

Application for Practitioner Enrollment

To begin the enrollment process, please complete all information as it applies to your specialty. Information that does not apply to your specialty may be left blank.

Last Name:		First Name:		Middle Initial:	
Physician Email Address:					
Date of Birth:		Social Security #:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Language(s) spoken:		Are you CAQH registered: <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, CAQH Provider ID:	
Applying as: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Allies/Consulting Health Professional				Requested Effective Date:	
Individual NPI #:		License/Registration #:		Licensed State:	
DEA Certificate #:		Medicare #:		Medicaid #:	
Primary Specialty:		Second Specialty:		Taxonomy Code:	
Group Name:		Group Tax ID:		Group NPI:	
<p>Have you, your agent or managing employee ever been convicted of a crime relating to Medicare, Medicaid or any government health program or the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide the following: Name/Title, DOB, Address, SSN:</p>					
Are you board-certified? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, board name and date:			
<p>Please select only one provider type:</p>	<input type="checkbox"/> Anesthesiologist <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalist <input type="checkbox"/> Locum Tenens <input type="checkbox"/> Pathologist		<input type="checkbox"/> Audiologist (AUD) <input type="checkbox"/> Certified Diabetic Educator (CDE) <input type="checkbox"/> Doctor of Podiatric Medicine (DPM) <input type="checkbox"/> Enterostomal Therapy <input type="checkbox"/> Medical Doctor (MD) <input type="checkbox"/> Certified Nurse Midwife (CNM) <input type="checkbox"/> Chiropractor (DC) * <input type="checkbox"/> Occupational Therapist (OT)		<input type="checkbox"/> Optometrist <input type="checkbox"/> Oral Maxillofacial Surgery (DMD/DDS) <input type="checkbox"/> Osteopathic Doctor (DO) <input type="checkbox"/> Registered Dietician (RDE) <input type="checkbox"/> Physical Therapist (PT) <input type="checkbox"/> Speech Pathologist (SP/SLP) <input type="checkbox"/> Pain Management
	* Provider Type is applicable to Essential Plan Only				
<p><i>If you selected Anesthesiologist, Emergency Room, Hospitalist, Locum Tenens or Pathologist, you must complete the disclosure questions on the last page</i></p>					
Experienced HIV/AIDS Provider:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Primary Office Address (street level only, No PO Box):				Suite:	
City:		County:		State:	
Office Phone:		Office Fax:		Zip Code:	
		Handicap Accessible:		Public Transportation:	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Email Address:					
Additional Office Address (Street Level only, No PO Box):				Suite:	
City:		County:		State:	
Office Phone:		Office Fax:		Zip Code:	
		Handicap Accessible:		Public Transportation:	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
All members can make an appointment and be treated at:		Primary Office:		Additional Office:	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please provide only ONE correspondence, ONE Remittance, and ONE Medical Records Address. Each address can be the same or different, but must be identified as a valid United States Postal Service mailing address. If PO BOX information is used, the corresponding City, State and ZIP Code for the PO Box must be provided and no street level information present.					
Same As:		Remittance Address:			Suite:
<input type="checkbox"/> Primary Address		City:		State:	
		Office Phone:		Zip Code:	
		Office Fax:			
Same As:		Correspondence Address:			Suite:
<input type="checkbox"/> Primary Address		City:		State:	
<input type="checkbox"/> Remittance		Office Phone:		Zip Code:	
		Office Fax:		Email	
Same As:		Medical Record Address:			Suite:
<input type="checkbox"/> Primary		City:		State:	
<input type="checkbox"/> Remittance		Office Phone:		Zip Code:	
<input type="checkbox"/> Correspondence		Office Fax:		EMR <input type="checkbox"/> Paper <input type="checkbox"/> EMR Vendor:	
		Medical Record Contact Name:			Phone:

Include the completed form along with a copy of the W-9 and Malpractice (Liability) Insurance, and Mail or Fax to:

• Monroe Plan for Medical Care • 1120 Pittsford-Victor Road, Pittsford NY 14534 • Fax 716-748-6987 • PFMemails@monroeplan.com

Hospital Affiliations

Hospital Name	Hospital Address

Office Hours

Primary Location:			Additional Location:		
Day:	Office Open:	Office Close:	Day:	Office Open:	Office Close:
Monday			Monday		
Tuesday			Tuesday		
Wednesday			Wednesday		
Thursday			Thursday		
Friday			Friday		
Saturday			Saturday		
Sunday			Sunday		

Office Contact Information

Contact Name:	Phone Number:
Contact Email Address:	
Contact Type: <input type="checkbox"/> Billing Manager <input type="checkbox"/> Office Manager <input type="checkbox"/> Provider <input type="checkbox"/> Office Staff <input type="checkbox"/> Other:	

Anesthesiologist, Emergency Room, Hospitalist, Locum Tenens and Pathologist
Must complete the following disclosure questions:

1. Has your license, registration or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?
 Yes No NA

2. Have your clinical privileges or medical staff membership at any hospital or health care institution (either voluntarily or involuntarily) ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected), or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee or governing board?
 Yes No NA

3. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action by any managed care organizations or health plans (including HMOs, PPOs, or provider organizations such as independent practice associations or private health organizations)?
 Yes No NA

4. Has your federal Drug Enforcement Administration and/or state controlled dangerous substances (CDS) certificates(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?
 Yes No NA

5. Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS-authorizing entities, education or training program, Medicare or Medicaid program, regulatory agency, or any other private, federal or state health program or been a defendant in any civil action that is reasonably related to your qualifications, competence, functions or duties as a medical professional for alleged fraud, an act of violence, child abuse or sexual offense or sexual misconduct?
 Yes No NA

6. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Databank or Healthcare Integrity and Protection Data Bank?
 Yes No NA

7. Has your Professional liability coverage ever been cancelled, restricted, declined, or not renewed by the carrier based on your individual liability history?
 Yes No NA

"I hereby attest, to the best of my knowledge that the information on this form is true accurate, and complete."

Provider Signature: _____ Date: _____