MUNSON HEALTHCARE

NEW PROVIDER REQUEST

Hospital Credentialing - It may take up to 60-90 days AFTER we receive all required information for final approval. **Payor Enrollment** - It may take up to 90-180 days AFTER we receive all required information for full enrollment.	**Submit form to local Medical Staff Office:** **East Region** (Charlevoix, Grayling, Otsego) – **Angela Gee agee02@mhc.net** **South Region** (Cadillac, Manistee, Paul Oliver) – **Heather Lucas hlucas@mhc.net** **Medical Center/Grand Traverse Region** – **Katryna Glettler kglettler@mhc.net** **Kalkaska Memorial Health Center - Teresa Smith tsmith9@mhc.net**
Person completing form:	Name:
	Title:
	Phone:
	Email:
Provider Start/Effective Date: *(Connect with your local Medical Staff Office for official start date)*	
Provider Information:	Name:
	Credentials:
	Specialty:
	Email:
	DOB:
	Phone:
Is Provider CONFIDENTIAL:	Yes ☐ No ☐
Currently Licensed in Michigan:	Yes ☐ No ☐ *if yes,* License #:
Provider NPI #:	
DEA for Michigan: *(If your DEA is out of state, please use the following website - https://apps.deadiversion.usdoj.gov/webforms/)*	MI DEA #:
Currently Practicing or in Training:	Practicing ☐ Training ☐
Provider Credentialing Contact: *(Office Manager or Locum Agency)*	Name:
	Phone:
	Email:
	Preferred method of contact: Phone ☐ Email ☐
Primary Practice/Office:	
Is Provider Part-time, Full-time or PRN:	Part-time ☐ Full-time ☐ PRN ☐
Other Locations provider will perform services: *(Ex: all clinic names and nursing home names)*	
APP Supervising Physician:	
Primary MHC Facility:	
Other MHC Facilities:	
Hospital Application Fee: Who pays?	☐ Applicant
	☐ Private office:
	☐ Munson Facility Dept. #:
Will Munson Healthcare be providing malpractice insurance?	Yes ☐ No ☐
Employed by Munson Healthcare? ***If employed, is this position benefitted?***	Yes ☐ No ☐ Yes ☐ No ☐ N/A ☐
Will Munson Healthcare be billing professional fees for provider? *(If yes, please complete the information below)*	Yes ☐ No ☐
Do you want this provider listed in the insurance payer directory as scheduling appointments at this location?	Yes ☐ No ☐
Provider will be listed in the insurance payer directory as:	PCP ☐ Specialist ☐ Hospital Based ☐
CAQH: **Call 1-888-599-1771 if need to obtain username/password**	CAQH #: Username: Password:
Other Comments/Special Requests:	

ATTESTATION OF VERIFICATION OF IDENTITY

Applicant Name		
Address		
City	State	Zip Code

ATTESTOR MUST VIEW ONE OF THE FOLLOWING (check which type viewed)

- ☐ U.S.Passport (unexpired or expired)
- ☐ Other valid picture ID issued by a state or federal agency (Driver's license, Military ID Card, State Identification Cards)
- ☐ Permanent Resident Card
- ☐ An unexpired foreign passport

ATTESTATION: I attest that (1) I have examined the document(s) presented by the above-named, and (2) the above-listed documents appear to be genuine and to relate to the individual above-named.

Signature of Authorized Representative	Date (mm/dd/yyyy)
Name of Authorized Representative (type or print legibly)	Title of Authorized Representative