



Network Participation Request Form Individual Provider

Thank you for your interest in joining Piedmont Community Health Plan as a network provider. Please note that completion of this request form and/or credentialing application does not guarantee acceptance or approval to the physician/professional networks administered by Piedmont Community Health Plan (Piedmont).

The credentialing and recredentialing processes encompass a thorough review and validation of a practitioner or provider's credentials and qualifications based upon NCQA and CMS standards. Piedmont's Medical Affairs Committee reviews the qualifications applicants and reapplicants and makes the final determination regarding provider membership.

The Credentialing Coordinator will notify you once the final determination has been made.

The credentialing process will not officially start until we receive all of the requested information below.

Please note that *full credentialing may take up to 60 days after receipt of all required information, including completed CAQH.*

You have the right to:

- Review information we obtain from outside sources (e.g., malpractice insurance carriers, state licensing boards) to support your credentialing application, except for references, recommendations, and peer-review protected information.
- Correct erroneous information.
- Receive the status of your credentialing or credentialing application, upon request.

You can contact us for further information regarding these rights.

If you have questions, please call Annette Stanley at (434) 947-4463, ext. 317 or contact by email at Annette.Stanley@pchp.net

Please return this form by email to: Annette.Stanley@pchp.net or by mail:

Piedmont Community Health Plan
Attn: Annette Stanley
2316 Atherholt Rd.
Lynchburg, VA 24501

Date Application Information Completed:

I. NETWORKS		
Select the networks in which participation of the listed provider is requested:		
HMO	PPO	Medicare Advantage PPO
VA Premier (Medicaid) <i>(If you/your group has a current contract with VA Premier <u>do not</u> check this box)</i>		
Select the type of agreement/contract requested:		
Solo Practitioner		
Practitioner Agreement (Physicians, Chiropractors, Optometrists, MFT, LCSW, PhD, etc.)		
New Provider with a New Group Agreement		
New Provider to be added to an existing Group Agreement		



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II. PRACTITIONER INFORMATION									
A. General Information									
First Name:		MI:		Last Name:		Suffix:		Degree(s):	
Gender:		DOB:		SSN:					
B. Professional Registration									
NPI (for provider):				License:			TIN:		
CAQH #:				DEA#:					
Malpractice Insurance Company:									
Claim Amount:									
Aggregate Amount:									
C. Practitioner Details									
Primary Specialty:									
Medicare Specialty <i>(used for publication of provider in the Medicare Provider Directory. Choose from the list provided)</i>									
							Code: <i>(will autopopulate)</i>		
Board Certified?	Name of Certifying Board:								
Yes No									
Subspecialty:									
Board Certified?	Name of Certifying Board:								
Yes No									
Additional Special Skills or Training:									
III. AFFILIATION & PRIVILEGES INFORMATION									
1.	Facility Name:								
	Address:								
	Phone Number:								
2.	Facility Name:								
	Address:								
	Phone Number:								
3.	Facility Name:								
	Address:								
	Phone Number:								



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IV. GROUP INFORMATION

*Please complete this section even if you are requesting the addition of a provider to an existing group.
If applying as a solo provider, this information should be applicable to the solo practice.*

A. General Information

Legal Group/Practice Name:

The name of the practice as it is registered with legal entities for billing, W-9, NPI, etc.

B. Contact and Address Information

Practice Manager Name:

Title:

This person may be contacted by us to update or confirm practice information.

Phone:

Email:

Fax:

Other Contact Info:

Mode of Contact Preference:

Phone

Email

Fax

Billing Address

*Check here if Billing
Address is the same as the
Physical Address listed in
Section IV.*

Address Line 1:

Address Line 2:

City:

State:

Zip:

Mailing Address

*Check here if Mailing
Address is the same as the
Physical Address listed in
Section IV.*

Address Line 1:

Address Line 2:

City:

State:

Zip:



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V. FACILITY DETAILS

This information pertains to the locations where the provider accepts appointments. It will be used for the practice listing in the provider directories. Please copy this page as needed if you schedule patients in more than two locations.

LOCATION 1 – PRIMARY LOCATION

Common Group/Practice Location Name:

The name of the practice as it is referred to when staff answer phones. This will be listed in the Medicare Provider Directory. CMS/Medicare may audit the accuracy of this information by calling the practice and reconciling the greeting with the name in the directory.

Location NPI:

Physical Address

Address Line 1:

Phone:

Address Line 2:

Fax:

City:

State:

Zip:

Email:

Tax ID:

TTY:

County or City of Physical Location:

Availability

Will only see patients within an age range (Accepted age range: _____)

Check which days of the week the provider is regularly available for accepting appointments. If the days of the week the provider is available for appointments is not on a regular schedule, choose “varies”.

Mon Tues Wed Thurs Fri Sat Sun Varies

Select all that currently apply to this individual provider at this location:

☐ Accepts Medicaid
☐ Accepting New Patients
☐ Accepts Medicare
☐ Accepting New Medicare Advantage Patients

Languages

Please list all languages other than English that are spoken by provider, clinical staff, and non-clinical staff in the group or practice other than English.

Language	Spoken by (check all that apply)		
	☐ Provider	☐ Clinical Staff	☐ Non-Clinical Staff
	☐ Provider	☐ Clinical Staff	☐ Non-Clinical Staff
	☐ Provider	☐ Clinical Staff	☐ Non-Clinical Staff

Handicap Access

Please list any provisions made in the practice location that allow access for patients with physical disabilities. This information will be used to advise our members.



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LOCATION 2 – SECONDARY LOCATION

Common Group/Practice Location Name: _____

The name of the practice as it is referred to when staff answer phones. This will be listed in the Medicare Provider Directory. CMS/Medicare may audit the accuracy of this information by calling the practice and reconciling the greeting with the name in the directory.

Location NPI: _____

Physical Address

Address Line 1: _____

Phone: _____

Address Line 2: _____

Fax: _____

City: _____

State: _____

Zip: _____

Email: _____

Tax ID: _____

TTY: _____

County or City of Physical Location: _____

Availability

Will only see patients within an age range (Accepted age range: _____)

Select all that currently apply to this individual provider at this location:

Check which days of the week the provider is regularly available for accepting appointments. If the days of the week the provider is available for appointments is not on a regular schedule, choose "varies".

Mon

Tues

Wed

Thurs

Fri

Sat

Sun

Varies

Accepts Medicaid

Accepting New Patients

Accepts Medicare

Accepting New Medicare Advantage Patients

Languages

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Language	Spoken by (check all that apply)		
	Provider	Clinical Staff	Non-Clinical Staff
	Provider	Clinical Staff	Non-Clinical Staff
	Provider	Clinical Staff	Non-Clinical Staff

Handicap Access

Please list any provisions made in the practice location that allow access for patients with physical disabilities. This information will be used to advise our members.

Completed by (Name): _____

Please return this form by email to: Annette.Stanley@pchp.net or by mail:

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