CONIFER
HEALTH SOLUTIONS®

Requested by: ____________________
Date: __________

Alliance Health Systems IPA: Intent to Contract Provider Form

Please complete the following information and return a signed copy to your Provider Relations Representative along with your current Curriculum Vitae and W-9. Your application will be reviewed by the IPA's Board of Directors.

Legal Entity Name: ____

Primary Contact Name & Title: ____________________

Primary Contact Phone: ____________________

☐Solo Practice

☐Group Practice

☐PCP ☐Ancillary ☐Specialist

Primary Contact Email: ____________________

Specialty: ____________________

Office Primary Address: *(if more than one location, please list on second page)*

Street: ______________________ City: ____________________ Zip Code: __________

Phone: ______________________ Fax:____________________ Email: ____________________

Practice NPI: ____________________ Practice Tax ID: ____________________

Please list providers in group practice including PA's and NP's: *(if additional providers, please list on second page)*

1. Provider Name: ____________________ Specialty: ______________ Sub-Specialty:________

   NPI: ____________________ License: __________ CAQH: ___________

2. Provider Name: ____________________ Specialty: ______________ Sub-Specialty:________

   NPI: ____________________ License: __________ CAQH: ___________

Please list any limitations, age restrictions or exclusions from your practice:

____

____

Please list current hospital and/or ASC privileges/affiliations:

____

This will serve as notice of my interest in becoming a Network Provider. I also understand that this request is not a Contract with the IPA. *(An IPA Agreement and Credentialing Application/CAQH will be forwarded to you for review pending approval from Network Management Team and the Board of Directors.)*

Provider Signature: __________________________ Date: ________________

FOR INTERNAL USE ONLY: ☐ Approved ☐Denied

Rationale for New Provider:

Management Signature: ______________________ Date: ______________

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Additional Address & Provider Form

Second Location Address:

Street: ________________________________ City: __________________________ Zip Code: _______________

Phone: ________________________________ Fax:____________________________ Email: ___________________________

Practice NPI: _____________________________ Practice Tax ID: ______________________________

Third Location Address:

Street: ________________________________ City: __________________________ Zip Code: _______________

Phone: ________________________________ Fax:____________________________ Email: ___________________________

Practice NPI: _____________________________ Practice Tax ID: ______________________________

Fourth Location Address:

Street: ________________________________ City: __________________________ Zip Code: _______________

Phone: ________________________________ Fax:____________________________ Email: ___________________________

Practice NPI: _____________________________ Practice Tax ID: ______________________________

Fifth Location Address:

Street: ________________________________ City: __________________________ Zip Code: _______________

Phone: ________________________________ Fax:____________________________ Email: ___________________________

Practice NPI: _____________________________ Practice Tax ID: ______________________________

Additional Providers:

3. Provider Name: _____________________________ Specialty: ____________________ Sub-Specialty:__________

   NPI: _____________________________ License: _______________ CAQH: ________________

4. Provider Name: _____________________________ Specialty: ____________________ Sub-Specialty:__________

   NPI: _____________________________ License: _______________ CAQH: ________________

5. Provider Name: _____________________________ Specialty: ____________________ Sub-Specialty:__________

   NPI: _____________________________ License: _______________ CAQH: ________________

6. Provider Name: _____________________________ Specialty: ____________________ Sub-Specialty:__________

   NPI: _____________________________ License: _______________ CAQH: ________________

7. Provider Name: _____________________________ Specialty: ____________________ Sub-Specialty:__________

   NPI: _____________________________ License: _______________ CAQH: ________________

8. Provider Name: _____________________________ Specialty: ____________________ Sub-Specialty:__________

   NPI: _____________________________ License: _______________ CAQH: ________________