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.

For application questions: Tiffani Butler, 501.442.5523, TButler@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 t	han above					
Practice Specialty						
Tax ID Number (TIN)		Practice/Group NPI				
Primary phone number	Secondary phon	e number	Fax nun	number		
Practice address (where providers see patient	ts)	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)? ☐ Yes ☐				1R Version		

Arkansas Health Network



Practice	<b>Contacts</b> Please fill in each	of the contact types below. They m	nay be the	e same person. C	heck on	e as the Primary Contact.	
Primary Contact?	Executive Director	First name	Mic	ddle initial	Last n	ame	
		Email address	Pho	one number		Position or title	
Primary Contact? Practice Manager		First name		ddle initial	Last n	ame	
	Tractice Wallager	Email address	Pho	one number		Position or title	
Primary Contact?	Credentialing Manager	First name	Mic	ddle initial	name		
	(for roster information updates)	Email address	Pho	one number		Position or title	
Primary Contact?	Other Contact	First name	Mic	ddle initial	Last n	name	
	(Optional)	Email address	Pho	Phone number		Position or title	
Insuran	ce Credentialing						
		If YES:					
Cigna Cre	edentialing	☐ In Process	☐ In Process Estimate				
☐ Yes ☐ No		☐ Completed Effi		Comple ective Date: Notifica		eted ation Date:	
		If YES:					
BCBS Cre	dentialing	☐ In Process Esti		stimated date of completion:			
☐ Yes	□ No	☐ Completed	Effective	e Date:	Comple	eted ation Date:	
		If YES:					
Centene/QualChoice Credentialing		☐ In Process Esti		timated date of completion:			
☐ Yes	□ No	☐ Completed	Effective	e Date:	Comple	eted ation Date:	
		If YES:					
Aetna Credentialing		☐ In Process	Estimate	stimated date of completion:			
☐ Yes	□No	☐ Completed	Effective	e Date:	Comple	eted ation Date:	
		If YES:					
UMR/UH	C Credentialing	☐ In Process	Estimate	stimated date of completion:			
☐ Yes ☐ No		☐ Completed	Effective	e Date:	Comple	eted ation Date:	

Arkansas Health Network



Additional Practice Location #\_\_\_\_

Practice Information (ALL fields are required)										
Legal business name										
"Doing bu	usiness as" (DBA) name, if differe	ent than abo	ove							
Practice S	specialty									
Practice Specialty										
Tax ID Nu	mber (TIN)			Practice/Grou	p NPI					
Primary p	hone number	Second	dary phone	number		Fax nui	mber	er		
Practice a	nddress (where providers see pa	tients)		City			State		Zip	
Mailing a	ddress (if different from above)			City			State		Zip	
Billing add	dress (if different from above)			City			State		Zip	
Practice e	email			Website (URL) if applicable						
Do you use an electronic medical record (EMR)? ☐ Yes ☐ No EMR Na			ıme	ne EMR Version						
Edition 1										
Practice	e Contacts Please fill in each	of the conto	ict types be	low. They may b	e the same p	erson. Ci	heck one	as the	Primary Contact.	
Primary Contact?	Executive Director	First name			Middle initial		Last name			
	Executive Director	Email address			Phone number			Position or title		
Primary		First name	<u> </u>		Middle initial		Last na	name		
Contact?	Practice Manager				<u> </u>		Lustille			
		Email add	ress		Phone nun	Phone number		Positi	on or title	
Primary Contact?	Credentialing Manager	First name		Middle initial La		Last na	Last name			
	(for roster information updates)	information updates)  Email address			Phone number			Position or title		
Primary Contact?	Other Contact	First name			Middle initial L		Last na	Last name		
	(Optional)	Email add	ress		Phone nun	nber		Positi	on or title	

If YES:

Arkansas Health Network

**Insurance Credentialing** 



Cigna Credentialing	tialing   In Process		Estimated date of completion:				
☐ Yes ☐ No	☐ Completed		Effective Date:		Completed Notification Da	ate:	
	If YES:			L			
BCBS Credentialing	☐ In Process		Estimated date	of compl	etion:		
□ Yes □ No	☐ Completed				Completed Notification Date:		
	If YES:			l .			
Centene/QualChoice Credentialing	☐ In Process		Estimated date	of compl	etion:		
□ Yes □ No	☐ Completed		Effective Date:	Completed			
	If YES:			•			
Aetna Credentialing	☐ In Process		Estimated date	of compl	etion:		
☐ 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 ar	re required)						
-							
Legal business name							
"Doing business as" (DBA) name, if differer	nt than above						
Practice Specialty		I					
Tax ID Number (TIN)			Practice/Group NPI				
Primary phone number	Secondary phone	number	Fax number				
Practice address (where providers see pati-	ents)	City			State	Zip	
Mailing address (if different from above)			City			Zip	

#### Arkansas Health Network



Billing address (if different fro	m above)			City		State	Zip
Practice email				Website (URL) if applicable			
Do you use an electronic medical record (EMR)?	☐ Yes	□No	EMR Na	me	EM	R Version	

<b>Practice Contacts</b> 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 na		name		
	Executive Director	Email address	Phone number		Position or title		
Primary Contact?	Practice Manager	First name	Middle initial Last n		name		
	Practice Manager	Email address	Phone number		Position or title		
Primary Contact?	Credentialing Manager	First name	Middle initial Last nan		name		
	(for roster information updates)	Email address	Phone number		Position or title		
Primary Contact?	Other Contact	First name	Middle initial	Last r	name		
	(Optional)	Email address	Phone number	•	Position or title		

Insurance Credentialing						
	If YES:					
Cigna Credentialing	☐ In Process	Estimated date of completion:				
☐ Yes ☐ No	☐ Completed	Effective Date:	Completed Notification Date:			
	If YES:					
BCBS Credentialing	☐ In Process	Estimated date of completion:				
☐ Yes ☐ No	☐ Completed	Effective Date:	Completed Notification Date:			
	If YES:					
Centene/QualChoice Credentialing	☐ In Process	Estimated date of com	pletion:			
☐ Yes ☐ No	☐ Completed	Effective Date:	Completed Notification Date:			

Arkansas Health Network



	If YES:			
Aetna Credentialing	☐ In Process	Estimated date of com	pletion:	
☐ 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:	