Arkansas Health Network



<u>Form instructions:</u> Please complete this form to submit supplemental information about active providers at your practice. Complete as many pages as needed to accommodate all your active providers. If applicable, attach this form 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, <u>HLFinley@stvincenthealth.com</u>

Section 1 - Practice Confirmation

Instructions: In this section, confirm which practice these additional providers are affiliated with.									
Practice Name:									
Practice Tax ID Number (TIN):									
Practice Address:									
Practice Phone Number:									

Section 2 - Additional Provider Details

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



Provider # Details (ALL fields are required)												
First name		Middle n	ame/initia	ıl	Last r	name				Name suffix (Jr., Sr., II, III, IV, etc.)		
Degrees (MD, DO, APRN, PhD, etc.))	Primar	y specialty	1				Secondary	econdary specialties			
Provider NPI	Ge	ender (M,	/F/NA)	Date	e of bir	rth (MM/	/DD/YY	YY)	Date hir	red at this practice		
Direct phone number (for outreach	арр)	Direc	t emai	ommunications)								
Tax ID (if different than practice)	Во	ard statu	JS			Panel st	nel status (check one)					
		Certified	l 🗆 El	igible		☐ Oper	n to ne	w patients	☐ Clos	ed to New Patients		
Languages spoken (in addition to English)												
Does this provider work at other practice locations? If so, please list here:												
AR State Medical License ID		AR State	Medic	al Lice	ense Effec	ective Date AR State Medical License Expiration Date						
DEA License ID		DEA Lice	nse Eff	ective	Date	DEA License Expiration Date						
Insurance Credentialing												
Cigna Credentialing		If Y	ES:									
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Degrees (MD, DO, APRN, PhD, etc.)		Primary	y specialty	_				Secondary	Secondary specialties			
Provider NPI	Gei	nder (M,	/F/NA)	Da	ite of bir	rth (M	IM/DD/YY	YY)	Date hir	ed at this practice		
Direct phone number (for outreach	l mobile	арр)	Dire	ect emai	il addr	ress (for access to analytics and communications)						
Tax ID (if different than practice)	ıs	اطنعنا				check one)						
☐ Certified ☐ Eligible ☐ Open to new patients ☐ Closed to New Patients										ed to New Patients		
Languages spoken (in addition to English)												
Does this provider work at other practice locations? If so, please list here:												
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DEA License ID		DEA Lice	nse E	ffective	Date	DEA License Expiration Date						
Insurance Credentialing												
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Direct phone number (for outreach	l mobile	арр)	Dire	ect emai	il addı	ress (for access to analytics and communications)						
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Tax ID (if different than practice) Board status							·	check one)	k one)			
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