

INSTRUCTIONS:

1. Complete this application in its entirety.
2. Use this cover sheet as the first page of your form submission.
3. Fax or email the enrollment form and supporting documents to **1-855-306-9762** or **michiganprovidernetwork@amerihealthcaritas.com**. Please submit a separate enrollment form for each provider.
4. Review the checklist at the end of this enrollment form to ensure all required supporting documentation is included with this form for each provider of that specialty.

Note: You must complete and maintain a credentialing application through the Council for Affordable Quality Healthcare® (CAQH) at **proview.caqh.org/pr***. For your AmeriHealth Caritas VIP Care affiliation request to be processed, you must complete your CAQH application within 14 calendar days. If you have already completed the CAQH application, your attestation must be up to date. If your CAQH application is not complete within 14 calendar days, or if your attestation is expired, your request will be closed and you will need to reapply once updated.

To avoid processing delays, complete all fields below.		
Fax to:	1-855-306-9762, attn: Provider Network Management	
Email to:	michiganprovidernetwork@amerihealthcaritas.com	
From (name):		
Date:		
Type 1 NPI:		
Type 2 NPI:		
State license number:		
Is provider enrolled in CHAMPS**?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, effective date:	End date:
Is provider already enrolled with Blue Cross Blue Shield of Michigan or Blue Care Network?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, you may be required to complete additional forms, which could delay the enrollment process.	

*AmeriHealth Caritas does not control this website and is not responsible for its content.

**The Community Health Automated Medicaid Processing System (CHAMPS) is the Michigan Department of Health and Human Services (MDHHS) Medicaid claims payment system. Provider must be registered with CHAMPS to receive Medicaid payments.

All fields marked with * are required.



Section 1: Demographic information	
1. First name*:	2. Last name*:
3. Middle name:	4. Degree or title*:
5. Gender:	6. CAQH ID number:
7. Date of birth (MM/DD/YYYY)*:	8. Ethnicity:
9. Social Security number:	10. Race:
11. Other names you have used (e.g., maiden name or nickname):	
12. Languages spoken other than English:	
13. Medicaid number*:	14. Medicare number*:

Section 2: Practice specialty for which you are seeking affiliation	
1. Provider type*: <input type="checkbox"/> Primary care provider <input type="checkbox"/> Specialist	
2. Specialty*:	Taxonomy:
Specialty and Taxonomy must match what is in NPPES.	
3. Board certified (M.D., D.O., D.M.D., D.P.M., D.D.S. only)*: <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Board eligible (M.D., D.O., D.M.D., D.P.M., D.D.S. only)*: <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Do you practice exclusively in a hospital setting?: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, Section 1 of the CAQH application must be updated to reflect hospital-based status.)	

Section 3: Advanced practice provider and allied health provider supervising physician	
1. Supervising physician name:	
2. Supervising physician specialty:	
3. Supervising physician NPI:	

Section 4: Medical care group, independent physician association, or integrated delivery system affiliation	
1. Medical care group name:	
2. Medical care group administrator name:	
3. Phone number:	4. Email address:

Section 5: Primary office information		
1. Primary office address (This must be an address where health care services are rendered and may be published in the AmeriHealth Caritas VIP Care provider directory. Primary care providers must practice a minimum of 20 hours per week, per location.)		
a. Group practice name (as it appears on W-9/SS4 form)*:		
b. Federal tax ID*:		
c. Tax exempt*: <input type="checkbox"/> Yes <input type="checkbox"/> No		
d. Street address*:		
e. City*:	f. State*:	g. ZIP code*:
h. County:		
i. Primary phone number*:	j. Fax number:	
k. Email address:		
l. Include in provider directory?* <input type="checkbox"/> Yes <input type="checkbox"/> No		



Section 5: Primary office information (continued)

2. Payment or remit address (if different from primary address)

Address must match the address on the W9 form.

a. Street address*:

b. City:	c. State:	d. ZIP code:
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3. Mailing address (if different from primary address)

a. Street address*:

b. City:	c. State:	d. ZIP code:
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4. Medical records request (MMR, if different from primary address)

a. Street address*:

b. City:	c. State:	d. ZIP code:
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5. Office hours*

From	To
a. Monday	
b. Tuesday	
c. Wednesday	
d. Thursday	
e. Friday	
f. Saturday	
g. Sunday	

6. Panel information

a. Is the office accepting new patients? Yes No

b. Does the office have 24-hour coverage? Yes No

c. Are interpreters available? Yes No

d. Does the office meet Americans with Disabilities Act (ADA) accessibility requirements? Yes No

