New Provider Applicant Information

Please note, all information must be completed in order for the application to be accepted.

Date: ______________________________________

Provider Information

Provider Name: ____ CAQH ID: ______________

Individual NPI:______________________ Primary Specialty: ___________________________

Is provider office based (appointments) or hospital based (no appointments)? ______________

Provider Type (Select One; *If Behavioral Health, go to next row):

MD DO DMD DDS DPM OD DC CRNP PA NMW

*Behavioral Health Provider? Y/N _______ Are you an SUD Treating Provider? Y/N ________

Behavioral Health Provider Type (Select One):

MD DO CRNP PA PhD PsyD LCSW LPC LMFT ABA Other:____________

Languages Spoken by Provider: _______________________________________

Participating with Medicare? Y/N _______ *If yes, please include CMS Approval Letter*

License State: _________________ License Number: _______________________

Physicians:

Residency Completed? Y/N __________ Fellowship Completed? Y/N ____________

Advanced Practice Providers:

Collaborating/Supervising Physician (if applicable) ______________________________________

Collaborating/Supervising Physician Specialty: __________________________________

If PCP specailty, will you accept Member assignment?______________________________

Call Coverage: (Choose all that apply) Answering Service After Hours Phone Number

Covering Provider: (Name and NPI) ______________________________________

Telehealth services provided? Y/N ________ Telehealth services ONLY? Y/N __________

Practice Information- Please include a W9

Practice Legal Business Name: ____

Practice DBA Name: ____

Practice NPI: _________________________ Practice TIN: ___________________________

Practice Credentialing Contact: __________________________________

Phone: __________________________ Email: _____________________________________

Practice Locations: For practice addresses, only include addresses where the provider will be accepting patient appointments. This information is used in VIVA HEALTH, Inc. provider directories. Include additional locations on a separate sheet or roster.

Primary Practice Address: ____

City: ______________________ State:__________________ Zip Code:_________________

Phone: __________________________ Fax:___________________________________

Languages spoken at location: (Choose all that apply)

English Spanish American Sign Language Other:_________________

Translation Services provided? Y/N _______

Secondary Practice Address: ____

City: ______________________ State:__________________ Zip Code:_________________

Phone: __________________________ Fax:___________________________________

Languages spoken at location: (Choose all that apply)

English Spanish American Sign Language Other:__________________

Translation Services provided? Y/N _______

Billing Address: ____

City: ______________________ State:__________________ Zip Code:_________________

Phone: __________________________ Fax:___________________________________

For Internal Use Only

Is APP practicing as PCP? Y/N ____ Is Collaborating Physician par? Y/N ____ Is provider listed in TXEN? Y/N _____

If so, what specialty? ____ List provider in Directory? Y/N _________

Special Arrangements: ____

Address Verified? Y/N _____________ Ready for CAQH? Y/N ______________