CONTRACT REQUEST/ PROVIDER ENROLLMENT FORM

This form is designed as a fillable form for providers wishing to participate in the Health One Alliance/Alliant Health Plans network. Upon completing the Contract Request Form, email this form to providerrelations@alliantplans.com, fax to (706) 529-4275 or mail to Health One Alliance, Attn: Provider Relations, PO Box 1128, Dalton, GA 30722.

Section I: Provider Information

Practitioner Name: _____ Degree: _____

CAQH #: _____ NPI: _____

Specialty: _____

Section II: Contact Information

Section II-A: Contracting Contact

Name: _____

Phone: _____ Fax: _____

Email: _____

Address: _____

If executed, should the contract be returned to the above address? ☐ Yes ☐ No

Section II-B: Credentialing Contact

Name: _____

Phone: _____ Fax: _____

Email: _____

Address: _____

If credentialed, should the decision letter be returned to the above address? ☐ Yes ☐ No

Section II-C: Medical Record Requests (specific to HEDIS, Risk Adjustment, RAD-V, etc.)

Name: _____

Phone: _____ Fax: _____

Email: _____

Address: _____

Preferred Method: ☐ Mail ☐ Phone ☐ Fax ☐ Email

Section III: Office Call Coverage & Hospital Admitting Privileges

Section III-A: Office Call Coverage – identify a practitioner, provider group or vendor who provides call coverage on a 24 hour/7 day a week basis.

Practitioner/Group/Vendor Name: _____

Phone: _____

Address: _____

If you do not currently have someone who serves as call coverage, please attest to the following:

I, _____, do not currently have call coverage, but I attest that I am able to provide the appropriate level of care to my patients based on the healthcare services I provide. ☐ Yes ☐ No

If no, please explain. _____

Section III-B: Hospital Admitting Privileges

Do you have hospital admitting privileges? ☐ Yes ☐ No

If yes:

Hospital Name: _____

Address: _____

If no, please attest to the following:

I, _____, am able to deliver satisfactory professional services without hospital admitting privileges. ☐ Yes ☐ No

If no, explain. _____

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Section IV: Peer References (Requirement: 3)

Name: _____
Phone: _____ Fax: _____
Email: _____
Address: _____

Name: _____
Phone: _____ Fax: _____
Email: _____
Address: _____

Name: _____
Phone: _____ Fax: _____
Email: _____
Address: _____

Section V: Addresses

Group Name and DBA: _____ Offers Telehealth: ☐
TIN: _____ Group NPI: _____
Phone: _____ Fax: _____
Service Address: _____
Pay To Name: _____
Pay To Address: _____
Pay To Phone: _____ Pay To Fax: _____
Vendor Address: _____

Group Name and DBA: _____ Offers Telehealth: ☐
TIN: _____ Group NPI: _____
Phone: _____ Fax: _____
Service Address: _____
Pay To Name: _____
Pay To Address: _____
Pay To Phone: _____ Pay To Fax: _____
Vendor Address: _____

Please attach a full listing of locations with all data elements if provided space is insufficient.

Please attach the following documentation:

- Medical Malpractice Certificate of Insurance
- W-9(s)