Network Application Form

Arkansas Health Network - Facility

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 – Facility Details

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

Important: If this facility has any locations that use a **different** Tax ID # (TIN), a separate Network Application Form is required!

Facility Information (*ALL fields are required*)			
Legal business name			
"Doing business as" (DBA) name			
Tax ID Number (TIN)	Facility NPI		
Facility Type (select one): ☐ Acute Care Hospital ☐ Ambulatory Surgery Center ☐ Dialysis Center ☐ Home Health Care Service ☐ Hospice Care ☐ Imaging Center ☐ Pediatric Hospital ☐ Psychiatric Hospital ☐ Rehabilitation Hospital ☐ Sleep Medicine Center ☐ Other: _____			
Primary phone number	Secondary phone number	Fax number	
Facility/Service address	City	State	Zip
Mailing address (if different from above)	City	State	Zip
Billing address (if different from above)	City	State	Zip
Facility email	Website (URL) if applicable		
Service area(s)	Facility owner/system affiliation (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:	
	☐ Completed	Effective Date:	Completed Notification Date:

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 facility and the facility 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: _____

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Appendix A: Additional Facility Location Forms

Form instructions: Please complete this form to submit supplemental information about additional facility 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. Electronic formats available upon request.

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

Important: If any of the facilities below use a **different** Tax ID or TIN, a separate AHN application must be submitted!

Additional Facility Location #____

Facility Information (*ALL fields are required*)			
Legal business name			
"Doing business as" (DBA) name			
Tax ID Number (TIN)	Facility NPI		
Facility Type (select one): ☐ Acute Care Hospital ☐ Ambulatory Surgery Center ☐ Dialysis Center ☐ Home Health Care Service ☐ Hospice Care ☐ Imaging Center ☐ Pediatric Hospital ☐ Psychiatric Hospital ☐ Rehabilitation Hospital ☐ Sleep Medicine Center ☐ Other: _____			
Primary phone number	Secondary phone number	Fax number	
Facility/Service address	City	State	Zip
Mailing address (if different from above)	City	State	Zip
Billing address (if different from above)	City	State	Zip
Facility email	Website (URL) if applicable		
Service area(s):	Facility owner/system affiliation (if applicable)		
Do you use an electronic medical record (EMR)? ☐ Yes ☐ No	EMR Name	EMR Version	

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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:	
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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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Additional Facility Location #____

Facility Information (***ALL fields are required***)			
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"Doing business as" (DBA) name			
Tax ID Number (TIN)	Facility NPI		
Facility Type (select one): ☐ Acute Care Hospital ☐ Ambulatory Surgery Center ☐ Dialysis Center ☐ Home Health Care Service ☐ Hospice Care ☐ Imaging Center ☐ Pediatric Hospital ☐ Psychiatric Hospital ☐ Rehabilitation Hospital ☐ Sleep Medicine Center ☐ Other: _____			
Primary phone number	Secondary phone number	Fax number	
Facility/Service address	City	State	Zip
Mailing address (if different from above)	City	State	Zip
Billing address (if different from above)	City	State	Zip
Facility email	Website (URL) if applicable		
Service area(s)	Facility owner/system affiliation (if applicable)		
Do you use an electronic medical record (EMR)? ☐ Yes ☐ No	EMR Name	EMR Version	

Facility 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? ☐	Facility 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

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☐		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:	
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