Select Health

Provider Participation Request

Instructions: This form must be filled out in its entirety and submitted electronically to your Provider Relations representative along with required documents applicable to your provider type (e.g., W9).

PLEASE NOTE:

- Select Health maintains a confidential practitioner database. The data elements collected on this form may be used by various Select Health entities, including Council for Affordable Healthcare (CAQH), to ensure that you receive credentialing application(s) and other documentation or notifications in a timely and accurate manner.
- Make sure your information with CAQH stays current and up to date to prevent impacts to your network participation. Any changes must be made in CAQH before this form is submitted to Select Health.

PROVIDER CONTACT INFORMATION

Full Name _____

Credentials (e.g., MD, DO, NP, PA, LCSW, DDS)* _____

Personal Email _____

Cell Area Code/Ph# _____

* If you are an APP (NP or PA), do you schedule and manage patients independent of a supervising physician? ☐ Yes ☐ No

Physician Assistants: How many hours in your current practice? (e.g., Family Medicine)?

☐ <4,000 hours ☐ 4,000 – 10,000 hours ☐ >10,000 hours

PROVIDER CREDENTIALS/AFFILIATIONS

Provider's Social Security Number (**last 4**) _____ Date of Birth _____

NPI_____ CAQH ID#_____

Primary Specialty _____

Covering/collaborating provider _____

What is the scope of your practice?

_____

_____

Hospital privileges:

Do you currently hold privileges at an Intermountain or Select Health-contracted hospital? ☐ Yes ☐ No

If yes, where do you hold privileges? _____

_____

If no, have you applied for privileges? ☐ Yes ☐ No

If yes, where have you applied? _____

If no, please explain: _____

_____

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PRACTICE LOCATION INFORMATION

How many office locations have you included with this questionnaire? (If more than two, please attach additional pages as needed.) _____

PRIMARY OFFICE

Clinic Name: _____

Mailing Address: _____

City/ST/Zip: _____

Main Office Area Code/Phone: _____

PHI-appropriate Area Code/Fax:_____

List address in the directory(s): ☐ Yes ☐ No

Proxy or Practice Manager

Name: _____

Email: _____

Telehealth

Do you provide telehealth services? ☐ Yes ☐ No

REMIT / BILLING ADDRESS

Taxpayer Name _____

Tax ID Number (TIN): _____

Mailing Address: _____

City/ST/Zip: _____

Claims should be paid to (**select ONE**):

☐ Self ☐ Group

If group, provide name of group and NPI

_____ _____

_____ _____

ADDITIONAL OFFICE LOCATION INFORMATION (if applicable)

If adding a location, which location will be primary _____ _____ _____

ADDITIONAL OFFICE

Clinic Name: _____

Mailing Address: _____

City/ST/Zip: _____

Main Office Area Code/Phone: _____

PHI-appropriate Areas Code/Fax:_____

List address in the directory(s): ☐ Yes ☐ No

Proxy or Practice Manager

Name: _____

Email: _____

Telehealth

Do you provide telehealth services? ☐ Yes ☐ No

REMIT / BILLING ADDRESS

Taxpayer Name _____

Tax ID Number (TIN): _____

Mailing Address: _____

City/ST/Zip: _____

Claims should be paid to (**select ONE**):

☐ Self ☐ Group

If group, provide name of group and NPI

_____ _____

_____ _____

DISCLAIMER: Decisions on requests are based on Select Health membership access and business needs. All requests are subject to approval by the Select Health Practitioner Panel Strategy Committee.

Select Health