

# 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:
Primary Taxonomy:	Secondary Taxonomy:	Indiv. TaxID:
Applying as: <input type="checkbox"/> Primary Care Physician (specify below) <input type="checkbox"/> Specialist <input type="checkbox"/> Allied Health		
<input type="checkbox"/> General Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> Med-Peds <input type="checkbox"/> Family Medicine <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:

### Physician Two

Last Name:	First Name:	Middle Initial
Date of birth:	Email Address:	
NPI:	Specialty:	Type of degree:
Primary Taxonomy:	Secondary Taxonomy:	Indiv. TaxID:
Applying as: <input type="checkbox"/> Primary Care Physician (specify below) <input type="checkbox"/> Specialist <input type="checkbox"/> Allied Health		
<input type="checkbox"/> General Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> Med-Peds <input type="checkbox"/> Family Medicine <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:

### Physician Three

Last Name:	First Name:	Middle Initial
Date of birth:	Email Address:	
NPI:	Specialty:	Type of degree:
Primary Taxonomy:	Secondary Taxonomy:	Indiv. TaxID:
Applying as: <input type="checkbox"/> Primary Care Physician (specify below) <input type="checkbox"/> Specialist <input type="checkbox"/> Allied Health		
<input type="checkbox"/> General Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> Med-Peds <input type="checkbox"/> Family Medicine <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:

Practice Information	
Practice Name:	
Practice Address:	
Practice Phone Number:	Practice Direct Phone Number:
Office Hours:	
Group Tax ID:	Group NPI:
Practice Mailing Address:	
Practice Manager Name:	
Practice Manager Email:	
Does your practice include employed midlevels: ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list below.	
Name:	<input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Other License :
Name:	<input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Other License :
Name:	<input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Other License :
Name:	<input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Other License :

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

Adult PCP and Pediatrician Offices Only	
Is your practice an NCQA-recognized Patient Centered Medical Home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, your practice was recognized under <input type="checkbox"/> 2011 Standards <input type="checkbox"/> 2014 Standards	<input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 3
If No, are you planning to become PCMH recognized?	<input type="checkbox"/> Yes <input type="checkbox"/> No

For AHP Use Only		
Date Received:	Date Reviewed:	Reviewed by:
Credentials:	Membership Committee:	Board:
Notes:		
Status	<input type="checkbox"/> Participation Documents Issued	<input type="checkbox"/> Clarification Request <input type="checkbox"/> 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.**

**Additional Physician Information****Physician Four**

Last Name:	First Name:	Middle Initial
Date of birth:	Email Address:	
NPI:	Specialty:	Type of degree:
Primary Taxonomy:	Secondary Taxonomy:	Indiv. TaxID:
Applying as: <input type="checkbox"/> Primary Care Physician (specify below) <input type="checkbox"/> Specialist <input type="checkbox"/> Allied Health		
<input type="checkbox"/> General Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> Med-Peds <input type="checkbox"/> Family Medicine <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:

**Physician Five**

Last Name:	First Name:	Middle Initial
Date of birth:	Email Address:	
NPI:	Specialty:	Type of degree:
Primary Taxonomy:	Secondary Taxonomy:	Indiv. TaxID:
Applying as: <input type="checkbox"/> Primary Care Physician (specify below) <input type="checkbox"/> Specialist <input type="checkbox"/> Allied Health		
<input type="checkbox"/> General Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> Med-Peds <input type="checkbox"/> Family Medicine <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:

**Physician Six**

Last Name:	First Name:	Middle Initial
Date of birth:	Email Address:	
NPI:	Specialty:	Type of degree:
Primary Taxonomy:	Secondary Taxonomy:	Indiv. TaxID:
Applying as: <input type="checkbox"/> Primary Care Physician (specify below) <input type="checkbox"/> Specialist <input type="checkbox"/> Allied Health		
<input type="checkbox"/> General Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> Med-Peds <input type="checkbox"/> Family Medicine <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:

**Physician Seven**

Last Name:	First Name:	Middle Initial
Date of birth:	Email Address:	
NPI:	Specialty:	Type of degree:
Primary Taxonomy:	Secondary Taxonomy:	Indiv. TaxID:
Applying as: <input type="checkbox"/> Primary Care Physician (specify below) <input type="checkbox"/> Specialist <input type="checkbox"/> Allied Health		
<input type="checkbox"/> General Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> Med-Peds <input type="checkbox"/> Family Medicine <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:

**Physician Eight**

Last Name:	First Name:	Middle Initial
Date of birth:	Email Address:	
NPI:	Specialty:	Type of degree:
Primary Taxonomy:	Secondary Taxonomy:	Indiv. TaxID:
Applying as: <input type="checkbox"/> Primary Care Physician (specify below) <input type="checkbox"/> Specialist <input type="checkbox"/> Allied Health		
<input type="checkbox"/> General Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> Med-Peds <input type="checkbox"/> Family Medicine <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:

**Physician Nine**

Last Name:	First Name:	Middle Initial
Date of birth:	Email Address:	
NPI:	Specialty:	Type of degree:
Primary Taxonomy:	Secondary Taxonomy:	Indiv. TaxID:
Applying as: <input type="checkbox"/> Primary Care Physician (specify below) <input type="checkbox"/> Specialist <input type="checkbox"/> Allied Health		
<input type="checkbox"/> General Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> Med-Peds <input type="checkbox"/> Family Medicine <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent:
Hospital Affiliation:	Medical Staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	Usage Percent: