



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 INFORM	1ATIO	N		
Group Name:						
	1					
Group NPI:	Taxonom	ny (Primary):			Taxonomy (Add	litional):
		LIVEICIANI ODCAL	117 A T	IONI		
		HYSICIAN ORGAI				
Medical Network	One (MNO)		IV	lichCar	e Organized Sys	tem of Care
		ON (Please attacl	h a co			
Tax ID Name (As it appears on W-9 or	SS4):			Tax ID	Number:	
DBA (If applicable):						
() ()						
Remittance Address:						
City:	State:		Zip:			
Phone:		Fax:				
Phone.		rax.				
Billing Contact Name:		Email:				
	PRIMARY P	PRACTICE LOCATI	ON IN	IFORI\	NATION	
Primary Practice Location Name:						
Address:						
City:	State:		Zip:			
City.	State.		Zip.			
Office Phone:			Office	Fax:		
Office/Practice Website:			Office	Email:		
	T	-				
Office Manager Name:	Office Mana	ger Phone:	Office	e Manag	er Email:	
Credentialing Contact Name:	Credentialin	g Contact Phone:	Crede	ntialing	Contact Email:	
G. G	0.000	8	0.500		,	
List Location in the Directory:	l		Yes			No
Appointment Phone (If Different than Office Phone):		:	After	Hours P	Phone (If Different	t Than Office Number):
Does this Practice Utilize Electronic Medical Records?			Yes			No
EMR Name and Version:					L-	

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				
		oratory Services?	(if Yes please		Yes		No			
	of current CLIA ation Offer Radi	Certificate iology Services? (if Yes please at	tach	1.03					
a copy of curr	ent Radiology C	Certificate)			Yes	Yes		No		
		avioral Health Ser			Yes			No		
Is this Practice	e PCMH Certifie	ed? (if yes please	attach a copy)		Yes			No		
NCQA PCMH (Level:	Certification	Level 1	Level 2	Leve	13	Effecti	ve Date:	En	End Date:	
Levei.			LOCATION O	FFICE	HOURS					
Monday	Tuesday	Wednesday	Thursday		Frida		Saturd	ay Sunday		
AM	AM	AM	AM	1		AM		AM	AM	
PM	PM	PM	PM	1		PM		PM	PM	
		MAILING A	DDRESS (If diff	ferent	than Pri	mary Lo	ocation)			
Address:										
City:		State:			Zip:					
	LOCATIO	N LANGUAGES	(List Langua	ges t	hat are	Spok	en by Offi	ice Sta	aff)	
			(=:00 =::::80:::				J , J		,	
		PRA	CTICE LOCATION	ON RI	ESTRICT	IONS				
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	e Services Only				Yes		No			
Skilled Nursin	g Services Only	:			Yes		No			
Telemedicine	Services Only:				Yes		No			
Urgent Care L	ocation Only:				Yes		No			
Veteran Affairs Location Only:			Yes			No				
		PRA	CTICE LOCATION	ON A	CCESSIB	ILITY				
Does Location meet ADA Accessibility Requirements?			Yes		No					
Does Location Offer American Sign Language Services?			Yes		No					
Does Location Table/Scale/C		o Accessible Exam			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 I	Handicap Accessible?	Yes	No		
Does Location Offer Mental/Phy	sical Impairment Services?	Yes	No		
Does Location Offer Other Service	es for the Disabled?	Yes	No		
Does Location have Handicap Ac	cessible Parking?	Yes	No		
Does Location have Handicap Ac	cessible Portable Lifts?	Yes	No		
Does Location have Handicap Ac	cessible Radiologic Equipment?	Yes	No		
Does Location have Handicap Ac	cessible Restroom?	Yes	No		
Does Location have Handicap Ac	cessible Signage & Documents?	Yes	No		
Does Location Meet State and Lo Requirements?	ocal Fire, Safety and Sanitation	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 Onsi	te Interpreters?	Yes	No		
Has Staff at Location Completed	Cultural Competence Training?	Yes	No		
Is this Location Accessible to Pub	lic Transportation?	Yes	No		
Is this Location Accessible by Rai	I/Train?	Yes	No		
Is this Location Accessible by Tax	di?	Yes	No		
Is this Location Accessible by Bus?		Yes	No		
	APPLICATION CH	ECK LIST			
Current Copy of Liability/Malpractice Coverage					
W-9					
Copy of Current CLIA Certificate	if Applicable				
Copy of Current Radiology Certif					
Copy of Current PCMH Certificat	e 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 LO	CA	LION IN	IFORIV	IATION		
Additional Prac	tice Location Na	ime:							
Address:									
City:		State:			Zip:				
Office Phone:					Office F	ax:			
Office/Practice	Website:				Office Email:				
Office Manage	r Name:	Office Mana	ger Phone:		Office Manager Email:				
Credentialing C	Contact Name:	Credentialin	g Contact Phone:		Creden	tialing Co	ontact Email:		
List Location in	the Directory:				Yes			No	
Appointment P	hone (If Differer	nt than Office Phone)	:		After H	ours Pho	ne (If Differe	nt Than	Office Number):
Does this Pra	ctice Utilize Ele	ectronic Medical Re	cords?		Yes			No	
EMR Name a	nd Version:				•				
Does this Loc	ation offer Tel	emedicine Services	?		Yes			No	
Does this Loc	ation Have E P	rescribing Capabilit	ies?		Yes		No		
Does this Loc	ation Have 24	Hour Phone Covera	ige?		Yes		No		
Does this Loc	ation Offer Ext	ended Office Hours	s?		Yes N			No	
attach a copy	of current CLI				Yes			No	
	ation Offer Rad ent Radiology	diology Services? (i Certificate)	if Yes please att	ach	Yes			No	
		navioral Health Ser	vices?		Yes			No	
Is this Practic	e PCMH Certifi	ed? (if yes please	attach a copy)		Yes		No		
NCQA PCMH Level:	Certification	Level 1	Level 2	Leve	13	Effecti	ve Date:	En	d Date:
			LOCATION OF	FICE					
Monday AM	Tuesday AM	Wednesday AM	Thursday AN		Frida	y AM	Saturd	ay AM	Sunday AM
PM	PM	PM	PIV			PM		PM	PM
		MAILING AD	DRESS (If diff	erent	: than Pri	imary Lo	ocation)		
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 A	CCESSIBILITY	
Does Location meet ADA Accessi	bility Requirements?	Yes	No
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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

	the Provider Enrollment and Crede		eea to
Last Name:	First:	Middle:	Suffix:
Degree:	NPI:	CAQH:	
Effective Date with Group	End Date with Group:	Specialty:	
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:	
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Degree:	NPI:	CAQH:	J
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Ellective Bate with Gloup.	End Date With Group.	Specialty.	
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Degree:	NPI:	CAQH:	
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Effective Date with Group:	End Date with Group:	Specialty:	
Last Name:	First:	Middle:	Suffix:
Degree:	NPI:	CAQH:	
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