Network Participation Request Form
Nurse Practitioner

To be used for Nurse Practitioners ONLY*

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).

Please note, per Virginia State Bill HB 793, there is **no longer a requirement for a practice agreement** with a patient care team physician for a licensed nurse practitioner who has **completed the equivalent of at least five years of full-time clinical experience and submitted an attestation from his patient care team physician** stating (i) that the patient care team physician has served as a patient care team physician on a patient care team with the nurse practitioner pursuant to a practice agreement; (ii) that while a party to such practice agreement, the patient care team physician routinely practiced wit h a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed; and (iii) the period of time for which the patient care team physician practiced with t he nurse practitioner under such a practice agreement.

In addition, per Virginia State Bill HB 1640, effective 10/01/19, health insurers and health services plan providers whose policies or contracts cover services that may be legally performed by a licensed nurse practitioner are required to provide equal coverage for such services when rendered by a licensed nurse practitioner. This bill also contains an enactment that exempts the measure from the requirement that the Health Insurance Reform Commission review any legislative measure containing a mandated health insurance benefit or provider.

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.

Credentialing may take up to 60 days after receipt of all required information, including completed CAQH.

****SECTION REQUIRED****

This application cannot be processed for any purpose unless this section is completed.

Do you wish to be credentialed with Piedmont Community Health Plan?

- ☐ **Yes, I attest that I have met the criteria to be credentialed without a practice agreement with a patient care team physician including at least five years of full-time clinical experience.**
- ☐ **No**

_____ _____

Nurse practitioner or Representative Signature Date

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 Keri Nelson at (434) 947-4463, ext. 276 or contact by email at PCHPCredentialing@PCHP.net.
Please return this form by email to: PCHPCredentialing@PCHP.net or by mail:

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

PIEDMONT COMMUNITY HEALTH PLAN

Network Participation Request Form
Nurse Practitioner

To be used for Nurse Practitioners ONLY*

Date Application Information Completed:

I. NETWORKS

Select the networks in which participation of the listed provider is requested:

- ☐ HMO ☐ 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

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:	
FBoard Certified?	Name of Certifying Board:
◯Yes ◯No	
Subspecialty:	
Board Certified?	Name of Certifying Board:
◯Yes ◯No	
Additional Special Skills or Training:	

PIEDMONT
COMMUNITY HEALTH PLAN

Network Participation Request Form
Nurse Practitioner

To be used for Nurse Practitioners ONLY*

III. AFFILIATION & PRIVILEGES INFORMATION

1.	Facility Name:	
	Address:	
	Phone Number:	
2.	Facility Name:	
	Address:	
	Phone Number:	
3.	Facility Name:	
	Address:	
	Phone Number:	

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:	

PIEDMONT COMMUNITY HEALTH PLAN

Network Participation Request Form
Nurse Practitioner

*****To be used for Nurse Practitioners ONLY*****

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.

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

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.

PIEDMONT
COMMUNITY HEALTH PLAN

Network Participation Request Form
Nurse Practitioner

To be used for Nurse Practitioners ONLY*

LOCATION 2 – SECONDARY LOCATION							
Common Group/Practice Location Name:							
The name of the practice as it is referred to when staff answer phones.							
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

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):_____