

Personal information

NAME (LAST, FIRST, MIDDLE)	DEGREE (DEGREE/PROFESSIONAL TITLE)
OTHER NAMES YOU MAY HAVE USED (MAIDEN, A.K.A. etc.)	DATE OF BIRTH (MONTH/DAY/YEAR)
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	ETHNICITY (Optional)
ARE YOU APPLYING AS A : <input type="checkbox"/> Primary Care Physician or	<input type="checkbox"/> Specialist (SPECIALTY) _____

Identification numbers

SOCIAL SECURITY	MI LICENSE
CAQH PROVIDER ID	NPI PROVIDER ID
DEA NUMBER	TAX ID

Priority Health contracts (Primary Care Providers Only)

HMO and PPO (please choose one)	<input type="checkbox"/> Accepting <u>new</u> patients	<input type="checkbox"/> Accepting <u>established</u> patients only
MEDICAID and MICHILD (please choose one)	<input type="checkbox"/> Accepting <u>new</u> patients	<input type="checkbox"/> Accepting <u>established</u> patients only
Will you accept Medicaid auto assignment of members?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
MEDICARE (please choose one)	<input type="checkbox"/> Accepting <u>new</u> patients	<input type="checkbox"/> Accepting <u>established</u> patients only

Laboratory and hospital choice (Primary Care Providers Only)

Please designate your lab choice for all Clinical and Pathology Laboratory Services:

Quest Diagnostics (MET)
 Detroit Bio Medical (Northern Michigan Providers Only)
 JVHL (Required selection for East Michigan Providers)

Participating Hospital Name _____

Credentialing contact/office manager

PROVIDER GROUP/BUSINESS NAME	
ADDRESS	CITY, STATE, ZIP
TELEPHONE NO.	FAX NO.
OFFICE CONTACT	E-MAIL ADDRESS

Consent and release:

I consent to the release of this information to the Council for Affordable Quality Healthcare (CAQH), for the purpose of allowing Priority Health access to my information in the CAQH Universal Credentialing DataSource (UCD).

By signing this pre-application, I affirm that the information I have supplied is correct and complete and that any misstatements in or omissions from this pre-application may be cause for denial of credentialing.

Name (Please print) _____

Physician/Physician Representative Signature _____ Date _____

**If your W-9 is not included with your CAQH application please forward a copy with this form.