AULTCARE

AULTCARE'S PRIMETIME HEALTH PLAN

PROVIDER INFORMATION FORM

- This form is a request for a provider application. Completing this form does not constitute approval of membership. All requests will go before our committee.
- This form may also be used to update provider information, including, but not limited to, the following:
  - » Provider name
  - » Telephone number
  - » Fax number
  - » Credentialing correspondence information of person to contact for provider updates
  - » Office manager information update
  - » Provider accepting or no longer accepting new patients
  - » Practice address change
  - » Practice office hours
  - » Practice affiliation change
  - » Physician leaving the practice
- Complete all pages of this form in its entirety to begin the process.
- Complete one form per provider.
- Fill out page 2 of the form for each location in which the provider is practicing.
- Outdated forms will not be accepted.
- Once your request is received, we will review the application to ensure it is complete and includes all required documentation. **All portions of this form are required.**
- If any portion of this form is missing information, we will attempt to contact you once per week for three weeks. As soon as we receive the outstanding information, we will send the application to the next committee meeting. If we are unable to reach out, you would need to re-request again if interested in the future.
- Once the committee has reviewed your request, you will be notified in writing of their decision.
- If approved for application, the credentialing process takes 60-90 days. (Your expediency will streamline this process.)
- If you have already completed your application with CAQH, please ensure you have authorized AultCare to access your data.
- Using CAQH does not grant participation or constitute applying for participation with AultCare.
- Please make sure you include all required documentation, as we will not process requests missing required information.
- Once credentialing is complete, a peer review is conducted.
- If approved through peer review, you will go before a committee for approval of contracts.
- If approved for final membership, your panel provider effective date will be after we receive your signed contract. Therefore, you should not be scheduling or seeing AultCare patients until that time.
- Per the Centers for Medicare and Medicaid Services (CMS), we are not required to verify the information contained in our provider files quarterly. This includes verification of information, such as your address, phone number, office hours, email, and affiliated physicians.
- Please submit this form and supporting documentation to one of the following:
  - » Email: credentialing@aultcare.com
  - » Fax: 330-363-6421
  - » Mail: AultCare | Attn: Network Analysis, Credentialing, and Contracting | PO Box 6910 | Canton, OH 44709
- Please submit a copy of your W-9 to providermaintenance@aultcare.com.
- If you have additional questions, you may contact AultCare and PrimeTime Network Analysis, Credentialing, and Contracting at 330-363-1400 between 8:00 am – 4:30 pm EST, Monday – Friday.

OVERALL REASON FOR REQUEST (Check all that apply)

☐ New Provider	Effective Date		
☐ Deleting Provider	Effective Date	Reason	
Where can medical records be retrieved?			
☐ Add Location	Effective Date	☐ Deleting Location	Effective Date
☐ Practice Address Change	Effective Date	☐ Correspondence Change	Effective Date
☐ Billing Address Change	Effective Date	☐ Update Information	Effective Date
☐ Other, please explain			

PRACTITIONER INFORMATION

DEA Certification Number (if applicable)		NPI Number (Individual)	
First Name	Middle Initial	Last Name	
Suffix	Maiden Name	Title (M.D. etc.)	
Social Security Number	☐ Male ☐ Female	Date of Birth	
Provider Direct Email		Languages Spoken	
Medicare Number of UPIN		Medicaid Number	
OH License Number		CAQH Number	
Primary Specialty	List in Directory? ☐ YES ☐ NO	Secondary Specialty	List in Directory? ☐ YES ☐ NO

If you are an extender (NP, PA, CNM, CNS), who is your standard care arrangement with? (Must submit copy of SCA)

If you are an OB/GYN or CNM, do you perform deliveries? ☐ YES ☐ NO

If you are an Ophthalmologist or Podiatrist, do you perform surgeries? ☐ YES ☐ NO

Hospital Privileges: At least one HOSPITAL must be an in-network AultCare participating hospital in the vicinity of the practice you are requesting for.

Hospital Name	Status/Type of Privileges	Effective Date

Does the provider have specialized training and experience in treating the following?

Blindness or Visual Impairment	☐ YES	☐ NO	Physical Disabilities	☐ YES	☐ NO
Chronic Illness	☐ YES	☐ NO	Serious Mental Illness	☐ YES	☐ NO
Co-Occurring Disorders	☐ YES	☐ NO	Substance Use Disorder	☐ YES	☐ NO
Deafness or Hard-of-Hearing	☐ YES	☐ NO	Are you a Ryan White HIV provider?	☐ YES	☐ NO
HIV/AIDS	☐ YES	☐ NO	Are you an Indian provider as defined by CMS?	☐ YES	☐ NO
Homelessness	☐ YES	☐ NO	Are you a family planning provider?	☐ YES	☐ NO
Intellectual and Developmental Disorders	☐ YES	☐ NO	Other?	☐ YES	☐ NO

Additional Comments

OFFICE INFORMATION (Please make additional copies and complete information for each location)

☐ Add Location ☐ Delete Location	Effective date with this location	Location_____of_____
Is this a multiple provider practice? ☐ YES ☐ NO If yes, include names of other providers		
Are you accepting new patients at this location? ☐ YES ☐ NO		
If approved, would you like this location to be listed in the directory? ☐YES ☐NO	Does this provider regularly schedule to see patients at this location? ☐YES ☐NO	Do you provide your patients with the option of e-prescriptions? ☐YES ☐ NO
Does this location take walk-ins? ☐ YES ☐ NO	Does this location provide extended hours? ☐ YES ☐ NO	Do you provide telehealth services at this location? ☐ YES ☐ NO

Tax ID	Group Name (legal name)
	Office Name (for directory purposes)

Street Address			Suite Number
City	State	County	Zip Code
Telephone Number	Fax Number	NPI Group Number (If applicable)	

Business Hours for Location

	Monday	Tuesday	Wednesday	Thursday	Friday
Start					
End					
Closed					

Location Detail Information

Is this location on an accessible transportation route? ☐ YES ☐ NO	Do you supply translation services for written material? ☐ YES ☐ NO
Do you provide and bill for lab services at this location? ☐ YES ☐ NO	Do you provide and bill for diagnostic radiology services at this location? ☐ YES ☐ NO
Do you provide and bill for mammography services at this location? ☐ YES ☐ NO	Other

Please specify which of the following accessibility options you have for individuals with physical disabilities

Handicap accessible parking spaces, curb ramps, or loading zones at building entrance? ☐ YES ☐ NO	Doorways wide enough to ensure safe passage by individuals using mobility aids? ☐ YES ☐ NO
Wheelchair accessible restrooms with grab bars and accessible lavatories? ☐ YES ☐ NO	ASL signage and raised tactile text characters at office, elevator, and restroom doors? ☐ YES ☐ NO
Medical equipment accessible to patients using mobility aids? ☐ YES ☐ NO	Exam rooms accessible to patients using mobility aids? ☐ YES ☐ NO
Other ECP? (Essential Community Provider) ☐ YES ☐ NO	Are you an FQHC (Federal Qualified Health Center) provider? ☐ YES ☐ NO
Other	

CONTACTS (Submission of email addresses and signing of this form authorizes us to contact you via email)

Correspondence Contact		
Phone Number	Email Address	
Practice Administrator		
Phone Number	Email Address	
Correspondence address for mailing purposes ☐ Same as office location		
Street Address		Suite Number
City	State	Zip Code
Billing address for remit purposes ☐ Same as office location ☐ Same as correspondence address		
Street Address		Suite Number
City	State	Zip Code

Printed name of person completing this form _____

Signature of person completing this form _____ Date _____

Additional Comments