RESET

Practitioner Application for Arkansas

For MultiPlan Use Only

Thank you for your interest in participating with MultiPlan, Inc. This application will serve to qualify you for participation in one or more of our networks (PHCS, MultiPlan, Beech Street) as indicated in your MultiPlan contract. Items marked with an asterisk (*) will be kept confidential to the extent permitted by law. PLEASE COMPLETE EVERY SECTION OF THIS FORM, PRINT YOUR RESPONSES AND SUBMIT ALL REQUESTED INFORMATION. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED. If you need assistance completing this form, contact Service Operations at https://provider.multiplan.com or 800-950-7040.

CONTRACT

Please indicate how you are applying to join our networks:
☐ Individual practitioner
☐ Individual practitioner as part of a group practice that has an existing contract with MultiPlan

Group Name: ______ CAQH ID: ______
Number of practitioners: ______ Beech Street Group Contract ID (if known): ______
MultiPlan Contract ID (if known): ______

INDICATIVE

LAST NAME | FIRST NAME | M.I. | TITLE *(e.g., Jr., Sr., III)*

PREVIOUS LEGAL NAME (IF APPLICABLE) ______

NPI (Required in WA)

*SOCIAL SECURITY NUMBER | *BIRTH DATE (mmddyyyy) | GENDER ☐ M ☐ F

E-MAIL ______

DEGREE

Professional Degree (check only one) NOTE: You must be independently licensed at the highest level for your discipline in your state.

☐ M.D. ☐ D.D.S. ☐ O.D. ☐ Th.D. ☐ M.S.W. ☐ M.S.N. ☐ B.S.N. ☐ B.S. ☐ Other (list below)
☐ D.O. ☐ D.P.M. ☐ D.Min. ☐ Ph.D. ☐ Ed.D. ☐ M.S. ☐ M.A. ☐ B.A.
☐ D.M.D. ☐ D.C. ☐ M.Min. ☐ Psy.D. ☐ M.Ed. ☐ M.S.P.T. ☐ M.C.

AFFILIATIONS

List all hospitals where you currently have admitting privileges. List your primary admitting facility first. Please attach an additional sheet if more than three.

Name of Hospital	Street Address, Suite	City, State, Zip Code
Name of Hospital	Street Address, Suite	City, State, Zip Code
Name of Hospital	Street Address, Suite	City, State, Zip Code

If you do not have admitting privileges, please indicate how you admit patients:

☐ Hospitalist ☐ Practitioner admits on my behalf (Name of hospitalist or practitioner: ______) ☐ Other, please explain: ______
Do you practice exclusively within the inpatient setting? ☐ Yes ☐ No

REGISTRATION

Current Federal DEA Certification*

Do you administer or prescribe controlled substances (Schedule II, III, V medications)?
☐ Yes: DEA Certificate # ______ Expiration Date (mmddyyyy) ______
☐ No: I do not administer or prescribe controlled substances; I do not have a DEA number.

ADDRESSES I

Address Information Please provide practice, billing and mailing information for each office in which you see patients under this contract. Attach additional sheets as necessary.

Address Information I (Please provide your payment address first. Note: If this is also a practice address, it cannot be a P.O. Box

☐ Payment Address ☐ Practice Address ☐ Mailing Address

Street | Suite

City | State | Zip

Phone Numbers

Appointments ______ Ext. ______ | Billing ______ Ext. ______ | Fax ______

Is This Office

Your primary practice location? ☐ Yes ☐ No
An address you wish to appear in the directory? ☐ Yes ☐ No
Open to new patients? ☐ Yes ☐ No
Accessible to handicapped patients? ☐ Yes ☐ No
Does this location provide Laboratory Services? ☐ Yes ☐ No If yes, provide accrediting/certifying program (e.g., CLIA, COLA, MLE) ______

Office Hours (Required for certain states)

MONDAY From - To	TUESDAY From - To	WEDNESDAY From - To	THURSDAY From - To	FRIDAY From - To	SATURDAY From - To	SUNDAY From - To

Average Appointment Scheduling Time (Required for certain states)

New patient ______ Hours / Days / Weeks Routine Visit ______ Hours / Days / Weeks Urgent Visit ______ Hours / Days / Weeks

Services

Please list only the specialties/services practiced at this location: ______
Do you offer Telemedicine Services? ☐ Yes ☐ No If Yes, in which states? ______

Contact Name

First Name | M.I. | Last Name | Title

Phone ______ Ext. ______ | Fax ______

Tax ID Information I – Address I All information must match the W-9 Form submitted to the IRS.