7. Limitations

a. Are there any practice limitations? If yes, please explain:

b. Are there any age limitations? Minimum age: _____ Maximum age: _____

c. Are there any gender limitations? Male only Female only

8. Contact information (Please provide the name and contact information of the person who can answer questions about the information on this form.)

a. Contact name*:

b. Phone number*:	c. Email address*:
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Section 6: Secondary office information

1. Secondary office address (This must be an address where health care services are rendered and may be published in the AmeriHealth Caritas VIP Care provider directory.)

a. Group practice name (as it appears on W-9/SS4 form)*:

b. Federal tax ID*:	c. Tax exempt*: <input type="checkbox"/> Yes <input type="checkbox"/> No
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d. Street address*:

e. City*:	f. State*:	g. ZIP code*:
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h. County:	i. Primary phone number*:
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j. Fax number:	k. Email address:
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l. Include in provider directory?* Yes No



Section 6: Secondary office information (continued)		
2. Payment or remit address (if different from secondary address)		
a. Street address:		
b. City:	c. State:	d. ZIP code:
3. Mailing address (if different from secondary address)		
a. Street address:		
b. City:	c. State:	d. ZIP code:
4. MMR (if different from secondary address)		
a. Street address:		
b. City:	c. State:	d. ZIP code:
5. Office hours*		
	From	To
a. Monday		
b. Tuesday		
c. Wednesday		
d. Thursday		
e. Friday		
f. Saturday		
g. Sunday		
6. Panel information		
a. Is the office accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		
b. Does the office have 24-hour coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
c. Are interpreters available? <input type="checkbox"/> Yes <input type="checkbox"/> No		
d. Does the office meet ADA accessibility requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Limitations		
a. Are there any practice limitations? If yes, please explain:		
b. Are there any age limitations? Minimum age: _____ Maximum age: _____		
c. Are there any gender limitations? <input type="checkbox"/> Male only <input type="checkbox"/> Female only		



Section 7: Enrollment signature

I agree that AmeriHealth Caritas VIP Care (“the Plan”), and any other corporation or entity directly or indirectly owned or controlled by, or under common control with, the Plan, may use the information that I have provided and this credentialing attestation for credentialing purposes.

I represent and warrant to the Plan that the information contained in the foregoing application is correct and complete to the best of my knowledge and belief, and I agree to inform the Plan promptly if any material change in such information occurs, whether before or after my entering agreement with the Plan for the provision of medical services. By my signature below, I certify that I have read, understood, and agree to adhere to the Code of Medical Ethics of the American Medical Association, the Code of Ethics of the American Osteopathic Association, or the standards of ethics of another professional organization applicable to my licensure category.

To facilitate compliance with the credentialing requirements of regulatory and accrediting agencies and organizations, I hereby authorize the Plan to inspect all records and documents and to verify with individuals, organizations, and other health care providers all information concerning my professional competence, character, and moral and ethical qualifications. I release the Plan and its employees and agencies from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I also hereby authorize and request all individuals and institutions to promptly reply to all requests from the Plan for information or verification of information as described above. I release from any and all liability all individuals and institutions furnishing such information to the Plan and their respective agents, employees, and representatives.

I authorize and agree that the Plan and its respective agents, employees, and representatives may disclose to another plan any information, including otherwise privileged or confidential information, concerning my ability and personal and professional qualifications for the purpose of credentialing, recredentialing, or peer review.

I understand that I have the right, unless prohibited by law or peer review protection, to:

- Review information that I submitted in support of my application.
- Review the information that was obtained from outside sources regarding my application.
- Correct any erroneous information in my application.

I authorize the Plan to use the information provided in their selection, credentialing, and recredentialing process, and to verify such information as being appropriate. I further understand that each of these plans has its own criteria for acceptance, and that I may be accepted or rejected by each independently. I agree that a photocopy of my signature below may be relied upon by any person or entity receiving a copy of this authorization.

I agree that, until I am fully credentialed, I will not treat the Plan’s members unless a single case agreement is in place. If credentialed by the Plan, I agree that I will not refer Plan members to an out-of-network provider unless the member requires urgent or emergent care, or the Plan pre-certifies such a referral.

Name*: _____

Provider signature*: _____

Date: _____

AmeriHealth Caritas MI Disclosure of Ownership and Control Interest Form

Per the Code of Federal Regulations, AmeriHealth Caritas MI is required to obtain a completed Disclosure of Ownership and Control Interest form from our contracted providers and delegates. One form is needed to be completed for each entity that has its own Tax ID number.

