

Participating Physician and Practice Profile Form

When you have completed the form, please email to Credentialing@opns.org and MosaicNetworkManagement@hfhs.org please include current CV in MM/YYYY format.

All fields are required to process

Practice Information

Legal Practice Name _____

DBA (If different than legal name) _____

Tax ID: _____

Group NPI: _____

Lead Physician _____

Other Physician Organizations (Include all that apply) _____

Do you use an EHR? Yes No Which EHR do you use? _____

Do you currently participate in BCBS PPO Trust: Yes No

Are you currently participating in PGIP: Yes No

Do you wish to participate in the following contracts:

GM ConnectedCare: Yes No

HFBN HAP held Contracts (CDHP Preferred, EPA Tiered Access, Pivotal and HF Choice): Yes No

Primary Location Information (address to send communication to practice management/administration):

Address _____ Suite _____

City _____ State _____ Zip _____ Phone (appointment line) _____

Please provide address and phone information for additional locations: (if more than 5, please write on a separate sheet and submit with profile):

#	Street Address	Suite	City	State	Zip	Phone
1						
2						
3						
4						
5						

Total Number of Practice Locations _____

Office Manager/Practice Administrator Name (first and last) _____

Office Manager Phone _____ Office Manager Email _____

Office Manager Fax _____ Practice Website _____

Please complete this section for each physician participating in the HFPN:

Provider Individual NPI: _____

Name (first, middle initial, last, Degree) _____

Cell Phone _____

Email Address: _____

Primary Specialty _____

Provider Type: PCP Specialist Hospitalist Attending Urgent Care

Board Certified? Yes No Board Certified Specialty: _____

Does the Provider have Hospital Affiliations with a HFHS Facility? Yes No

If yes, please list them below:

HFHS Hospital Affiliation(s) _____

If no, please indicate which facility you are applying for privileges? _____

CAQH # _____

State License Number: _____

DEA License Number: _____

Controlled Substance License Number: _____

Birth Date (mm/dd/yyyy) _____ Gender Female Male

SSN: _____

Languages Spoken (Other than English) _____

Practice Location (s) (please enter # from page 1 that the physician is associated with) _____

ACO Affiliation (Include all that apply) _____

Do you provide any of the following services at any of your practice locations or an owned stand-alone location?
(check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Lab Services | <input type="checkbox"/> Imaging-X-Ray | <input type="checkbox"/> Imaging-Ultrasound |
| <input type="checkbox"/> Imaging-CT Scan | <input type="checkbox"/> Imaging-PET Scan | <input type="checkbox"/> Imaging-MRI |

Do you offer Virtual Care? _____

(Check all that apply) E-Visits Video Visits Other _____

Please include the following attachments:

CV for the provider: Included

W9 for the provider/practice (based on how services are billed) Included