

HCAP USE: DB _____ INITIALS _____ DATE: _____
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HCAP **PHYSICIAN** INFORMATION SHEET

GENERAL INFORMATION

Please Submit Current W-9

EFFECTIVE DATE _____

BOARD CERTIFIED ~ YES OR NO _____

Board Certified Specialty: _____

PROVIDER'S SOCIAL SECURITY NUMBER ~ _____

Last Name	First Name	MI	Degree
Practice/Group Name	Employer Name <i>(if applicable)</i>		
Federal Tax ID Number	License Number	National Provider ID#	DEA Number
Do you bill under the group? <small>(please circle one)</small> YES or NO	Group NPI # <i>(if applicable)</i>		Date of Birth

CORPORATE ADDRESS

Street		Suite No., P.O. Box No.	
City	State	Zip	County
Telephone ()		Fax ()	

In the following section, please list addresses as you want them to appear in the HCAP Provider Directory. These would include addresses where you typically see patients.

Primary Site Address

Street		Suite No., P.O. Box No.	
City	State	Zip	County
Telephone ()		Fax ()	
Federal Tax ID Number (if different than above)			

Secondary Site Address

Street		Suite No., P.O. Box No.	
City	State	Zip	County
Telephone ()		Fax ()	
Federal Tax ID Number (if different than above)			

Use additional sheet(s) of paper for other locations.

Billing Remittance Address (if different than primary address)

Billing Company Name <i>(if applicable)</i> :			
Street		Suite No., P.O. Box No.	
City	State	Zip	County
Telephone ()		Fax ()	

CONTINUED ON OTHER SIDE

MEDICAL SPECIALTY ~

Primary Care Physician OR **Specialist** (please check one)

Hospitalist ~ YES or NO (please circle one)

Please place an "x" in the appropriate box to designate under which service you wish to be listed in the *HCAP Directory of Network Providers*. More than one box can be checked.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Adolescent Medicine | <input type="checkbox"/> Hand Surgery | <input type="checkbox"/> Oncology/Gynecology | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Allergy/Asthma | <input type="checkbox"/> Hematology | <input type="checkbox"/> Oncology/Hematology | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Allergy/Immunology | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Pulmonary Disease |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Ophthalmology/Neurology | <input type="checkbox"/> Radiation Oncology |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Internal Medicine/Pediatrics | <input type="checkbox"/> Ophthalmology/Pediatrics | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Maxillofacial Surgery | <input type="checkbox"/> Optometry | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Cardiovascular Surgery | <input type="checkbox"/> Medical Genetics | <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Sports Medicine |
| <input type="checkbox"/> Cardiovascular/Thoracic Surgery | <input type="checkbox"/> Medical Oncology | <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> Technical Surgical Assist |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Neonatology | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Thoracic Surgery |
| <input type="checkbox"/> Colon & Rectal Surgery | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Outpatient Mental Health | <input type="checkbox"/> Urgent Care |
| <input type="checkbox"/> Critical Care Medicine | <input type="checkbox"/> Neurological Surgery | <input type="checkbox"/> Pain Management | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Neurology | <input type="checkbox"/> Pathology | <input type="checkbox"/> Vascular Surgery |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Neurology/Pediatric | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Optometry |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Neurology/Psychology | <input type="checkbox"/> Pediatrics/Cardiology | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Neurology/Sleep Disorders | <input type="checkbox"/> Pediatrics/Psychology | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Neurology/Surgery | <input type="checkbox"/> Pediatrics/Pulmonary | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Psychiatry | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> General Practice | <input type="checkbox"/> Nuclear Radiology | <input type="checkbox"/> Physical Medicine & Rehabilitation | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Obstetrics/Gynecology – OB/GYN | <input type="checkbox"/> Plastic Surgery | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> Geriatric Medicine | <input type="checkbox"/> Occupational Medicine | <input type="checkbox"/> Plastic Surgery/Facial | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> Gynecology | <input type="checkbox"/> Oncology | <input type="checkbox"/> Podiatry | <input type="checkbox"/> OTHER _____ |

Are you accepting new patients: Yes _____ No _____

HOSPITAL AFFILIATION(S)

Please list hospital(s) where you have admitting privileges. (List those you routinely admit to first.) Attach a separate sheet, if necessary.

Primary Hospital Affiliation

Hospital Name: _____

- | |
|--------------------------------------|
| <input type="checkbox"/> Active |
| <input type="checkbox"/> Courtesy |
| <input type="checkbox"/> Provisional |

Hospital Name: _____

- | |
|--------------------------------------|
| <input type="checkbox"/> Active |
| <input type="checkbox"/> Courtesy |
| <input type="checkbox"/> Provisional |

Hospital Name: _____

- | |
|--------------------------------------|
| <input type="checkbox"/> Active |
| <input type="checkbox"/> Courtesy |
| <input type="checkbox"/> Provisional |

OFFICE CONTACT PERSON

The person identified below may be contacted for additional information regarding the above information or other information as needed.

Name _____

Title _____

Telephone (____) _____

Fax (____) _____

E-mail Address _____

PROVIDER CERTIFICATION

I certify that the information contained herein is true and correct to the best of knowledge. I understand that misrepresentation may result in non-selection or, if discovered after selection, in termination as an HCAP provider. I understand that this application does not entitle participation in the HCAP network. I authorize HCAP to consult with and inspect all documents from individuals and organizations having information bearing on qualifications and authorize the copy of my signature on the application to be as binding as the original. I agree that HCAP, its representatives, and any individuals or entities providing information to HCAP in good faith shall not be liable for any act of omission related to the evaluation or verification contained in this application. I further agree to notify HCAP in a timely manner of any change to the information requested in this application. HCAP will treat all information requested in this application that is not publicly available, as confidential.

Print Name

Signature
(Original Physician Signature Required)

Date

RETURN APPLICATION TO:
Health Care Alliance Pool
315 Mulholland Street
Bay City, MI 48708

FOR QUESTIONS CALL: 989-891-8820 (locally or outside state of Michigan) OR 1-800-799-6172 (Michigan only long distance)
FAX: 989-891-8161