AmeriHealth Caritas
VIP Care Plus

MI HEALTH LINK
Linking Medicare & Medicaid for you

Provider Credentialing and Enrollment Form

INSTRUCTIONS:

1. Complete this application in its entirety.
2. Use this cover sheet as the first page of your form submission.
3. Fax or email the enrollment form and supporting documents to **1-855-306-9762** or **michiganprovidernetwork@amerihealthcaritas.com.** Please submit a separate enrollment form for each provider.
4. Mail completed form and documentation to AmeriHealth Caritas VIP Care Plus, Provider Network Management, 100 Galleria Officentre, Suite 210, Southfield, MI 48034.
5. Review the checklist at the end of this enrollment form to ensure all required supporting documentation is included with this form for each provider of that specialty.

Note: You must complete and maintain a credentialing application through the Council for Affordable Quality Healthcare® (CAQH) at **proview.caqh.org/pr***. For your AmeriHealth Caritas VIP Care Plus affiliation request to be processed, you must complete your CAQH application within 14 calendar days. If you have already completed the CAQH application, your attestation must be up to date. If your CAQH application is not complete within 14 calendar days, or if your attestation is expired, your request will be closed and you will need to reapply once updated.

To avoid processing delays, complete all fields below.		
Fax to:	**1-855-306-9762**, attn: Provider Network Management	
Email to:	**michiganprovidernetwork@amerihealthcaritas.com**	
From (name):		
Date:		
Type 1 NPI:		
Type 2 NPI:		
State license number:		
Is provider enrolled in CHAMPS**?		
❑ Yes ❑ No	If yes, effective date:	End date:
Is provider already enrolled with Blue Cross Blue Shield of Michigan or Blue Care Network?		
❑ Yes ❑ No	If no, you may be required to complete additional forms, which could delay the enrollment process.	

*AmeriHealth Caritas does not control this website and is not responsible for its content.

**The Community Health Automated Medicaid Processing System (CHAMPS) is the Michigan Department of Health and Human Services (MDHHS) Medicaid claims payment system. Provider must be registered with CHAMPS to receive Medicaid payments.

All fields marked with * are required.

Section 1: Demographic information	
1. First name*:	2. Last name*:
3. Middle name:	4. Degree or title*:
5. Gender:	6. CAQH ID number:
7. Date of birth (MM/DD/YYYY)*:	8. Ethnicity:
9. Social Security number:	10. Race:
11. Other names you have used (e.g., maiden name or nickname):	
12. Languages spoken other than English:	
13. Medicaid number*:	14. Medicare number*:

Section 2: Practice specialty for which you are seeking affiliation
1. Provider type*: ❑ Primary care provider ❑ Specialist
2. Specialty*:
3. Board certified (M.D., D.O., D.M.D., D.P.M., D.D.S. only)*: ❑ Yes ❑ No
4. Board eligible (M.D., D.O., D.M.D., D.P.M., D.D.S. only)*: ❑ Yes ❑ No
5. Do you practice exclusively in a hospital setting?: ❑ Yes ❑ No (If yes, Section 1 of the CAQH application must be updated to reflect hospital-based status.)

Section 3: Advanced practice provider and allied health provider supervising physician
1. Supervising physician name:
2. Supervising physician specialty:
3. Supervising physician NPI:

Section 4: Medical care group, independent physician association, or integrated delivery system affiliation	
1. Medical care group name:	
2. Medical care group administrator name:	
3. Phone number:	4. Email address:

Section 5: Primary office information		
1. Primary office address (This must be an address where health care services are rendered and may be published in the AmeriHealth Caritas VIP Care Plus provider directory. Primary care providers must practice a minimum of 20 hours per week, per location.)		
a. Group practice name (as it appears on W-9/SS4 form)*:		
b. Federal tax ID*:		
c. Tax exempt*: ❑ Yes ❑ No		
d. Street address*:		
e. City*:	f. State*:	g. ZIP code*:
h. County:	i. Primary phone number*:	
j. Fax number:	k. Email address:	
l. Include in provider directory?* ❑ Yes ❑ No		

Section 5: Primary office information (continued)		
2. Payment or remit address (if different from primary address)		
a. Street address*:		
b. City:	c. State:	d. ZIP code:
3. Mailing address (if different from primary address)		
a. Street address*:		
b. City:	c. State:	d. ZIP code:
4. Medical records request (MMR, if different from primary address)		
a. Street address*:		
b. City:	c. State:	d. ZIP code:
5. Office hours*	From	To
a. Monday		
b. Tuesday		
c. Wednesday		
d. Thursday		
e. Friday		
f. Saturday		
g. Sunday		
6. Panel information		
a. Is the office accepting new patients? ❑ Yes ❑ No		
b. Does the office have 24-hour coverage? ❑ Yes ❑ No		
c. Are interpreters available? ❑ Yes ❑ No		
d. Does the office meet Americans with Disabilities Act (ADA) accessibility requirements? ❑ Yes ❑ No		
7. Limitations		
a. Are there any practice limitations? If yes, please explain:		
b. Are there any age limitations? Minimum age: Maximum age:		
c. Are there any gender limitations? ❑ Male only ❑ Female only		
8. Contact information (Please provide the name and contact information of the person who can answer questions about the information on this form.)		
a. Contact name*:		
b. Phone number*:	c. Email address*:	

Section 6: Secondary office information		
1. Secondary office address (This must be an address where health care services are rendered and may be published in the AmeriHealth Caritas VIP Care Plus provider directory.)		
a. Group practice name (as it appears on W-9/SS4 form)*:		
b. Federal tax ID*:	c. Tax exempt*: ❑ Yes ❑ No	
d. Street address*:		
e. City*:	f. State*:	g. ZIP code*:
h. County:	i. Primary phone number*:	
j. Fax number:	k. Email address:	
l. Include in provider directory?* ❑ Yes ❑ No		