- Respond to all questions. Read the instructions in each shaded box:
 - ✓ If standard applies, complete the fields.
 - ✓ If standard does not apply, please check the box next to N/A.
- No questions can be left blank. Please attach a separate sheet if necessary.
- Website and email addresses are not acceptable answers to any of the questions.
- Dates of birth and Social Security numbers (SSNs) must be provided for validation purposes, as outlined in 42 CFR 455.104 (b)(1)(ii).
- Any authorized/designated representative of the provider/disclosing entity may complete and sign this form on behalf of the provider/disclosing entity.
- This disclosure will be renewed every three (3) years and/or at any time there is a revision to the information or upon a request for updated information.

Practice Information

Check one that most closely describes you: <input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> Disclosing Entity		
Name of Provider / Disclosing Entity:		
Doing Business as Name:		
Complete Address:		
Street 1:	Street 2:	
City:	State:	ZIP Code:
Tax Identification Number:		
NPI Type 1 Number:	NPI Type 2 Number:	

Section 1 – Managing Employee

Complete the information below for any managing employees of the Disclosing Entity, if applicable. If not, check here: <input type="checkbox"/> NA		
Complete Name:		
First:	Last:	
Social Security #:	Tax ID #:	Date of birth:
Complete Address:		
Street 1:	Street 2:	
City:	State:	ZIP Code:
Complete Name:		
First:	Last:	
Social Security #:	Tax ID #:	Date of birth:
Complete Address:		
Street 1:	Street 2:	
City:	State:	ZIP Code:



Section 2 – Ownership and Control Interests

List and individual or corporation with an ownership or control interest of 5% or more in the Disclosing Entity.

- For Individuals: List the name, title, home address, date of birth (DOB) and Social Security Number (#), if applicable.
- For Entities: List the name, entity Tax Identification Number (Tax ID #), business address of each organization, corporation, or entity if applicable.
- If neither apply, check here: NA

Complete Name:			
First:		Last:	
Social Security #:	Tax ID #:		Date of birth:
Complete Address:			
Street 1:		Street 2:	
City:	State:	ZIP Code:	
Complete Name:			
First:		Last:	
Social Security #:	Tax ID #:		Date of birth:
Complete Address:			
Street 1:		Street 2:	
City:	State:	ZIP Code:	

Section 2A – Relationships

Complete this section if any of the individuals in Section 2 are related (e.g., spouse, sibling, parent, child, etc.) to each other, if applicable. If not, check here: NA

Complete Name:	Relationship:
Complete Name:	Relationship:

Section 3 – Subcontractors

Complete this section if any of the individuals in Section 2 are related (e.g., spouse, sibling, parent, child, etc.) to each other, if applicable. If not, check here: NA

Name of subcontractor:
Name of subcontractor:

Section 3A – Subcontractors

Complete for any person with an ownership or control interest in any subcontractor in section 3. Also indicate if related to anyone in section 2 (e.g., spouse, sibling, parent, child, etc.), if applicable. If not, check here: NA

Complete Name:			
First:		Last:	
Social Security #:	Tax ID #:		Date of birth:
Complete Address:			
Street 1:		Street 2:	
City:	State:	ZIP Code:	



Section 3A – Subcontractors

Complete Name:		
First:	Last:	
Social Security #:	Tax ID #:	
Date of birth:	% of ownership:	
Complete Address:		
Street 1:	Street 2:	
City:	State:	ZIP Code:
Relationship Name Section 2		
Name:	Relationship:	
Complete Name:		
First:	Last:	
Social Security #:	Tax ID #:	
Date of birth:	% of ownership	
Complete Address:		
Street 1:	Street 2:	
City:	State:	ZIP Code:
Relationship Name Section 2		
Name:	Relationship:	

Section 4 – Other Disclosing Entity (or Fiscal Agent or Managed Care Entity)

Complete the fields below if the Disclosing Entity has an ownership or control interest for any Other Disclosing Entity, if applicable. If not, check here: NA

Other Disclosing Entity Name		
First:	Last:	
Social Security #:	Tax ID #:	
Date of birth:	% of ownership	
Complete Address:		
Street 1:	Street 2:	
City:	State:	ZIP Code:
Name of person with ownership or control interest:		
First:	Last:	
Other Disclosing Entity Name		
First:	Last:	
Social Security #:	Tax ID #:	
Date of birth:	% of ownership	
Complete Address:		
Street 1:	Street 2:	
City:	State:	ZIP Code:
Name of person with ownership or control interest:		
First:	Last:	



Section 5 – Business Transactions Disclosures

Indicate if the provider/disclosing entity or part B supplier has any business transactions with a Subcontractor totaling more than \$25,000 in the previous twelve (12) months period (12-month period ending as of the date of this request), if applicable. If not, check here: NA

