

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 contact our office: 501.552.3547 or info@arkansashealthnetwork.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 <i>(ALL fields are required)</i>			
Legal business name			
"Doing business as" (DBA) name			
Tax ID Number (TIN)		Facility NPI	
Facility Type (select one): <input type="checkbox"/> Acute Care Hospital <input type="checkbox"/> Hospice Care <input type="checkbox"/> Rehabilitation Hospital <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Imaging Center <input type="checkbox"/> Sleep Medicine Center <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Pediatric Hospital <input type="checkbox"/> Other: _____ <input type="checkbox"/> Home Health Care Service <input type="checkbox"/> Psychiatric Hospital			
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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	EMR Name	EMR Version

Network Application Form

Arkansas Health Network - Facility



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? <input type="checkbox"/>	Executive Director	First name	Middle initial	Last name
		Email address	Phone number	Position or title
Primary Contact? <input type="checkbox"/>	Practice Manager	First name	Middle initial	Last name
		Email address	Phone number	Position or title
Primary Contact? <input type="checkbox"/>	Credentialing Manager <i>(for roster information updates)</i>	First name	Middle initial	Last name
		Email address	Phone number	Position or title
Primary Contact? <input type="checkbox"/>	Other Contact <i>(Optional)</i>	First name	Middle initial	Last name
		Email address	Phone number	Position or title

Insurance Credentialing

Cigna Credentialing <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES: <input type="checkbox"/> In Process	Estimated date of completion:	
	<input type="checkbox"/> Completed	Effective Date:	Completed Notification Date:
BCBS Credentialing <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES: <input type="checkbox"/> In Process	Estimated date of completion:	
	<input type="checkbox"/> Completed	Effective Date:	Completed Notification Date:
Centene/QualChoice Credentialing <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES: <input type="checkbox"/> In Process	Estimated date of completion:	
	<input type="checkbox"/> Completed	Effective Date:	Completed Notification Date:
Aetna Credentialing <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES: <input type="checkbox"/> In Process	Estimated date of completion:	
	<input type="checkbox"/> Completed	Effective Date:	Completed Notification Date:
UMR/UHC Credentialing <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES: <input type="checkbox"/> In Process	Estimated date of completion:	
	<input type="checkbox"/> Completed	Effective Date:	Completed Notification Date:

Network Application Form

Arkansas Health Network - Facility



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: _____

Network Application Form

Arkansas Health Network - Facility



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 contact our office: 501.552.3547 or info@arkansashealthnetwork.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): <input type="checkbox"/> Acute Care Hospital <input type="checkbox"/> Hospice Care <input type="checkbox"/> Rehabilitation Hospital <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Imaging Center <input type="checkbox"/> Sleep Medicine Center <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Pediatric Hospital <input type="checkbox"/> Other: _____ <input type="checkbox"/> Home Health Care Service <input type="checkbox"/> Psychiatric Hospital			
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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	EMR Name	EMR Version

Network Application Form

Arkansas Health Network - Facility



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? <input type="checkbox"/>	Executive Director	First name	Middle initial	Last name
		Email address	Phone number	Position or title
Primary Contact? <input type="checkbox"/>	Practice Manager	First name	Middle initial	Last name
		Email address	Phone number	Position or title
Primary Contact? <input type="checkbox"/>	Credentialing Manager <i>(for roster information updates)</i>	First name	Middle initial	Last name
		Email address	Phone number	Position or title
Primary Contact? <input type="checkbox"/>	Other Contact <i>(Optional)</i>	First name	Middle initial	Last name
		Email address	Phone number	Position or title

Insurance Credentialing

Cigna Credentialing <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If YES:</i> <input type="checkbox"/> In Process	Estimated date of completion:	
	<input type="checkbox"/> Completed	Effective Date:	Completed Notification Date:
BCBS Credentialing <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If YES:</i> <input type="checkbox"/> In Process	Estimated date of completion:	
	<input type="checkbox"/> Completed	Effective Date:	Completed Notification Date:
Centene/QualChoice Credentialing <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If YES:</i> <input type="checkbox"/> In Process	Estimated date of completion:	
	<input type="checkbox"/> Completed	Effective Date:	Completed Notification Date:
Aetna Credentialing <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If YES:</i> <input type="checkbox"/> In Process	Estimated date of completion:	
	<input type="checkbox"/> Completed	Effective Date:	Completed Notification Date:
UMR/UHC Credentialing <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If YES:</i> <input type="checkbox"/> In Process	Estimated date of completion:	
	<input type="checkbox"/> Completed	Effective Date:	Completed Notification Date:

Network Application Form

Arkansas Health Network – Facility



Additional Facility Location # _____

Facility Information <i>(ALL fields are required)</i>			
Legal business name			
"Doing business as" (DBA) name			
Tax ID Number (TIN)		Facility NPI	
Facility Type (select one): <input type="checkbox"/> Acute Care Hospital <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Home Health Care Service <input type="checkbox"/> Hospice Care <input type="checkbox"/> Imaging Center <input type="checkbox"/> Pediatric Hospital <input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Rehabilitation Hospital <input type="checkbox"/> Sleep Medicine Center <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	EMR Name	EMR Version

Facility Contacts <i>Please fill in each of the contact types below. They may be the same person. Check one as the Primary Contact.</i>			
Primary Contact? <input type="checkbox"/>	Executive Director	First name	Middle initial Last name
		Email address	Phone number Position or title
Primary Contact? <input type="checkbox"/>	Facility Manager	First name	Middle initial Last name
		Email address	Phone number Position or title
Primary Contact? <input type="checkbox"/>	Credentialing Manager <i>(for roster information updates)</i>	First name	Middle initial Last name

Network Application Form

Arkansas Health Network - Facility



<input type="checkbox"/>		Email address	Phone number	Position or title
Primary Contact?	Other Contact (Optional)	First name	Middle initial	Last name
<input type="checkbox"/>		Email address	Phone number	Position or title

Insurance Credentialing				
Cigna Credentialing <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If YES:</i>		Estimated date of completion:	
	<input type="checkbox"/> In Process		Effective Date:	Completed Notification Date:
BCBS Credentialing <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If YES:</i>		Estimated date of completion:	
	<input type="checkbox"/> In Process		Effective Date:	Completed Notification Date:
Centene/QualChoice Credentialing <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If YES:</i>		Estimated date of completion:	
	<input type="checkbox"/> In Process		Effective Date:	Completed Notification Date:
Aetna Credentialing <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If YES:</i>		Estimated date of completion:	
	<input type="checkbox"/> In Process		Effective Date:	Completed Notification Date:
UMR/UHC Credentialing <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If YES:</i>		Estimated date of completion:	
	<input type="checkbox"/> In Process		Effective Date:	Completed Notification Date:
	<i>If YES:</i>		Estimated date of completion:	
	<input type="checkbox"/> In Process		Effective Date:	Completed Notification Date: