AHP Provider Participation Request

Physician Information (please use a separate sheet for additional physicians)

Physician One

Last Name:	First Name:	Middle Initial
Date of birth:	Email Address:	
NPI:	Specialty:	Type of degree:

Applying as: ☐ Primary Care Physician (specify below) ☐ Specialist ☐ Allied Health

☐ General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Med-Peds ☐ Family Medicine ☐ Geriatrics

State Medical License Issued in:	Medical License Number:

Other IPA Memberships:

Malpractice Insurance Carrier:

Professional Liability: Aggregate Coverage $_____ Per Occurrence $_____

Comprehensive General Liability: Aggregate Coverage $_____ Per Occurrence $_____

Hospital Affiliation:	Medical Staff: ☐ Yes ☐ No	Usage Percent:
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Hospital Affiliation:	Medical Staff: ☐ Yes ☐ No	Usage Percent:

Physician Two

Last Name:	First Name:	Middle Initial
Date of birth:	Email Address:	
NPI:	Specialty:	Type of degree:

Applying as: ☐ Primary Care Physician (specify below) ☐ Specialist ☐ Allied Health

☐ General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Med-Peds ☐ Family Medicine ☐ Geriatrics

State Medical License Issued in:	Medical License Number:

Other IPA Memberships:

Malpractice Insurance Carrier:

Professional Liability: Aggregate Coverage $_____ Per Occurrence $_____

Comprehensive General Liability: Aggregate Coverage $_____ Per Occurrence $_____

Hospital Affiliation:	Medical Staff: ☐ Yes ☐ No	Usage Percent:
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Physician Three

Last Name:	First Name:	Middle Initial
Date of birth:	Email Address:	
NPI:	Specialty:	Type of degree:

Applying as: ☐ Primary Care Physician (specify below) ☐ Specialist ☐ Allied Health

☐ General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Med-Peds ☐ Family Medicine ☐ Geriatrics

State Medical License Issued in:	Medical License Number:

Other IPA Memberships:

Malpractice Insurance Carrier:

Professional Liability: Aggregate Coverage $_____ Per Occurrence $_____

Comprehensive General Liability: Aggregate Coverage $_____ Per Occurrence $_____

Hospital Affiliation:	Medical Staff: ☐ Yes ☐ No	Usage Percent:
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Practice Information	
Practice Name:	
Practice Address:	
Practice Phone Number:	Practice Direct Phone Number:
Office Hours:	
Practice Mailing Address:	
Practice Manager Name:	
Practice Manager Email:	
Does your practice include employed midlevels: ? ☐ Yes ☐ No If yes, please list below.	
Name:	☐ NP ☐ PA ☐ Other License :
Name:	☐ NP ☐ PA ☐ Other License :
Name:	☐ NP ☐ PA ☐ Other License :
Name:	☐ NP ☐ PA ☐ Other License :

Practice Technology Profile		
Does your practice have an high-speed Internet connection?	☐ Yes ☐ No	
Does your practice have an EMR?	☐ Yes ☐ No	System name:
If no, do you plan on implementing one in the next 12 months?	☐ Yes ☐ No	
Does your practice have a Practice Management System?	☐ Yes ☐ No	System name:
If no, do you plan on implementing one in the next 12 months?	☐ Yes ☐ No	

For AHP Use Only		
Date Received:	Date Reviewed:	Reviewed by:
Credentials:	Membership Committee:	Board:
Notes:		
Status ☐ Participation Documents Issued	☐ Clarification Request	☐ Denied
Denial Reason:		

Please complete the form and mail to Accountable Health Partners, 135 Corporate Woods, Suite 320, Rochester, NY 14623-1466 or fax to 585-424-1268. AHP will acknowledge receipt of the request within seven business days and review your request to ensure you meet current requirements for participation, as well as filling network needs for your specialty.

This form allows providers to request participation in Accountable Health Partners IPA. Please note that acceptance of a provider's request form does not guarantee acceptance into AHP.

Should you have questions or concerns please call Renée Sutton at (585) 758-0911.