Section 6: Secondary office information (continued)		
2. Payment or remit address (if different from secondary address)		
a. Street address:		
b. City:	c. State:	d. ZIP code:
3. Mailing address (if different from secondary address)		
a. Street address:		
b. City:	c. State:	d. ZIP code:
4. MMR (if different from secondary address)		
a. Street address:		
b. City:	c. State:	d. ZIP code:
5. Office hours*	From	To
a. Monday		
b. Tuesday		
c. Wednesday		
d. Thursday		
e. Friday		
f. Saturday		
g. Sunday		
6. Panel information		
a. Is the office accepting new patients? ❑ Yes ❑ No		
b. Does the office have 24-hour coverage? ❑ Yes ❑ No		
c. Are interpreters available? ❑ Yes ❑ No		
d. Does the office meet ADA accessibility requirements? ❑ Yes ❑ No		
7. Limitations		
a. Are there any practice limitations? If yes, please explain:		
b. Are there any age limitations? Minimum age: Maximum age:		
c. Are there any gender limitations? ❑ Male only ❑ Female only		

Section 7: Enrollment signature

I agree that AmeriHealth Caritas VIP Care Plus ("the Plan"), and any other corporation or entity directly or indirectly owned or controlled by, or under common control with, the Plan, may use the information that I have provided and this credentialing attestation for credentialing purposes.

I represent and warrant to the Plan that the information contained in the foregoing application is correct and complete to the best of my knowledge and belief, and I agree to inform the Plan promptly if any material change in such information occurs, whether before or after my entering agreement with the Plan for the provision of medical services. By my signature below, I certify that I have read, understood, and agree to adhere to the Code of Medical Ethics of the American Medical Association, the Code of Ethics of the American Osteopathic Association, or the standards of ethics of another professional organization applicable to my licensure category.

To facilitate compliance with the credentialing requirements of regulatory and accrediting agencies and organizations, I hereby authorize the Plan to inspect all records and documents and to verify with individuals, organizations, and other health care providers all information concerning my professional competence, character, and moral and ethical qualifications. I release the Plan and its employees and agencies from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I also hereby authorize and request all individuals and institutions to promptly reply to all requests from the Plan for information or verification of information as described above. I release from any and all liability all individuals and institutions furnishing such information to the Plan and their respective agents, employees, and representatives.

I authorize and agree that the Plan and its respective agents, employees, and representatives may disclose to another plan any information, including otherwise privileged or confidential information, concerning my ability and personal and professional qualifications for the purpose of credentialing, recredentialing, or peer review.

I understand that I have the right, unless prohibited by law or peer review protection, to:

- Review information that I submitted in support of my application.
- Review the information that was obtained from outside sources regarding my application.
- Correct any erroneous information in my application.

I authorize the Plan to use the information provided in their selection, credentialing, and recredentialing process, and to verify such information as being appropriate. I further understand that each of these plans has its own criteria for acceptance, and that I may be accepted or rejected by each independently. I agree that a photocopy of my signature below may be relied upon by any person or entity receiving a copy of this authorization.

I agree that, until I am fully credentialed, I will not treat the Plan's members unless a single case agreement is in place. If credentialed by the Plan, I agree that I will not refer Plan members to an out-of-network provider unless the member requires urgent or emergent care, or the Plan pre-certifies such a referral.

Name*:_____

Provider signature*:_____

Date:_____

Provider enrollment required document checklist

Current copies of the following documents must be submitted with this application:	
• State medical licenses. • Collaborative agreement (if applicable). • Drug Enforcement Administration (DEA) certificate. • Face sheet of professional liability policy or certification. • Board certification (if applicable).	• Curriculum vitae. • Certified registered nurse practitioner (CRNP) certification. • Educational Commission for Foreign Medical Graduates (ECFMG) (if applicable). • Ownership disclosure.

Provider classification	To avoid processing delays, please ensure all items are submitted.
Anesthesia assistant	• Type 1 National Provider Identifier (NPI) number. • Tax identification number (TIN) and Internal Revenue Service (IRS) document identifying TIN and associated payee name. • Supervising physician information.
Audiologist	• Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Certified nurse midwife (CNM)	• Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available). • For CNMs performing deliveries, the following are also required: – Written confirmation of established privileges with hospitals or hospital-affiliated birthing centers. – Written confirmation of an established, interdependent relationship for medical consultation, collaboration, or referral to an OB/GYN.
CRNP	• Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Certified registered nurse anesthetist	• Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Chiropractor	• Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).

Provider classification	To avoid processing delays, please ensure all items are submitted.
Certified nurse specialist	• Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Doctor of medicine	• Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Doctor of osteopathic medicine	• Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Hearing aid dealer	• Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Independent occupational or physical therapist	• Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Ophthalmologist	• Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Optometrist	Our network of providers for routine vision care is administered through a partnership with Avesis. To participate with AmeriHealth Caritas VIP Care Plus, you must first enroll with Avesis. Please visit **www.avesis.com** to enroll. Direct enrollment to AmeriHealth Caritas VIP Care Plus is limited and based on network needs. Please attach information on medical services provided and supporting clinical criteria documentation along with the following: • Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).

Provider classification	To avoid processing delays, please ensure all items are submitted.
Oral surgeon	• Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).
Physician assistant	• Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available). • Supervising physician name and NPI number.
Podiatrist	• Type 1 NPI number. • TIN and IRS document identifying TIN and associated payee name. • State of Michigan professional license number. • CAQH number (if available).