GROUP PRACTICE ENROLLMENT FORM

Please complete all sections of the MNO and MichCare Group Enrollment Application Form. Completed form can be emailed to enrollment@hcscredentialing.com or faxed to (248) 436-4758.

GROUP INFORMATION		
Group Name:		
Group NPI:	**Taxonomy (Primary):**	**Taxonomy (Additional):**
PHYSICIAN ORGANIZATION		
☐ **Medical Network One (MNO)**	☐ **MichCare Organized System of Care**	
BILLING INFORMATION (Please attach a copy of W-9 or SS4)		
Tax ID Name (As it appears on W-9 or SS4):	**Tax ID Number:**	
DBA (If applicable):		
Remittance Address:		
City:	**State:**	**Zip:**
Phone:	**Fax:**	
Billing Contact Name:	**Email:**	
PRIMARY PRACTICE LOCATION INFORMATION		
Primary Practice Location Name:		
Address:		
City:	**State:**	**Zip:**
Office Phone:		**Office Fax:**
Office/Practice Website:		**Office Email:**
Office Manager Name:	**Office Manager Phone:**	**Office Manager Email:**
Credentialing Contact Name:	**Credentialing Contact Phone:**	**Credentialing Contact Email:**
List Location in the Directory:		**Yes** ☐ **No** ☐
Appointment Phone (If Different than Office Phone):		**After Hours Phone (If Different Than Office Number):**
Does this Practice Utilize Electronic Medical Records?		**Yes** ☐ **No** ☐
EMR Name and Version:		

Does this Location offer Telemedicine Services?	Yes ☐	No ☐
Does this Location Have E Prescribing Capabilities?	Yes ☐	No ☐
Does this Location Have 24 Hour Phone Coverage?	Yes ☐	No ☐
Does this Location Offer Extended Office Hours?	Yes ☐	No ☐
Does this Location Offer Laboratory Services? (if Yes please attach a copy of current CLIA Certificate	Yes ☐	No ☐
Does this Location Offer Radiology Services? (if Yes please attach a copy of current Radiology Certificate)	Yes ☐	No ☐
Does this Location Offer Behavioral Health Services?	Yes ☐	No ☐
Is this Practice PCMH Certified? (if yes please attach a copy)	Yes ☐	No ☐

NCQA PCMH Certification Level:	Level 1 ☐	Level 2 ☐	Level 3 ☐	Effective Date:	End Date:

LOCATION OFFICE HOURS

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM

MAILING ADDRESS (If different than Primary Location)

Address:		
City:	State:	Zip:

LOCATION LANGUAGES (List Languages that are Spoken by Office Staff)

PRACTICE LOCATION RESTRICTIONS

Hospital Based Location Only:	Yes ☐	No ☐
In Home Services Only:	Yes ☐	No ☐
Indian Health Services Only:	Yes ☐	No ☐
Minute Clinic Services Only:	Yes ☐	No ☐
Nursing Home Services Only	Yes ☐	No ☐
Skilled Nursing Services Only:	Yes ☐	No ☐
Telemedicine Services Only:	Yes ☐	No ☐
Urgent Care Location Only:	Yes ☐	No ☐
Veteran Affairs Location Only:	Yes ☐	No ☐

PRACTICE LOCATION ACCESSIBILITY

Does Location meet ADA Accessibility Requirements?	Yes ☐	No ☐
Does Location Offer American Sign Language Services?	Yes ☐	No ☐
Does Location have Handicap Accessible Exam Table/Scale/Chair?	Yes ☐	No ☐
Is the Location Exterior Building Handicap Accessible?	Yes ☐	No ☐

