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
____
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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.

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