MUNSON HEALTHCARE

ALL FIELDS ARE REQUIRED

NEW PROVIDER REQUEST

Hospital Credentialing - It may take up to 120 days AFTER we receive all required information for final approval. **Payor Enrollment** - It may take up to 180 days AFTER we receive all required information for full enrollment.	**SUBMIT FORM TO LOCAL MEDICAL STAFF OFFICE:** **East** (Charlevoix/Grayling/Otsego) – Nikki Karbginsky **nkarbginsky@mhc.net** **South** (Cadillac/Manistee/Paul Oliver) – Kim Loveland **kloveland@mhc.net** **Medical Center/Grand Traverse Region** – Jen Mathews **jmathews@mhc.net** **Kalkaska Memorial Health Center** – Teresa Smith **tsmith9@mhc.net**

PERSON COMPLETING FORM

Name:	**Title:**
Phone:	**Email:**
Projected/Proposed Provider Start/Effective Date: *(Local Med Staff will provide official start date)*	

PROVIDER INFORMATION

Last Name:	**First Name:**	**DOB:**
Specialty:	**Email:**	
Credentials:	**Phone:**	
Is Provider CONFIDENTIAL:	**Yes ☐ No ☐**	
Currently Licensed in Michigan:	**Yes ☐ No ☐** ***if yes,*** **License #**	
Provider NPI #		
DEA for Michigan: *(If DEA is out of state, please use the following website - https://apps.deadiversion.usdoj.gov/webforms/)*	**MI DEA #**	
Currently Practicing or in Training:	**Practicing ☐ Training ☐**	
PROVIDER CREDENTIALING CONTACT *(Office Manager, Locum Agency, Practice Administrator, SLED, etc. Please list the name of the person who is the best contact for ensuring paperwork is complete, and can provide follow up or expediting assistance to the Med Staff Offices.)*	**Name:**	
	Phone:	
	Email:	
	Preferred method of contact: Phone ☐ Email ☐	
Primary Practice/Office:		
Will provider have an in-hospital presence:	**Yes ☐ No ☐**	
Will provider have an ambulatory presence:	**Yes ☐ No ☐**	
Is Provider Part-time, Full-time or PRN:	**Part-time ☐ Full-time ☐ PRN ☐**	
Other Locations provider will perform services: *(Ex: all clinic names and nursing home names)*		
APP Supervising Physician:		
Primary MHC Facility:		
Other MHC Facilities:		
Hospital Application Fee: Who pays?	**☐ Applicant**	
	☐ Private office:	
	☐ Munson Facility Dept. #	
Will MHC be providing malpractice insurance:	**Yes ☐ No ☐**	
Employed by MHC: ***If employed, is this position benefitted:***	**Yes ☐ No ☐** **Yes ☐ No ☐ N/A ☐**	
Will Munson Healthcare be billing professional fees for the provider? ***(If yes, please complete the information below)***	**Yes ☐ No ☐**	
Do you want this provider listed in the insurance payer directory as scheduling appointments at this location:	**Yes ☐ No ☐**	
Provider will be listed in the insurance payer directory as:	**PCP ☐ Specialist ☐ Hospital Based ☐**	
CAQH	**CAQH #:**	
(Call 1-888-599-1771 if need to obtain username/password)	**Username:**	**Password:**
Other Comments/Special Requests:		

MUNSON HEALTHCARE

ATTESTATION OF VERIFICATION OF IDENTITY

Applicant Name		
Address		
City	State	Zip Code

ATTESTOR MUST VIEW ONE OF THE FOLLOWING (check which type viewed)

- ☐ U.S.Passport (unexpired or expired)
- ☐ Other valid picture ID issued by a state or federal agency (Driver's license, Military ID Card, State Identification Cards)
- ☐ Permanent Resident Card
- ☐ An unexpired foreign passport

ATTESTATION: I attest that (1) I have examined the document(s) presented by the above-named, and (2) the above-listed documents appear to be genuine and to relate to the individual above-named.

Signature of Authorized Representative	Date (mm/dd/yyyy)
Name or Authorized Representative (type or print legibly)	Title of Authorized Representative