective Date:		Completed Notification Date:		
	If YES:						
UMR/UHC Credentialing	☐ In Process		Estimated date of completion:				
Yes No Completed			Effective Date:		Completed Notification Date:		
Additional Practice # Practice Information (ALL fields are	e required)						
Logal business name							
Legal business name							
"Doing business as" (DBA) name, if differen	than above						
Practice Specialty							
Tax ID Number (TIN)			Practice/Group NPI				
Primary phone number	Secondary phone	number	Fax number				
				1			
Practice address (where providers see patients)					State	Zip	
Mailing address (if different from above)			City			Zip	

Arkansas Health Network



Billing address (if different from above)			City			!	Zip		
Practice email				Website (URL) if applicable					
Do you us	se an electronic medical record (EMR)?	EMR Na	ame EN			MR Version		
			l			l			
Practice	e Contacts Please fill in each	of the contac	t types bei	low. They may	be the same persor	n. Check on	e as the	Primary Contact.	
Primary Contact?	Primary First name		Middle initial		Last r	Last name			
	Executive Director	Email addre			Phone number	l	Positi	on or title	
Primary		First name			Middle initial	Last r	name		
Contact? Practice Manager		Email address			Phone number			Position or title	
Primary Contact? Credentialing Manager	First name			Middle initial	Middle initial Last r		name		
(for roster information updates)		Email address			Phone number	Phone number		on or title	
Contact? Other Contact (Optional)		First name			Middle initial	Middle initial Last r		name	
		Email address			Phone number		Positi	on or title	
Insuran	ce Credentialing								
If YES:									
Cigna Credentialing ☐ Yes ☐ No		☐ In Process			Estimated date of com		ipletion:		
		☐ Completed					Completed Notification Date:		
BCBS Credentialing		If YES:							
		☐ In Process		E	Estimated date of completion		on:		
		☐ Completed		E ⁻	Effective Date:		Completed Notification Date:		
		If YES:							
Centene/QualChoice Credentialing		☐ In Process		E	Estimated date of completion:				
☐ Yes ☐ No		☐ Completed E			Effective Date: Cor		Completed Notification		

Date:

Arkansas Health Network



	If YES:				
Aetna Credentialing	☐ In Process	Estimated date of completion:			
☐ Yes ☐ No	☐ Completed	Effective Date:	Completed Notification Date:		
	If YES:				
UMR/UHC Credentialing	☐ In Process	Estimated date of completion:			
☐ Yes ☐ No	☐ Completed	Effective Date:	Completed Notification Date:		