Hometown Health Senior Care Plus

PROVIDER ADDITION FORM

Date _____

Practice Name _____ Tax ID _____

Group NPI _____

CREDENTIALING CONTACT/ADDRESS

Contact/Title _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

INFORMATION ABOUT PROVIDER BEING ADDED TO PRACTICE

Provider Name _____ Title _____

Specialty 1 _____ Specialty 2 _____

Start Date with Group _____ DOB _____ NPI# _____

CAQH# _____

Check One ☐ Telehealth Only ☐ Telehealth & In Office ☐ No Telehealth

Interpreter Available ☐ ***YES*** ☐ ***NO***

MEDICAL SETTINGS

Please mark all applicable boxes below indicating the setting(s) where services are provided

☐ Hospital *Please list Hospital affiliations* _____

☐ Ambulatory Surgery Center *Please list ASC affiliations* _____

☐ Office

PRACTICE ADDRESSES

PRIMARY PRACTICE LOCATION ADDRESS

ACCESSIBILITY FOR PEOPLE WITH PHYSICAL DISABILITIES ☐ ***YES*** ☐ ***NO***

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

☐ **Check Box if Primary Practice Location Address is the Same as the Practice Mailing/Notification Address**

PRACTICE MAILING/NOTIFICATION ADDRESS

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

IF YOU HAVE ADDITIONAL ADDRESSES TO ADD, PLEASE ATTACHED A ROSTER WITH THIS FORM.

Upon completion please email to **ProviderUpdates@HometownHealth.com** with a SUBJECT LINE INCLUDING THE GROUP NAME AND TIN