



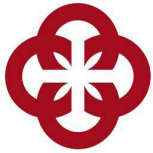
SAINT ALPHONSUS

HEALTH ALLIANCE

PRACTICE AND PROVIDER INFORMATION SHEET

The information provided on this form is required for claims processing and payer directories. Please complete the entire form for new providers.

Effective Date of Change or Start Date of Provider: <i>Note: SAHA is unable to guarantee an effective date. Some network payers assign their own effective date.</i>			
Add Provider to Group		Change Information	
Add a New Location		Add Provider to Hospital Based Location ¹	
Termination Reason:			
PROVIDER INFORMATION (name as shown on license)			NPI: <input type="text"/>
Name:		Degree/Title:	Date of Birth: <input type="text"/>
Idaho State License:	Oregon State License:	Provider Email: <input type="text"/>	
DEA and State:	Controlled Substance:	Type(s) of Insurance Accepted: Commercial Medicare Advantage Medicaid	
Does provider practice at a Group/TIN other than that listed below? Yes No If yes, what percent of provider's time is spent at group listed below: %			
PRACTICE LOCATION INFORMATION (place of service as billed on patient claims)			TIN: <input type="text"/>
Primary Practice Name (as it should appear in directories):			EMR System:
Practice Website Address:			
Group NPI (CMS 1500 Box 33a or UB Box 56)	Office Phone:	Office Fax:	Referral Fax:
Office Address (Address, City, State, Zip)			Publish Provider at Location in Directories: Yes No
Provider Specialty: (as practicing at this location)			Accepting New Patients: Yes No
Provider Type at Location (only check 1) PCP Specialist Urgent Care Hospital Based		Ages Treated:	Accepting Appointments at Location: Yes No
Location Days and Hours of Operation:			TeleHealth ² Available: Yes No
ADA Accessibility at Location: (Check all that apply) Wide Entry Wheelchair Access Lifts Scales Accessible Exam Rooms/Tables Bathrooms/Stalls Grab Bars Access to Interpreters at Location Translation Available On-site			Excluded Genders: Male Female None
Credentialing Contact Name:		Credentialing Contact Email:	
Practice Manager Name:		Practice Manager Email:	
BILLING INFORMATION (as billed on CMS 1500 box 33a or UB box 2)			
Payee/Remit Name (as it appears on claims):			
Remit Address (Address, City, State, Zip):			
Billing Phone:		Billing Fax:	
Billing Contact Name:		Billing Contact Email:	
ADDITIONAL PRACTICE LOCATION INFORMATION <i>please complete the below for any additional locations the provider will provide services. Providers will need to be affiliated to all locations they see members to avoid claim issues.</i>			
Additional Practice Name (as it should appear in directories):			
Group NPI (CMS 1500 Box 33a or UB Box 56)	Office Phone:	Office Fax:	Referral Fax:
Office Address (Address, City, State, Zip)			Publish Provider at Location in Directories: Yes No
Provider Specialty: (as practicing at this location)			Accepting New Patients: Yes No
Provider Type at Location (only check 1) PCP Specialist Urgent Care Hospital Based		Ages Treated:	Accepting Appointments at Location: Yes No
Location Days and Hours of Operation:			TeleHealth Available: Yes No
ADA Accessibility at Location: (Check all that apply) Wide Entry Wheelchair Access Lifts Scales Accessible Exam Rooms/Tables Bathrooms/Stalls Grab Bars Access to Interpreters at Location Translation Available On-site			Excluded Genders: Male Female None



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Additional Practice Name (as it should appear in directories):			
Group NPI (CMS 1500 Box 33a or UB Box 56)	Office Phone:	Office Fax:	Referral Fax:
Office Address (Address, City, State, Zip)		Publish Provider at Location in Directories: Yes No	
Provider Specialty: (as practicing at this location)		Accepting New Patients: Yes No	
Provider Type at Location (only check 1) PCP Specialist Urgent Care Hospital Based	Ages Treated:		Accepting Appointments at Location: Yes No
Location Days and Hours of Operation:		TeleHealth Available: Yes No	
ADA Accessibility at Location: (Check all that apply) Wide Entry Wheelchair Access Lifts Scales Accessible Exam Rooms/Tables Bathrooms/Stalls Grab Bars Access to Interpreters at Location Translation Available On-site		Excluded Genders: Male Female None	
Additional Practice Name (as it should appear in directories):			
Group NPI (CMS 1500 Box 33a or UB Box 56)	Office Phone:	Office Fax:	Referral Fax:
Office Address (Address, City, State, Zip)		Publish Provider at Location in Directories: Yes No	
Provider Specialty: (as practicing at this location)		Accepting New Patients: Yes No	
Provider Type at Location (only check 1) PCP Specialist Urgent Care Hospital Based	Ages Treated:		Accepting Appointments at Location: Yes No
Location Days and Hours of Operation:		TeleHealth Available: Yes No	
ADA Accessibility at Location: (Check all that apply) Wide Entry Wheelchair Access Lifts Scales Accessible Exam Rooms/Tables Bathrooms/Stalls Grab Bars Access to Interpreters at Location Translation Available On-site		Excluded Genders: Male Female None	
Additional Practice Name (as it should appear in directories):			
Group NPI (CMS 1500 Box 33a or UB Box 56)	Office Phone:	Office Fax:	Referral Fax:
Office Address (Address, City, State, Zip)		Publish Provider at Location in Directories: Yes No	
Provider Specialty: (as practicing at this location)		Accepting New Patients: Yes No	
Provider Type at Location (only check 1) PCP Specialist Urgent Care Hospital Based	Ages Treated:		Accepting Appointments at Location: Yes No
Location Days and Hours of Operation:		TeleHealth Available: Yes No	
ADA Accessibility at Location: (Check all that apply) Wide Entry Wheelchair Access Lifts Scales Accessible Exam Rooms/Tables Bathrooms/Stalls Grab Bars Access to Interpreters at Location Translation Available On-site		Excluded Genders: Male Female None	
SUMMARY OF CHANGES/NOTES			
Completed By:	Email:	Phone:	

¹Hospital-Based Provider: A practitioner is not required to credential with SAHA and is considered "Hospital-Based" if he/she:

- Provides health care services within a facility (i.e. Hospital, Ambulatory Surgery Center, etc.) in which they are privileged by that facility,
- Does not accept appointments for health care services at the facility (will not appear in directories), and
- Exclusively sees patients who have been directed to the facility for health care services.

²TeleHealth: If a TeleHealth Only provider please indicate this information in the Practice Name.

If the practitioner provides health care services at any other location not identified as Hospital-Based, credentialing is required.

Submit form via email to SAHS-Alliance@sarmc.org or fax to 208-367-8762