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, <u>TButler@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	name/initia	l Last na	me				Name suffix (Jr., Sr., II, III, IV, etc.)		
	linduic		Lastina							
Degrees (MD, DO, APRN, PhD, etc.)		ry specialty			Secondary specialties (list all)					
Provider NPI	Gender	N/A	Date of bi	irth (M	IM/DD/YY	YY)	red at this practice			
Direct phone number (for outreach))		il addr	dress (for access to analytics and essential communications)						
	Board stat	us (select o	ne):	Pane	el status (select one):					
Tax ID (if different than practice)	Certifie	Certified Eligible 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 Lice	ense E	ffective Da	ate	AR State N	Nedical License Expiration Date		
DEA License ID	nse Effective	e Date	e DEA License Expiration Date							
Insurance Credentialing										
	lf	YES:								
Cigna Credentialing		In Process			Estimate	Estimated date of completion:				
🗆 Yes 🔲 No		Completed			Effective	ve Date: Notifica		eted ation Date:		
	lf	YES:								
BCBS Credentialing	In Process			Estimated date of completion:						
🗆 Yes 🔲 No		Completed			Effective	eted ation Date:				
	lf	YES:								
Centene/QualChoice Credentialing		In Process			Estimated date of completion:					
🗆 Yes 🔲 No		Completed			Completed Effective Date: Notification Date:					
	lf	YES:								
Aetna Credentialing		In Process			Estimated date of completion:					
🗆 Yes 🔲 No		Completed			Effective	e Date:	Comple	eted ation Date:		
	lf	YES:								
UMR/UHC Credentialing		In Process			Estimate	ed date of co	mpletion:			
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			I							
Degrees (MD, DO, APRN, PhD, etc.)	Gender	y specialty	Ι			Secondary specialties (list all)				
Provider NPI	DM F	N/A	Date of bi	rth (M	IM/DD/YY	//DD/YYYY) Date hired at this practice				
Direct phone number (for outreach))		il addr	lress (for access to analytics and essential communications)						
	Board stat	rd status (select one): Panel status (select one):								
Tax ID (if different than practice)	Certified	ed Eligible Open to new patients Closed to New Patients								
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	Воа	ard statu	ıs (select o	one):		Pane	el status (s	elect one):				
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Tax ID (if different than practice)		ard statu Certified	rd status (select one): Panel status (select one): Certified Eligible Correction Closed to New Patients									
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