

Provider information form

Complete the applicable sections to add or make a change to a provider.

Save it for your records, then email to PH-PELC@priorityhealth.com.

About the provider			
Name/degree		Provider NPI	
DOB		Provider CAQH ID	
Gender		Provider specialty	
Race/ethnicity		Provider primary hospital	
Group/facility name		Group/facility NPI	
Provider ID/vendor number			
Description of request			
Has the provider completed Cultural Competence training?	Yes	No	

Contact/person responsible for completion of this form			
Name		Today's date	
Phone number			
E-mail address			

Provider's practice setting		
Is the provider changing from a PCP to a specialist?	Yes	No
Is the provider a hospitalist?	Yes	No
Is the provider hospital based?	Yes	No
Does this provider practice concierge medicine?	Yes	No

Change a Provider's name, tax ID or NPI			
Current name		New name	
Current tax ID		New tax ID	
Current NPI		New NPI	
Current DBA name		New DBA name	

Change age panel limit

Family practice (0-99+ years)	General practice (0-99+ years)
IM/peds (0-99+ years)	Internal medicine (16-99+ years)
Pediatrics (0-21 years)	Gynecology (13-99+ years)
OB/Gyn (13-99+ years)	Other:

Product status – Open/closed status (PCPs only)

Open to new members	HMO	PPO	Medicaid	Medicare
Closed to new members	HMO	PPO	Medicaid	Medicare
Terming a new product	HMO	PPO	Medicaid	Medicare
Reason for closure	Panel full	Part-time	Other:	
Reason for product term	Panel full	Part-time	Other:	

Demographic information (address, phone, fax)

Add location	Effective date			
Group billing name (name on claim)				
Group “Name on the Door” of this location				
Practice website				
Address				
City	State	Zip		
Phone	Fax*			
Can Priority Health members call this phone number to make an appointment with the provider at this location?			Yes	No
Address type	Primary		Secondary	
	Billing/remit		Tax (include updated W9)	
	Other:			
Billing TIN				
Group billing NPI				
Provider’s scope at this location	PCP, physician		Specialist, physician	
	Other:			
NPI of a Priority Health-participating physician with whom the APP holds a current practice agreement	APP/midlevel PCP		APP/midlevel specialist	
	Hospitalist/rounding		Assisting in surgeries	

Provider office hours (hours available for appointments)

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Open – If blank, provider directory will read “Hours Vary”							
Closed – If blank, provider directory will read “Hours Vary”							
General office hours (building/facility open)							

Cross coverage (list covering providers)			
Name, title		Specialty	
Address		Phone	
Name, title		Specialty	
Address		Phone	
Name, title		Specialty	
Address		Phone	
If none, please explain			
Do you currently admit and care for your hospitalized patients?	Yes	No	
If no, explain the formal inpatient coverage you have for each inpatient facility.			

Type of change – Provider leaving a participating provider group of Priority Health Network. Priority Health requires a written notice 90 days in advance. Visit requirements and responsibilities in the provider center at www.priorityhealth.com for more information.

Priority Health maintains that the primary care relationship resides between the member and the PCP. Members will remain with their current PCP as long as the change of location distance is less than 30 miles. When applicable, Priority Health will reach out to the provider group to determine where members should be transferred. Members will be transferred to a new PCP when any of the following reasons exist:

- Provider deceased or retired
- Provider changes from a PCP to SPC
- PCP moved out of current Priority Health Michigan service area or PCP moved greater than 30 miles from their current primary location
- PCP is no longer participating/contracted
- Age panel limit with member transfer
- Network termination due to sanction/license suspension

Remove location	Termination/effective date			
Group billing name (name on claim)				
Group "name on the door" of this location				
Address				
City		State		Zip
Reasons for leaving	Deceased Leave of absence Retired Moving to another group Moving outside the service area Moving to another location under the same group			
PCP authorizing EOC?	EOC terms accepted EOC terms refused			

Behavioral health providers only		
Type of practice	Federally qualified health center	Group practice
	Facility	Private practice
Accreditation(s)	CARF	COA
	BCBA	TJC/The Joint Commission
	None	
Professional services	Domestic violence	Dual diagnostics
	Gay/lesbian issues	Post-traumatic stress disorder
	Sexual trauma	Transgender issues
	Eating disorders	Opiate addiction treatment
	ADD/ADHD (criteria: Doctorate level, full licensure)	Psychological testing (criteria: Doctorate level, full licensure)
	EMDR (copy of certificate required)	Neuropsychology (training and work experience required)
Age panel	Children (0 – 12 years) Adolescents (12 – 18 years) Adults (18 – 99 years) Other (specify)	

This section for facility or services only		
Are you submitting informations on behalf of:	Hospital	Other healthcare organization
Community-based health clinic (convenient care centers and walk-in clinics)	Long term acute care	Skilled nursing facility
End stage renal dialysis	Pathology	Hospice
Free standing surgery center	Urgent care facilities	Laboratories
Rural health clinic	School-based health clinic	Federally qualified health clinic
Sleep disorder centers (AASM accreditation is required)	Retail health clinic	Tribal health clinic
Home infusion (Choose all that apply): Chemotherapy Outpatient infusion	Mental health (Choose all that apply): Inpatient services # of CMS beds: Outpatient services	Home health care (Choose all that apply): Home health care – Telemonitoring services
Substance abuse (Choose all that apply): Inpatient services Outpatient services	Rehab outpatient facilities (Choose all that apply): Occupational therapy Physical therapy Speech therapy	

Additional services – please list any additional services from above on the list below

Ambulance	Dialysis	Prosthetics/orthotics
Cardiac catheterization services	Cardiac surgery program	Critical care services
Independent diagnostic services (Choose all that apply): Radiology/imaging centers Mammography Therapeutic radiology	Durable medical equipment (Choose all that apply): Prosthetics/orthotics Bathroom safety bars	

Provider Information form acknowledgment – This form will be used as a supplement to the provider’s Council for Affordable Quality Healthcare (CAQH) application.

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 Data Source (UC).

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.

Physician/representative signature	Your typed name confirms your electronic signature.
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Submit the below along with your application.

W-9 form

Send completed forms to:

Email: PH-PHELC@priorityhealth.com
Attn: Credentialing and Provider Data Management department
Fax: 616.975.8857

**You must notify edisetup@priorityhealth.com for any fax number change where electronic claim receipt notices are sent.*

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 Verify all information is complete and any required supporting documentation is included.
 Incomplete forms and missing documentation create delays.
