# Provider Enrollment Form

**INSTRUCTIONS:** Please complete this document to apply for participation in Arkansas Health Network. Return your completed Application Questionnaire to: **Arkansas Health Network, ATTN: Bob Sarkar, Two St. Vincent Circle, Little Rock, AR 72205**

## SECTION I: Provider/Practice Demographics & Contact Information

| **Submitter Information** (person filling out form) | | | | |
|---|---|---|---|---|
| **Last** | **First** | **Middle** | **Suffix** | **Title** |
| **Phone #** | **Email Address** | | | |

| **Individual Provider Information*** (Complete Attachment A for each health care professional for whom the Group Practice submits bills to payers under its Tax Identification #) | | | | |
|---|---|---|---|---|
| **Last** | **First** | **Middle** | **Degree** | |
| **Gender** | **Date of Birth** | **SSN** | **NPI** | **TIN** |
| **Specialty** | **Secondary Specialty** | | ***Practicing as** ☐ **PCP** ☐ **Specialist** | |
| **Panel Status:** ☐ **Open to new patients** ☐ **Existing patients only** ☐ **Closed** | | | | |
| **Provider Contact Name** | **Provider Contact Phone #** | **Provider Contact Email** | | |
| **Provider Contact Street Address** | **Provider Contact City** | **Provider Contact State** | **Provider Contact Zip** | |

| **Individual Provider Billing Detail** | | | |
|---|---|---|---|
| **Billing Name** | **Billing Phone #** | **Billing Fax #** | |
| **Billing Street Address** | **Billing City** | **Billing State** | **Billing Zip** |

| **Group Practice Provider Information** (contact information will be utilized for Group Practice correspondence including contracting, credentialing, and quality) | | | | |
|---|---|---|---|---|
| **Group Practice Name** | | **Phone #** | **Fax #** | |
| **Street Address** | **City** | | **State** | **Zip** |
| **Group NPI** | **Group TIN** | **Additional TINs?** ☐ **Yes** ☐ **No** | **If yes, indicate below:** | |

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| Group Practice Provider Information Cont.<br>(contact information will be utilized for Group Practice correspondence including contracting, credentialing, and quality) | | | |
|---|---|---|---|
| **Specialties:** | | | |
| **Practice Contact Name** | **Practice Phone #** | **Practice Fax #** | |
| **Practice Contact Email Address** | | | |
| **Practice Contact Street Address (*If different than Individual*)** | **City** | **State** | **Zip** |

| Group Provider Billing Detail | | | |
|---|---|---|---|
| **Billing Group Name** | **Billing Phone #** | **Billing Fax #** | |
| **Billing Street Address** | **Billing City** | **Billing State** | **Billing Zip** |

## Primary Service Area:

To enable AHN to complete its antitrust analysis, for each specialty offered, please list the lowest number of ZIP codes from which each specialty, as a group that bills under the Participant's TIN, obtains 75% of its patients[1]:

| Specialty | # Zip Codes |
|---|---|
| | |
| | |
| | |
| | |

[1] AHN may need to request follow-up information to complete its antitrust analysis. Please contact us if you have questions regarding how to obtain this data or about the need for or use of this information.

## SECTION II: Questionnaire

Please complete Section II (A) for Group Practice. Complete for each Individual health care professional identified on Attachment A if answers are different from Group Practice.

**A: Have you agreed to participate in any other Medicare or commercial ACOs?**

☐ Yes ☐ No If yes, list sponsor: _____

# Provider Enrollment Form

## B: Participation in CMS Pilots and Incentive Programs

1. ☐ Yes ☐ No Do you currently participate in any of the following Medicare programs?
   - Comprehensive Primary Care Initiative (CPCI)
   - Pioneer Accountable Care Organization Model Demonstration
   - Independence at Home Medical Practice Demonstration
   - Medicare Health Care Quality Demonstration Programs
   - Multipayer Advanced Primary Care Practice Demonstration with shared savings arrangement
   - Care Management for High-Cost Beneficiaries Demonstration

2. ☐ Yes ☐ No Do you currently participate in any of the following Medicare programs?

   If yes, through which of the following do you report (check one):

   ☐ to CMS on Medicare Part B claims
   ☐ to a qualified Physician Quality Reporting registry, or
   ☐ to CMS via a quality electronic health record (EHR) product

## C: Health Information Technology

3. ☐ Yes ☐ No Do you currently use an Electronic Health Record (EHR)?

   If yes, please specify vendor (including version): _____
   If yes, have you applied for certification of "meaningful use" with CMS? _____

4. ☐ Yes ☐ No Do you currently e-prescribe?

   If yes, have you applied for the Electronic Prescribing (eRx) Incentive Program with CMS?
   _____

5. ☐ Yes ☐ No Do you perform any electronic clinical data exchanges with other providers?

6. ☐ Yes ☐ No Do you participate in a Health Information Exchange?

   If yes, please specify: _____

## D: Patient Management

7. ☐ Yes ☐ No Are you an NCQA-recognized Patient Centered Medical Home (PCMH)?

   If yes, please specify level: _____

8. ☐ Yes ☐ No Do you maintain a Disease Registry?

9. ☐ Yes ☐ No Does your staff include a nurse dedicated to patient/care management?

10. ☐ Yes ☐ No Do you use a hospitalist group?

11. ☐ Yes ☐ No Do you have processes for identifying potential care gaps?

12. ☐ Yes ☐ No Are you engaging in other forms of patient/care management?

If yes, please describe:

_____

_____

_____

_____

_____

## SECTION III: AHN Involvement

13. List the physicians identified on Attachment A who may in interested in participating in an AHN committee or subcommittee (Clinical Care, Finance & Contracting, Network Development, Information Technology, & Coworker Health Services). Be specific if a particular committee is desired.

_____

_____

_____

_____

_____

**Verification.** I represent and warrant that I have authority to submit this Provider Enrollment Form on behalf of the individuals listed on Attachment A. To the best of my knowledge, the information provided in this Provider Enrollment Form is complete and accurate. I authorize Arkansas Health Network to access information regarding my practice and the practice entity (listed by TIN) listed as a Participant on this Provider Enrollment Form to evaluate this application to participate in AHN. I also agree to provide additional information that AHN might reasonably request in connection with that evaluation. I understand that completing this enrollment form neither obligates nor entitles the Participant to participate in AHN. I further understand and agree that if my application is accepted, the Participant and the individuals listed on Attachment A may need to execute a Participation Agreement and other agreements and take certain other actions to participate in AHN.

**Signature:** _____

**Print Name and Title:** _____

**Name of Participant:** _____

**Date:** _____