Practitioner Data Form

silversummit healthplan

PLEASE TYPE OR PRINT CLEARLY AND COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING THE ADDITIONAL DOCUMENTS LISTED BELOW SO THAT WE MAY PROCESS YOUR REQUEST. *This form includes Personally Identifiable Information (PHI) such as practitioner name, date of birth and SSN and should be sent in a secure manner.*

- ☐ Provider's W-9 (one per tax entity)
- ☐ Ownership and Disclosure form
- ☐ Behavioral Health Providers: Behavioral Health Addendum
- ☐ Documentation of board certification or scheduled exam date
- ☐ Supplemental sheet for additional locations
- ☐ Completed Provider Assessment of Cognitive and Physical Disabilities and Accommodations tool (one per location)

INDIVIDUAL PRACTITIONER

Practitioner Name and Degree [Last] [First] [MI] [Degree]	Practitioner has CAQH? ☐ YES ☐ NO CAQH #:	☐ Female ☐ Male DOB
Practitioner Type ☐ PCP ☐ OBGYN ☐ Specialist ☐ Intern ☐ Other _____		Requested Effective Date
Line of Business ☐ Medicaid ☐ Medicare ☐ Commercial	Hospital-based Only? ☐ YES ☐ NO	Participating in Medicaid? ☐ YES ☐ NO ☐ Pending Participating in Medicare? ☐ YES ☐ NO ☐ Pending
SSN	Individual NPI #	Medicaid ID # Medicare ID #
License # State Exp Date	DEA# State Exp Date ☐ N/A	
Primary Practicing Specialty	Specialty Taxonomy *(must match NPPES)*	Board Certification: ☐ YES ☐ NO Date of Exam:
Secondary Practicing Specialty	Specialty Taxonomy *(must match NPPES)*	Board Certification: ☐ YES ☐ NO Date of Exam:

Accepting New Patients ☐ YES ☐ YES, Existing Patients Only ☐ NO	Patient Gender Restrictions ☐ None ☐ Female Only ☐ Male Only	Ages Treated Restrictions ☐ None Age Limits ☐ Min Age: _____ Max Age: _____	Ages treated for Psychiatrists/ Psychologists who treat child/adolescent ☐ 0-6 ☐ 7-12 ☐ 13-17 ☐ 18-21
Any PCP panel size and restrictions (accepting referrals only, etc) ☐ YES ☐ NO If YES, please explain:			Visit by ☐ Telemedicine ☐ In-person ☐ Both

Do you provide services to individuals with special needs/chronic conditions? *(check all that apply)*
☐ Physical ☐ Developmental ☐ Behavioral ☐ Emotional ☐ None

Do you provide services/accommodations to individuals who have difficulty communicating or cooperating (i.e., those with autism or intellectual disabilities)? ☐ YES ☐ NO	Do you provide services to individuals with mobility limitations (i.e., wheelchair bound)? ☐ YES ☐ NO

Do you treat any of the following diagnoses? *(check all that apply)*
☐ Anxiety ☐ EPSDT ☐ HIV ☐ None
☐ AHDS ☐ Depression ☐ Substance Abuse

PCPs and OBs ONLY: Do you provide any of the following services? ☐ EPSDT ☐ OB ☐ None

Revised 10/2024

PROVIDER GROUP

W-9 Registered Name (Required)	Group Type *(check all that apply)* ☐ FQHC/RHC ☐ IC ☐ Multi-Specialty ☐ Other_____
Group Practice Name (DBA) if applicable	

BILLING (PAY TO) INFORMATION	Billing Contact Name							
	Address						Phone #	
	City		State		Zip Code		Fax #	
PRIMARY ADDRESS *(Physical location where services are performed)*	Address					City		State
	Zip Code		County			Phone #		Fax #
	Office Hours	**DAY**	**OPEN**	**CLOSE**	**DAY**	**OPEN**	**CLOSE**	☐ Supplemental sheet attached for additional addresses
		Monday			Friday			
		Tuesday			Saturday			
		Wednesday			Sunday			TIN:
		Thursday						Group NPI:
	List Practitioner in Directories at this address? ☐ YES ☐ NO							
OFFICE CONTACT	Name/Title				Phone #		Fax #	
	Email				Practice Website			
	Address				City	State		Zip Code
CREDENTIALING CONTACT	Name/Title				Phone #		Fax #	
	Email							
	Address				City	State		Zip Code
Languages other than English spoken by PRACTITIONER								
Languages other than English spoken by OFFICE STAFF								

Race Ethnicity

☐ Black/African ☐ Hispanic/Latino/Spanish ☐ Asian
☐ Native American/American Indian ☐ Native Hawaiian ☐ White/Caucasian
☐ Prefer not to disclose ☐ Pacific Islander
☐ Other (please add) _____

PRACTITIONER LOCATION ADDRESS			
Accomodation	**YES**	**NO**	**NA**
Provider/Staff trained to assist individuals with a cognitive disability, i.e., autism or intellectual disabilities			
Provider/Staff trained to assist individuals with a physical disability, i.e., mobility limittions or wheelchair bound			
Flexible appointment times available - sick appointments, same day appointments - please specify			
Assistance available to members to fill out forms			
In-home and/or community services			
Large print materials			
Materials in electronic format			
Augmentative/alternative communication devices			
American Sign Language translator			
Signage in Braille and raise tactile text characters at office, elevator stairwells, and restroom doors mounted 60in from floor			
Visible and audible alarms - emergency systems			
Railings between 30 and 38in high on both sides			
Paths are at least 36in wide and free of protruding objects			
Cane detectible objects on ground as a warning barrier			
Widened doorways (at least 32in clearance)			
Lever or loop handles vs knobs			
5ft circle or T-shaped space for turning a wheelchair completely			
A clear floor space, 30"x48" minimum, adjacent to the exam table and adjoining accessible route make it possible to do a side transfer			
Adjustable height exam table or chair (lowers to 17-19in from floor)			
Celing or floor based patient lift			
Wheelchair accessible scales			
Adjustable height radiologic equipment			
Handicap parking			
Handicap accessible restroom			
Access ramps			
Accessible by bus			
Accessible by Valley Metro Rail			
Provider/Staff has completed cultural competence training			
Do you provide Field Clinic services? (A "clinic" consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than a Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis)			
Do you provide Virtual Clinic services? (Integrated services provided in community settings through the use of innovative strategies for care coordination such as telemedicine, integrated medical records, and virtual interdisciplinary treatment team meetings)			

ADDITIONAL PRACTICE LOCATIONS *(Physical location where services are performed)*	Address					City		State
	Zip Code		County			Phone #		Fax #
	Office Hours	**DAY**	**OPEN**	**CLOSE**	**DAY**	**OPEN**	**CLOSE**	
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