# PROVIDER ENROLLMENT APPLICATION

This form is designed as a fillable form for providers wishing to participate in the Health One Alliance/Alliant Health Plans network. Upon completing the Provider Enrollment Application, email this form to ProviderRelations@AlliantPlans.com, fax to (706) 529-4275 or mail to Health One Alliance, Attn: Provider Relations, PO Box 1128, Dalton, GA 30722.

## Section I: Provider Information

Practitioner Name: _____ Degree: _____

CAQH #:_____ NPI: _____

Specialty: _____ Taxonomy: _____

## Section II: Contact Information

Section II-A: Contracting Contact

Name: _____

Phone: _____ Fax: _____

Email: _____

Address: _____

If executed, should the contract be returned to the above address? ☐ Yes ☐ No

Section II-B: Credentialing Contact

Name: _____

Phone: _____ Fax: _____

Email: _____

Address: _____

If credentialed, should the decision letter be returned to the above address? ☐ Yes ☐ No

Section II-C: Medical Record Requests (specific to HEDIS, Risk Adjustment, RAD-V, etc.)

Name: _____

Phone: _____ Fax: _____

Email: _____

Address: _____

Preferred Method: ☐ Mail ☐ Phone ☐ Fax ☐ Email

Section II-D: Newsletter

Please indicate the recipients for our newsletter, provider insider, and the preferred method of delivery.

Name: _____

Phone: _____ Fax: _____

Email: _____

Address: _____

Preferred Method: ☐ Mail ☐ Phone ☐ Fax ☐ Email

## Section III: APRN Requirements

A Nurse Protocol Agreement for each state where ARPN is providing services must be submitted.

Name: _____

State(s) of Licensure: _____ License number(s): _____

State(s) of DEA: _____ DEA number(s): _____

Supervising Physician: _____

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## Section IV: Addresses

Group Name: _____

TIN: _____ Group NPI: _____

Phone: _____ Fax: _____

Service Address: _____

Office Hours: _____

Show in Directory: ☐ Yes ☐ No (If yes, this location will show in the Provider directory and subject to accuracy verification.)

Pay to Name: _____

Pay to Address: _____

Pay to Phone: _____ Pay to Fax: _____

Correspondence Address: _____

Vendor Address: _____

Group Name: _____

TIN: _____ Group NPI: _____

Phone: _____ Fax: _____

Service Address: _____

Office Hours: _____

Show in Directory: ☐ Yes ☐ No (If yes, this location will show in the Provider directory and subject to accuracy verification.)

Pay to Name: _____

Pay to Address: _____

Pay to Phone: _____ Pay to Fax: _____

Vendor Address: _____

## Section V: TeleHealth

Offers TeleHealth Services: ☐ Yes ☐ No

If yes, please list all the locations where TeleHealth is offered: _____

State(s) TeleHealth is offered: _____

License number for each State: _____

Please attach a full listing of locations with all data elements if provided space is insufficient.

Please attach the following documentation:

- Medical Malpractice Certificate of Insurance
- W-9(s)
- Curriculum Vitae
- Nurse Protocol Agreement for each state services are provided (if applicable)

To the extent permitted by law, we recognize a provider's right to review submitted information supporting the credentialing application. Providers may obtain information regarding their initial or re-credentialing application status by contacting Provider Relations at (706) 629-8848 or ProviderRelations@AlliantPlans.com. This number can also be used to request information regarding general requirements for participation and correct any erroneous information.