



HOSPITAL BASED PROVIDER - REQUEST FOR PARTICIPATION

This form is to be completed in its entirety and submitted to enrollment@centercare.com.

INSTRUCTIONS FOR COMPLETION:

This form must be completed in its entirety and the following supporting documents must be provided. An incomplete form and/or missing supporting documentation may result in resubmission of the provider's application and/or delay in provider's effective date for participation.

Required Supporting Documentation:

- Copy of current State License (applies to all provider types);
- Copy of DEA Certificates (for applicable provider types);
- Copy of Certificate of current Malpractice Insurance Coverage including group name, coverage amounts, expiration date, and name of covered provider(s) (applies to all provider types);
- For APRNs: please provide your Collaborative Agreement for Prescriptive Authority;
- Completed W-9 Form;
- Sample Claim Form (without PHI). A sample claim form is necessary to ensure accurate loading of provider.

HCFA 1500 Form – Professional Providers

- a. Box 24j = This is where the individual or group NPI # must be entered
- b. Box 25 = Federal Tax Identification #
- c. Box 31 = Rendering Provider's Name/Degree
- d. Box 32 = Service Location of where services were rendered
- e. Box 33 = Provider's pay to address
- f. Box 32a & 33a = Group or Individual NPI, whichever is applicable

UB04 = Institutional Providers

- a. Box 1 = Physical Location
- b. Box 2 = Billing Address (if different)
- c. Box 5 = Vendor TIN
- d. Box 56 = NPI #

I. PERSONAL INFORMATION			
Full Legal Name:		Maiden Name:	
Social Security Number:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
II. IDENTIFICATION NUMBERS			
Individual NPI:			
KY Medicaid ID:		Medicare ID:	
DEA Number(s):		DEA Exp. Date:	
Primary Taxonomy:		Secondary Taxonomy:	
III. LICENSURE			
State:	License #:	Issue Date:	Exp. Date:
State:	License #:	Issue Date:	Exp. Date:
IV. LIABILITY INSURANCE			
Carrier:		Limits:	
Policy #:		Exp. Date:	
V. BOARD CERTIFICATION			
Indicate your specialty/sub-specialty field(s) of practice and respective board certification:			
Specialty	Board Certified Y/N	Sub-Specialty	Board Certified Y/N
	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
VI. SCOPE OF PRACTICE			
<input type="checkbox"/> Anesthesiology <input type="checkbox"/> Hospitalist <input type="checkbox"/> Pathology <input type="checkbox"/> Other (please specify)			
<input type="checkbox"/> Emergency Medicine <input type="checkbox"/> Neonatology <input type="checkbox"/> Radiology			
<input type="checkbox"/> Telemedicine _____			
Supervising Physician (for PAs or APRNs):			
Supervising Physician Specialty:			
Does provider practice as a locum tenens provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		Provider Start Date:	
Languages spoken by provider other than English (including American Sign Language):			

VII. PRACTICE INFORMATION (See next page for additional locations)

Primary Location		Billing/Pay To
Practice Name:		
Address:		
City/State/Zip:		
Tax ID:		
Group NPI:		
Phone:		
Fax:		
Telemedicine: (Y/N)		

VIII. HOSPITAL PRIVILEGES

List all facilities where you currently provide hospital based services.

	Hospital Name	City/State	Type of Privileges	Department
Primary:				
Secondary:				
Other:				

IX. EDUCATION and TRAINING – Complete the following or attach CV

	Degree/Specialty	Start Date (MM/YY)	End Date (MM/YY)	Mailing Address
Medical School:				
Internship:				
Residency #1:				
Residency #2 or Fellowship #1:				

X. CONTACT INFORMATION

Contact Name:		Contact Title:	
Contact Email:		Contact Phone:	
Practice Website:			
Practice Email:		Date Submitted:	

XI. SUPPLEMENTAL PRACTICE INFORMATION**

Alternate Location #1		Alternate Location #2
Practice Name:		
Address:		
City/State/Zip:		
Tax ID:		
Group NPI:		
Phone:		
Fax:		
Telemedicine: (Y/N)		
Billing Address:		
City/State/Zip:		
Billing Phone		
Billing Fax		
Alternate Location #3		Alternate Location #4
Practice Name:		
Address:		
City/State/Zip:		
Tax ID:		
Group NPI:		
Phone:		
Fax:		
Telemedicine: (Y/N)		
Billing Address:		
City/State/Zip:		
Billing Phone		
Billing Fax		

****If the number of locations exceeds the amount provided above, please attach a roster of locations, complete with the information requested in the above table.**

Should you have any questions, please contact Center Care at 270.745.1517 or 800.972-7038.