Network Application Form

Arkansas Health Network – Individual/Group Practices

AHN Application instructions: Please complete this application and attachments (if needed) completely and accurately. To be considered a legal participant in the network, AHN will also require a signed Participating Provider Agreement and Business Associate Agreement. For more details, visit our website at http://www.arkansashealthnetwork.com/providers. Electronic formats available upon request.

For application questions: Tiffani Butler, 501.442.5523, TButler@stvincenthealth.com

Section 1 – Individual/Group Practice Details

Instructions: In this section, enter details about your practice. If the practice has multiple locations that all **use the same Tax ID Number (TIN)**, complete the Additional Practice Form and include with your submitted application.

Important: If this practice has any locations that use a **different** Tax ID Number (TIN), a separate Network Application Form must be submitted!

Practice Information			
Legal business name			
"Doing business as" (DBA) name, if different than above			
Practice Specialty			
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	

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

Section 2 – Provider Details

Instructions: In this section, enter details for all active providers at your practice. If there are more than two providers, and all of them **use the same Tax ID or TIN** entered on page 1 of this form, complete the Additional Provider Form and include with your submitted application.

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

Provider #___ Details			
First name	Middle name/initial	Last name	Name suffix (Jr., Sr., II, III, IV, etc.)
Degrees (MD, DO, APRN, PhD, etc.)	Primary specialty	Secondary specialties	
Provider NPI	Gender (M/F/NA)	Date of birth (MM/DD/YYYY)	Date hired at this practice
Direct phone number (for outreach and mobile app)	Direct email address (for access to analytics and communications)		
Tax ID (if different than practice)	Board status… ☐ Certified ☐ Eligible	Panel status (check one)… ☐ Open to new patients ☐ Closed to New Patients	
Languages spoken (in addition to English)			

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Does this provider work at other practice locations? If so, please list here:		
AR State Medical License ID	AR State Medical License Effective Date	AR State Medical License Expiration Date
DEA License ID	DEA License Effective Date	DEA License Expiration Date

Insurance Credentialing

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

Provider #___ Details

First name	Middle name/initial	Last name	Name suffix (Jr., Sr., II, III, IV, etc.)
Degrees (MD, DO, APRN, PhD, etc.)	Primary specialty	Secondary specialties	
Provider NPI	Gender (M/F/NA)	Date of birth (MM/DD/YYYY)	Date hired at this practice
Direct phone number (for outreach and mobile app)	Direct email address (for access to analytics and communications)		
Tax ID (if different than practice)	Board status… ☐ Certified ☐ Eligible	Panel status (check one)… ☐ Open to new patients ☐ Closed to New Patients	

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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 Medical License Effective Date	AR State Medical License Expiration Date
DEA License ID	DEA License Effective Date	DEA License Expiration Date

Insurance Credentialing

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

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Section 3 – Practice Questionnaire

Instructions: Please complete the entire questionnaire below. All questions are required.

A. Insurance Credentialing

BCBS Credentialing ☐ Yes ☐ No	Cigna Credentialing ☐ Yes ☐ No	Centene/QualChoice Credentialing ☐ Yes ☐ No
Aetna Credentialing ☐ Yes ☐ No	UMR/UHC Credentialing ☐ Yes ☐ No	Other(s): ☐ Yes ☐ No _____

i) From the list above, are there any insurance types for which your practice is not accepting new patients? If yes, indicate which ones below.

_____

_____

B. Facilities & Hospitals

i) Please list which facilities your provider(s) are credentialed with:

Inpatient Facilities/Hospitals: _____

Outpatient Facilities/Surgery Centers: _____

Post-Acute Facilities: _____

Other: _____

C. Participation in Value-based Programs

i) Please check all programs that you are actively participating in. If checked, please also share the associated payor/sponsor of the program and the start date of your participation.