Tax Identification Number

Tax ID Name ______
Tax ID Address ______

ADDRESSES II

Address Information II Please provide practice, billing and mailing information for each office in which you see patients under this contract.

☐ Payment Address ☐ Practice Address ☐ Mailing Address

Street | Suite

City | State | Zip

Phone Numbers

Appointments | Ext. | Billing | Ext. | Fax

Is This Office

Your primary practice location? ☐ Yes ☐ No
An address you wish to appear in the directory? ☐ Yes ☐ No
Open to new patients? ☐ Yes ☐ No
Accessible to handicapped patients? ☐ Yes ☐ No
Does this location provide Laboratory Services? ☐ Yes ☐ No If yes, provide accrediting/certifying program (e.g., CLIA, COLA, MLE) ____________

Office Hours (Required for certain states)

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Services

Please list only the specialties/services practiced at this location: ____________
Do you offer Telemedicine Services? ☐ Yes ☐ No If Yes, in which states?____________

Contact Name

First Name | M.I. | Last Name | Title

Phone | Ext. | Fax

Tax ID Information II – Address II All information must match the W-9 Form submitted to the IRS.

Tax Identification Number

Tax ID Name____________

Tax ID Address ____________

PROF HISTORY

Education

Medical School | City, State | Degree Awarded MD ☐ DO ☐

Country | Attended (mmddyyyy) From | To

LANGUAGES

Please indicate language(s) spoken in addition to English ____________

Please indicate if you communicate in Sign Language ☐ Yes ☐ No

ATTESTATION/RELEASE

I hereby submit this application for participation in MultiPlan, Inc.'s networks as indicated in my MultiPlan contract. I understand that this application will be reviewed based on the information I have provided herein.

I hereby certify that the information contained and enclosed with this form is complete and accurate, and that information found to be false could result in denial or subsequent termination of my participation in any or all of the MultiPlan networks. I understand that I have an obligation to alert MultiPlan of any material changes to the items attested to above.

A photocopy of this permission will be as valid as the original.

X____________ ____________ ____________
Signature of Provider | Name (please type or print) | Date (mm.dd.yy)

*Information will be kept confidential to the extent permitted by law.

APPLICATION CHECKLIST

- Completed and signed application.
- Signed CCVS Authorization and Release Form.
- If applying as an individually contracted practitioner, submit completed and signed copy of the MultiPlan Participating Professional Agreement (with all Exhibits stapled to the Agreement).
- If you or your practitioner is not the owner of the TIN, a letter from the TIN owner giving you permission to use the TIN must accompany this application. Please note that TIN Name must match the name of your W-9.
- Copy of current insurance certificate which includes Professional and Comprehensive General Liability.
- Send your completed application and all supporting materials to MultiPlan:
  - Online via the Provider Service Portal: http://provider.multiplan.com
  - Email: registrar@multiplan.com
  - Fax: 781-487-8273
  - Mail: MultiPlan, ATTN: Registrar
16 Crosby Drive, Bedford, MA 01730
- Keep a copy of this application for your records.

MULTIPLAN USE ONLY

PPO Fee Schedule ________________________ Agreement ID ________________________

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CCVS Organization-Specific
AUTHORIZATION AND RELEASE

I hereby authorize the Arkansas State Medical Board to provide my credentialing information gathered by the Board to ____
(a Credentialing Organization) with whom I am affiliating and seeking privileges.

This Authorization shall remain in effect for a period not to exceed two (2) years unless revoked by me in writing.

I understand that if I have provided this organization with permission to utilize my electronic signature for the purpose of obtaining my credentialing information from the Arkansas State Medical Board's CCVS, this is the legal equivalent of my signature on this form and is as valid as if I signed the form with pen and ink and it can be enforced in the same way.

Typed or Printed Name of Physician: ____

Licensure Number: ____

**Signature of Physician: _____________________________ Date Signed: ____________
(Stamped signature is not acceptable, Electronic signatures only acceptable if signed on this form)

**This document does not authorize the Arkansas State Medical Board to release information collected to third parties except as later authorized by the above physician and Arkansas law.*

***In no event shall the practitioner or healthcare organization utilizing the electronic signature hold the employees of the Arkansas State Medical Board and CCVS responsible or liable, either personally or in their official capacity, directly or indirectly, for any damage or loss caused or alleged to be caused by or in connection with the use of or reliance on the practitioner's electronic signature in providing the credentialing information requested to the credentialing organization identified on this document. This statement will serve as an attestation that the practitioner's electronic signature affixed to this Organization Authorization and Release is true and correct and represents the practitioner's true signature.*