Does Location have Handicap Accessible Gurneys/Stretchers?		**Yes** ☐	**No** ☐
Is the Location Interior Building Handicap Accessible?		**Yes** ☐	**No** ☐
Does Location Offer Mental/Physical Impairment Services?		**Yes** ☐	**No** ☐
Does Location Offer Other Services for the Disabled?		**Yes** ☐	**No** ☐
Does Location have Handicap Accessible Parking?		**Yes** ☐	**No** ☐
Does Location have Handicap Accessible Portable Lifts?		**Yes** ☐	**No** ☐
Does Location have Handicap Accessible Radiologic Equipment?		**Yes** ☐	**No** ☐
Does Location have Handicap Accessible Restroom?		**Yes** ☐	**No** ☐
Does Location have Handicap Accessible Signage & Documents?		**Yes** ☐	**No** ☐
Does Location Meet State and Local Fire, Safety and Sanitation Requirements?		**Yes** ☐	**No** ☐
Does Location have TDD Phone?	**Number:**	**Yes** ☐	**No** ☐
Does Location have TTY Phone?	**Number:**	**Yes** ☐	**No** ☐
Does Location have Wheelchair Accessible Exam Rooms?		**Yes** ☐	**No** ☐
Does Location offer Language Line Services?		**Yes** ☐	**No** ☐
Does Location have Documents Available in Other Languages?		**Yes** ☐	**No** ☐
Does Location Offer Document Translation Services?		**Yes** ☐	**No** ☐
Does Location Offer Care Management Services?		**Yes** ☐	**No** ☐
Does Location off Qualified Onsite Interpreters?		**Yes** ☐	**No** ☐
Has Staff at Location Completed Cultural Competence Training?		**Yes** ☐	**No** ☐
Is this Location Accessible to Public Transportation?		**Yes** ☐	**No** ☐
Is this Location Accessible by Rail/Train?		**Yes** ☐	**No** ☐
Is this Location Accessible by Taxi?		**Yes** ☐	**No** ☐
Is this Location Accessible by Bus?		**Yes** ☐	**No** ☐

APPLICATION CHECK LIST
Current Copy of Liability/Malpractice Coverage
W-9
Copy of Current CLIA Certificate if Applicable
Copy of Current Radiology Certificate if Applicable
Copy of Current PCMH Certificate if Applicable

I certify that all information included in my application and the accompanying documents are correct and complete to the best of my knowledge.

Each submission requires an original signature and current date. Rubber stamped and electronic signatures are not acceptable.

Provider Group Representative Signature:	
Printed Name:	**Date:**

ADDITIONAL PRACTICE LOCATION INFORMATION

Additional Practice Location Name:				
Address:				
City:	**State:**	**Zip:**		
Office Phone:		**Office Fax:**		
Office/Practice Website:		**Office Email:**		
Office Manager Name:	**Office Manager Phone:**	**Office Manager Email:**		
Credentialing Contact Name:	**Credentialing Contact Phone:**	**Credentialing Contact Email:**		
List Location in the Directory:		**Yes** ☐	**No** ☐	
Appointment Phone (If Different than Office Phone):		**After Hours Phone (If Different Than Office Number):**		
Does this Practice Utilize Electronic Medical Records?		**Yes** ☐	**No** ☐	
EMR Name and Version:				
Does this Location offer Telemedicine Services?		**Yes** ☐	**No** ☐	
Does this Location Have E Prescribing Capabilities?		**Yes** ☐	**No** ☐	
Does this Location Have 24 Hour Phone Coverage?		**Yes** ☐	**No** ☐	
Does this Location Offer Extended Office Hours?		**Yes** ☐	**No** ☐	
Does this Location Offer Laboratory Services? (if Yes please attach a copy of current CLIA Certificate		**Yes** ☐	**No** ☐	
Does this Location Offer Radiology Services? (if Yes please attach a copy of current Radiology Certificate)		**Yes** ☐	**No** ☐	
Does this Location Offer Behavioral Health Services?		**Yes** ☐	**No** ☐	
Is this Practice PCMH Certified? (if yes please attach a copy)		**Yes** ☐	**No** ☐	
NCQA PCMH Certification Level:	**Level 1** ☐	**Level 2** ☐	**Level 3** ☐	**Effective Date:** / **End Date:**

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Minute Clinic Services Only:		**Yes** ☐	**No** ☐
Nursing Home Services Only		**Yes** ☐	**No** ☐
Skilled Nursing Services Only:		**Yes** ☐	**No** ☐
Telemedicine Services Only:		**Yes** ☐	**No** ☐
Urgent Care Location Only:		**Yes** ☐	**No** ☐
Veteran Affairs Location Only:		**Yes** ☐	**No** ☐
PRACTICE LOCATION ACCESSIBILITY			
Does Location meet ADA Accessibility Requirements?		**Yes** ☐	**No** ☐
Does Location Offer American Sign Language Services?		**Yes** ☐	**No** ☐
Does Location have Handicap Accessible Exam Table/Scale/Chair?		**Yes** ☐	**No** ☐
Is the Location Exterior Building Handicap Accessible?		**Yes** ☐	**No** ☐
Does Location have Handicap Accessible Gurneys/Stretchers?		**Yes** ☐	**No** ☐
Is the Location Interior Building Handicap Accessible?		**Yes** ☐	**No** ☐
Does Location Offer Mental/Physical Impairment Services?		**Yes** ☐	**No** ☐
Does Location Offer Other Services for the Disabled?		**Yes** ☐	**No** ☐
Does Location have Handicap Accessible Parking?		**Yes** ☐	**No** ☐
Does Location have Handicap Accessible Portable Lifts?		**Yes** ☐	**No** ☐
Does Location have Handicap Accessible Radiologic Equipment?		**Yes** ☐	**No** ☐
Does Location have Handicap Accessible Restroom?		**Yes** ☐	**No** ☐
Does Location have Handicap Accessible Signage & Documents?		**Yes** ☐	**No** ☐
Does Location Meet State and Local Fire, Safety and Sanitation Requirements?		**Yes** ☐	**No** ☐
Does Location have TDD Phone?	**Number:**	**Yes** ☐	**No** ☐
Does Location have TTY Phone?	**Number:**	**Yes** ☐	**No** ☐
Does Location have Wheelchair Accessible Exam Rooms?		**Yes** ☐	**No** ☐
Does Location offer Language Line Services?		**Yes** ☐	**No** ☐

Does Location have Documents Available in Other Languages?	**Yes** ☐	**No** ☐
Does Location Offer Document Translation Services?	**Yes** ☐	**No** ☐
Does Location Offer Care Management Services?	**Yes** ☐	**No** ☐
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Is this Location Accessible to Public Transportation?	**Yes** ☐	**No** ☐
Is this Location Accessible by Rail/Train?	**Yes** ☐	**No** ☐
Is this Location Accessible by Taxi?	**Yes** ☐	**No** ☐
Is this Location Accessible by Bus?	**Yes** ☐	**No** ☐

GROUP PROVIDER INFORMATION (Please List All Group Providers, each provider will need to complete the Provider Enrollment and Credentialing Form)

Last Name:	First:	Middle:	Suffix:
Degree:	NPI:	CAQH:	
Effective Date with Group	End Date with Group:	Specialty:	
Last Name:	First:	Middle:	Suffix:
Degree:	NPI:	CAQH:	
Effective Date with Group:	End Date with Group:	Specialty:	
Last Name:	First:	Middle:	Suffix:
Degree:	NPI:	CAQH:	
Effective Date with Group:	End Date with Group:	Specialty:	
Last Name:	First:	Middle:	Suffix:
Degree:	NPI:	CAQH:	
Effective Date with Group:	End Date with Group:	Specialty:	
Last Name:	First:	Middle:	Suffix:
Degree:	NPI:	CAQH:	
Effective Date with Group:	End Date with Group:	Specialty:	
Last Name:	First:	Middle:	Suffix:
Degree:	NPI:	CAQH:	
Effective Date with Group:	End Date with Group:	Specialty:	
Last Name:	First:	Middle:	Suffix:
Degree:	NPI:	CAQH:	
Effective Date with Group:	End Date with Group:	Specialty:	