

PROVIDER LOCATION ADDITION OR CHANGE REQUEST

ALL FIELDS ARE REQUIRED

Form 12525 09/25

<p>Hospital Credentialing - It may take up to 120 days AFTER we receive all required information for final approval.</p> <p>Payor Enrollment - It may take up to 180 days AFTER we receive all required information for full enrollment.</p>	<p>SUBMIT FORM TO LOCAL MEDICAL STAFF OFFICE:</p> <p>East (Charlevoix/Grayling/Otsego) – Nikki Karbginsky nkarbginsky@mhc.net</p> <p>South (Cadillac/Manistee/Paul Oliver) – Kim Loveland kloveland@mhc.net</p> <p>Medical Center/Grand Traverse Region – Jen Mathews jmathews@mhc.net</p> <p>Kalkaska Memorial Health Center – Teresa Smith tsmith9@mhc.net</p>
PERSON COMPLETING FORM	
Name:	Title:
Phone:	Email:
<p style="text-align: center;">Projected/Proposed Provider Start/Effective Date: (Local Med Staff will provide official start date)</p>	
PROVIDER INFORMATION	
Last Name:	First Name:
Provider Credentials:	
Specialty:	
<p>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.)</p>	
<p>Name:</p>	
<p>Phone:</p>	
<p>Email:</p>	
<p>New location addition(s) and employment status: (full/part time, etc.,)</p>	
<p>List all locations the provider will perform services and indicate primary location: (list each clinic or nursing home name)</p>	
<p>Will provider have an in-hospital presence: Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Will provider have an ambulatory presence: Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p style="text-align: center;"><u>APP ONLY</u></p> <p>Note the collaborating or supervising physician for each location:</p>	
<p>Is this provider employed by Munson: Yes <input type="checkbox"/> No <input type="checkbox"/> - <i>If no, are they:</i> <input type="checkbox"/> Private <input type="checkbox"/> 1099</p>	
<p>Do you want this provider listed in the insurance payer directory as scheduling appointments at this location:</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Provider will be listed in the insurance payer directory as:</p>	<p>PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based <input type="checkbox"/></p>
<p>Is this location change confidential:</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Will Munson Healthcare be providing malpractice insurance:</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p style="text-align: center;">CAQH</p> <p>Call 1-888-599-1771 if need to obtain username/password</p>	
<p>CAQH:</p>	
<p>Username:</p>	
<p>Password:</p>	
<p>Other Comments/Special Requests:</p>	