Subcontractor Complete Name

First:	Last:
Social Security #:	Tax ID #:
Date of birth:	Transaction amount:

Complete Address:

Street 1:	Street 2:	
City:	State:	ZIP Code:

Subcontractor Complete Name

First:	Last:
Social Security #:	Tax ID #:
Date of birth:	Transaction amount:

Complete Address:

Street 1:	Street 2:	
City:	State:	ZIP Code:

Section 5A – Significant Business Transactions Disclosure

Indicate if the provider/disclosing entity or part B supplier had any significant business transactions with a wholly Owned Supplier or subcontractor during the previous 5-year period (5-year period ending on the date on this request), if applicable. If not, check here: NA

Complete Name

First:	Last:
<input type="checkbox"/> Wholly Owned Supplier <input type="checkbox"/> Subcontractor	
Social Security #:	Tax ID #:
Date of birth:	Transaction amount

Complete Address:

Street 1:	Street 2:	
City:	State:	ZIP Code:

Complete Name

First:	Last:
<input type="checkbox"/> Wholly Owned Supplier <input type="checkbox"/> Subcontractor	
Social Security #:	Tax ID #:
Date of birth:	Transaction amount

Complete Address:

Street 1:	Street 2:	
City:	State:	ZIP Code:



Section 6 – Criminal Offense Disclosure

Identify any person who has ownership or control interest in the provider; or is an agent or managing employee of the provider; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare and/or Medicaid, or the title XX services program since the inception of those programs, if applicable. If not, check here: NA

Complete Name:		
First:	Last:	
Title:	Social Security #:	
Tax ID #:	Date of birth:	
Complete Address:		
Street 1:	Street 2:	
City:	State:	ZIP Code:
Description of offense(s):		

Complete Name:		
First:	Last:	
Title:	Social Security #:	
Tax ID #:	Date of birth:	
Complete Address:		
Street 1:	Street 2:	
City:	State:	ZIP Code:
Description of offense(s):		

Attestation

Through signature below, I certify that the information provided herein is true, accurate and complete. Additions to or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate or incomplete data may result in denial of participation. Individuals and Sole Proprietors must sign their own form. An authorized representative may sign for Partnership, Corporation, LLC or Other disclosing entities.

Provider or Authorized Agent name (please print):
Title (or indicate if Authorized Agent):
Provider or Authorized Agent signature:
Date:



Provider enrollment required document checklist

Current copies of the following documents must be submitted with this application:	
<ul style="list-style-type: none"> • State medical licenses. • Collaborative agreement (if applicable). • Drug Enforcement Administration (DEA) certificate. • Face sheet of professional liability policy or certification. • Board certification (if applicable). 	<ul style="list-style-type: none"> • Curriculum vitae. • Certified registered nurse practitioner (CRNP) certification. • Educational Commission for Foreign Medical Graduates (ECFMG) (if applicable). • Ownership disclosure.
Provider classification	To avoid processing delays, please ensure all items are submitted.
Anesthesia assistant	<ul style="list-style-type: none"> • Type 1 National Provider Identifier (NPI) number. • Tax identification number (TIN) and Internal Revenue Service (IRS) document identifying TIN and associated payee name. • Supervising physician information.
Audiologist	<ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Behavioral Health Professionals and Physicians	<ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Certified nurse midwife (CNM)	<ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available). • For CNMs performing deliveries, the following are also required: <ul style="list-style-type: none"> – Written confirmation of established privileges with hospitals or hospital-affiliated birthing centers. – Written confirmation of an established, interdependent relationship for medical consultation, collaboration, or referral to an OB/GYN.
CRNP	<ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Certified registered nurse anesthetist	<ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).



Provider classification	To avoid processing delays, please ensure all items are submitted.
Chiropractor	<ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Certified nurse specialist	<ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Doctor of medicine	<ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Doctor of osteopathic medicine	<ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Hearing aid dealer	<ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Independent occupational or physical therapist	<ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Ophthalmologist	<ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Optometrist	<p>Our network of providers for routine vision care is administered through a partnership with Avesis. To participate with AmeriHealth Caritas VIP Care, you must first enroll with Avesis. Please visit www.avesis.com to enroll.</p> <p>Direct enrollment to AmeriHealth Caritas VIP Care is limited and based on network needs. Please attach information on medical services provided and supporting clinical criteria documentation along with the following:</p> <ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).



Provider classification	To avoid processing delays, please ensure all items are submitted.
Oral surgeon	<ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Physician assistant	<ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available). • Supervising physician name and NPI number.
Podiatrist	<ul style="list-style-type: none"> • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).