- ☐ Comprehensive Primary Care Plus (CPC+)
- ☐ Primary Care First
- ☐ Medicare Shared Savings Program (MSSP)
- ☐ Patient-Centered Medical Home (PCMH)
- ☐ Commercial Accountable Care Organization
  (i.e. ABCBS Collaborative Health Initiative, Cigna Collaborative Accountable Care, United, Humana, etc)
- ☐ Bundled Payment Arrangements (BPCI, BPCI-A, CJR etc)
- ☐ Medicare Advantage Plans
- ☐ Employer-Sponsored Accountable Care Organization
- ☐ Other: _____

ii) Do you currently have any staff dedicated to the value-based programs checked above or other quality/cost performance improvement (i.e. care managers, social workers, counselors etc)? If so, please describe the roles and their functions within your practice below.

_____

_____

_____

_____

iii) Are you engaging in other forms of patient/care management? If so, please describe below.

_____

_____

_____

_____

iv) Do you offer telehealth services? If so, please describe below.

_____

_____

_____

_____

Section 4 – Quality Measure Performance

Please provide quality performance data for the listed measures for the last two complete performance years. Measures will vary for Primary Care and Specialty Care practices. Data should represent performance for all eligible providers and patients in your practice. If preferred, you may attach separate dashboards provided they contains all the necessary elements.

Primary Care Providers: *Submit performance data for all the required measures shown below. Measure definitions can be viewed here: https://qpp.cms.gov/mips/explore-measures?tab=qualityMeasures&py=2021*

Measure Name	**Prior Year #1** **20_____ (fill in year)**	**Prior Year #2** **20_____ (fill in year)**
Diabetes Management Diabetes: HbA1c Poor Control (> 9%) CMS122v9	Numerator: Denominator: Performance (%):	Numerator: Denominator: Performance (%):

Diabetes Management Diabetes: Medical Attention for Nephropathy CMS134v9	Numerator: Denominator: Performance (%):	Numerator: Denominator: Performance (%):
Diabetes Management Diabetes: Eye Exam CMS131v9	Numerator: Denominator: Performance (%):	Numerator: Denominator: Performance (%):
Hypertension Management: Blood Pressure Control (<140/<90) CMS165v9	Numerator: Denominator: Performance (%):	Numerator: Denominator: Performance (%):
Annual Wellness Visits (AWVs): Patients with Completed AWVs	Numerator: Denominator: Performance (%):	Numerator: Denominator: Performance (%):

Performance Notes (Optional):

_____

_____

_____

_____

Specialty Care Providers: *Submit performance data for the three measures of your choosing from the applicable MIPS Specialty Measure Set relevant to your specialty. Measure sets and definitions can be viewed here: https://qpp.cms.gov/mips/explore-measures?tab=qualityMeasures&py=2021*

MIPS Specialty Measure Set: _____

Measure Name	**Prior Year #1** **20_____ (fill in year)**	**Prior Year #2** **20_____ (fill in year)**
Measure #1:	Numerator: Denominator: Performance (%):	Numerator: Denominator: Performance (%):
Measure #2:	Numerator: Denominator: Performance (%):	Numerator: Denominator: Performance (%):

Measure #3:	Numerator: Denominator: Performance (%):	Numerator: Denominator: Performance (%):

Performance Notes (Optional):

_____

_____

_____

_____

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Section 5 – AHN Involvement

i) List physicians identified in this AHN Application who are interested in participating in an AHN committee or subcommittee (Clinical Care, Finance & Contracting, Network Development, Analytics & IT, and Coworker Health Services). Be specific if a particular committee is desired.

_____

_____

_____

_____

_____

Verification. *I represent and warrant that I have authority to submit this AHN Application on behalf of the individuals listed herein. To the best of my knowledge, the information provided in this AHN Application is complete and accurate. I authorize Arkansas Health Network to access information regarding my practice and the practice entity (listed by TIN) defined as the Participant on this AHN Application to evaluate this application to participate in AHN. I also agree to provide additional information that AHN might reasonably request in connection with that evaluation. I understand that completing this enrollment form neither obligates nor entitles the Participant to participate in AHN. I further understand and agree that if my application is accepted, the Participant and the individuals listed herein may need to execute a Participation Agreement and other agreements and take certain other actions to participate in AHN.*

Signature: _____

Print name and title: _____

Name of Participant: _____

Date signed: _____