HCS HEALTHCARE CREDENTIALING SERVICES LLC

MedNetOne HEALTH SOLUTIONS

GROUP PRACTICE ENROLLMENT FORM

Please complete all sections of the HCS 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 OSC**

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: