Additional Provider Form

Arkansas Health Network

Form instructions: 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

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!

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Provider #___ Details (*ALL fields are required*)			
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 (list all)	
Provider NPI	Gender ☐ M ☐ F ☐ N/A	Date of birth (MM/DD/YYYY)	Date hired at this practice
Direct phone number (for outreach)	Direct email address (for access to analytics and essential communications)		
Tax ID (if different than practice)	Board status (select one): ☐ Certified ☐ Eligible	Panel status (select one): ☐ Open to new patients ☐ Closed to New Patients	
Languages spoken (in addition to English)			
Does this provider work at other practice locations? If so, please list all			
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:	
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