HCAP USE:
DB _____
INITIALS _____
DATE: _____

HCAP INFORMATION SHEET

Please Select the Provider Type Enrolling ~

❑ **Physician** ❑ **Chiropractor** ❑ **Allied Health** ❑ **DDS** ❑ **Optometrist**

GENERAL INFORMATION

Please Submit Current W-9

EFFECTIVE DATE (to be determined by HCAP or the "employing" entity: _____

BOARD CERTIFIED ~ YES OR NO _____

Board Certified Specialty: _____

PROVIDER'S SOCIAL SECURITY NUMBER ~ _____

Last Name		First Name		MI	Degree
Practice/Group Name		Employer Name *(if applicable)*			
Federal Tax ID Number	**CAQH #** Be sure to HCAP to your CAQH Registry to approve HCAP.	License Number	National Provider ID#	DEA Number	
Do you bill under the group? (please circle one) YES or NO		Group NPI # *(if applicable)*	Gender *(M or F)*	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: Practice Name:

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

Secondary Site: Practice Name:

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

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

CONTINUED ON OTHER SIDE

MEDICAL SPECIALTY ~ ❑ **Primary Care 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.

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