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 Tammie Kovach at (434) 947-4463, ext. 226 or contact by email at Tammie.Kovach@pchp.net
Please return this form by email to: Tammie.Kovach@pchp.net or by mail:

Piedmont Community Health Plan
Attn: Tammie Kovach
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) *(If you/your group has a current contract with VA Premier do not check this box)*

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

PIEDMONT COMMUNITY HEALTH PLAN

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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 *(used for publication of provider in the Medicare Provider Directory. Choose from the list provided)*	
Kidney Transplant Program	Code: *(will autopopulate)* 064

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:	

PIEDMONT COMMUNITY HEALTH PLAN

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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:)

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.

Completed by (Name):_____

Please return this form by email to: Tammie.Kovach@pchp.net or by mail:

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Attn: Tammie Kovach
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Lynchburg, VA 24501