

GROUP PRACTICE ENROLLMENT FORM

Please complete all sections of the OPNS Group Practice Enrollment Form Application. Completed applications and applicable documents can be emailed to Credentialing@opns.org

SECTION 1: GROUP INFORMATION					
Group Name:					
DBA:					
Group NPI:		Taxonomy (Primary):		Taxonomy (Additional):	
SECTION 2: BILLING INFORMATION (Attach a copy of W-9 or SS4)					
Tax ID Name (As it appears on W-9 or SS4):				Tax ID Number:	
DBA (If applicable):					
Remittance Address:					
City:		State:		Zip:	
Phone:			Fax:		
Billing Contact Name:			Email:		
SECTION 3: PRIMARY LOCATION INFORMATION					
Primary Practice Location Name:					
Address:					
City:		State:		Zip:	
Office Phone:			Office Fax:		
Office/Practice Website:				Office Email:	
Office Manager Name:		Office Manager Phone:		Office Manager Email:	
Credentialing Contact Name:		Credentialing Contact Phone:		Credentialing Contact Email:	
For PCP's Offices: Quality Person's Contact Name:		Value Based Care Contact Phone:		Office Quality/Value Based Care Email:	
For PCP's Offices: Health Focus Contact Name:		Health Focus Contact Phone:		Health Focus Contact Email:	
List Location in the OPNS Directory:				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Appointment Phone (If Different than Office Phone):			After Hours Phone (If Different Than Office Number):		
Does this Practice Utilize Electronic Medical Records?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
EMR Name and Version:					

Does this Location offer Telemedicine Services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does this Location Have E-Prescribing Capabilities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does this Location Have 24 Hour Phone Coverage?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does this Location Offer Extended Office Hours?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does this Location Accept Medicaid?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does this Location Medicare?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is this Practice PCMH Certified? (if yes please attach a copy)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

LOCATION OFFICE HOURS						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM

SECTION 4: MAILING ADDRESS (If different than Primary Location)		
Address:		
City:	State:	Zip:

SECTION 5: LOCATION LANGUAGES (List Languages that are Spoken by Staff)

SECTION 6: PRACTICE LOCATION RESTRICTIONS		
Hospital Based Location Only:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
In Home Services Only:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Indian Health Services Only:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Minute Clinic Services Only:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Nursing Home Services Only:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Skilled Nursing Services Only:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Telemedicine Services Only:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Urgent Care Location Only:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Veteran Affairs Location Only:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

SECTION 7: PRACTICE LOCATION ACCESSIBILITY		
Does Location meet ADA Accessibility Requirements?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location Offer American Sign Language Services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Does Location have Handicap Accessible Exam Table/Scale/Chair?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the Location Exterior Building Handicap Accessible?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location have Handicap Accessible Gurneys/Stretchers?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the Location Interior Building Handicap Accessible?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location Offer Mental/Physical Impairment Services?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location Offer Other Services for the Disabled?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location have Handicap Accessible Parking?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location have Handicap Accessible Portable Lifts?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location have Handicap Accessible Radiologic Equipment?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location have Handicap Accessible Restrooms?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location have Handicap Accessible Signage & Documents?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location Meet State and Local Fire, Safety and Sanitation Requirements?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location have TDD Phone?	Number:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location have TTY Phone?	Number:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location have Wheelchair Accessible Exam Rooms?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location Offer Language Line Services?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location Offer Documents Available in Other Languages?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location Offer Document Translation Services?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location Offer Care Management Services?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location Offer Qualified Onsite Interpreters?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has Staff at Location Completed Cultural Competence Training?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is this Location Accessible to Public Transportation?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is this Location Accessible by Rail/Train?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is this Location Accessible by Taxi?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is this Location Accessible by Bus?		Yes <input type="checkbox"/>	No <input type="checkbox"/>

APPLICATION CHECK LIST

Completed Group Enrollment Form
W-9 or SS4
Disclosure of Ownership & Controlling Interest Form

I certify that all information included in my application and the accompanying documents are correct and complete to the best of my knowledge.

Each submission requires a signature and current date.

Signature

Provider Group Authorized Signature:	Title:
Printed Name:	Date:

SECTION 8: GROUP PROVIDER INFORMATION

List All Group Providers, each provider will need to complete the Provider Enrollment and Credentialing Form. Please attach additional pages if needed

Last Name:	First:	Middle:	Suffix:
Degree:	NPI:	PCP/SPC	
CAQH ID:	Effective Date with Group:	Specialty:	
Last Name:	First:	Middle:	Suffix:
Degree:	NPI:	PCP/SPC	
CAQH ID:	Effective Date with Group:	Specialty:	
Last Name:	First:	Middle:	Suffix:
Degree:	NPI:	PCP/SPC	
CAQH ID:	Effective Date with Group:	Specialty:	
Last Name:	First:	Middle:	Suffix:
Degree:	NPI:	PCP/SPC	
CAQH ID:	Effective Date with Group:	Specialty:	
Last Name:	First:	Middle:	Suffix:
Degree:	NPI:	PCP/SPC	
CAQH ID:	Effective Date with Group:	Specialty:	
Last Name:	First:	Middle:	Suffix:
Degree:	NPI:	PCP/SPC	
CAQH ID:	Effective Date with Group:	Specialty:	

SECTION 9: ADDITIONAL LOCATION INFORMATION

Practice Location Name:							
Address:							
City:		State:		Zip:			
Office Phone:				Office Fax:			
Office/Practice Website:				Office Email:			
Office Manager Name:		Office Manager Phone:		Office Manager Email:			
Credentialing Contact Name:		Credentialing Contact Phone:		Credentialing Contact Email:			
List Location in the Directory:				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Appointment Phone (If Different than Office Phone):				After Hours Phone (If Different Than Office Phone):			
Does this Practice Utilize Electronic Medical Records?				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
EMR Name and Version:							
Does this Location offer Telemedicine Services?				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Does this Location Have E Prescribing Capabilities?				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Does this Location Have 24 Hour Phone Coverage?				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Does this Location Offer Extended Office Hours?				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Does this Location Offer Laboratory Services? (if Yes please attach a copy of current CLIA Certificate)				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Does this Location Offer Radiology Services? (if Yes please attach a copy of current Radiology Certificate)				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Does this Location Offer Behavioral Health Services?				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Is this Practice PCMH Certified? (if yes please attach a copy)				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
NCQA PCMH Certification Level:		Level 1	<input type="checkbox"/>	Level 2	<input type="checkbox"/>	Level 3	<input type="checkbox"/>
			Effective Date:		End Date:		

LOCATION OFFICE HOURS

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SECTION 10: MAILING ADDRESS (If different than Primary Location)

Address:		
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SECTION 11: LOCATION LANGUAGES (List Languages that are Spoken by Office Staff)**SECTION 12: PRACTICE LOCATION RESTRICTIONS**

Hospital Based Location Only:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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SECTION 13: PRACTICE LOCATION ACCESSIBILITY

Does Location meet ADA Accessibility Requirements?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location Offer American Sign Language Services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does Location have Handicap Accessible Exam Table/Scale/Chair?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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