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.

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 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)? ☐ Yes ☐ No	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

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:	
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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)? ☐ Yes ☐ No	EMR Name	EMR Version	

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
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Insurance Credentialing			
Cigna Credentialing ☐ Yes ☐ No	*If YES:* ☐ In Process	Estimated date of completion:	
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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:	
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Practice Information (*ALL fields are required*)			
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"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

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Billing address (if different from above)	City	State	Zip
Practice email	Website (URL) if applicable		
Do you use an electronic medical record (EMR)? ☐ Yes ☐ No	EMR Name	EMR Version	

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	
☐	Practice Manager	First name	Middle initial	Last name	
		Email address	Phone number	Position or title	
☐	Credentialing Manager *(for roster information updates)*	First name	Middle initial	Last name	
		Email address	Phone number	Position or title	
☐	Other Contact *(Optional)*	First name	Middle initial	Last name	
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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:	
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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: