

# Premier Health Networks of Alabama



## PROVIDER APPLICATION

### Preferred Provider Network

PLEASE TYPE OR PRINT USING BALL POINT PEN

NOTE: THIS INFORMATION WILL ALSO BE USED TO DEVELOP THE PROVIDER DIRECTORY

PHYSICIAN NAME LAST FIRST MIDDLE				DEGREE <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> OTHER:		STATE LICENSE NUMBER (PROVIDE COPY)	
<input type="checkbox"/> PROFESSIONAL CORPORATION <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> IPA <input type="checkbox"/> SOLO PRACTICE <input type="checkbox"/> OTHER:						DEA NUMBER (PROVIDE COPY)	
MEDICAL GROUP NAME OR IPA AFFILIATION NAME			DATE OF BIRTH		PRACTICE HOURS OF OPERATION		DO YOU HAVE A CURRENT DEA NARCOTICS LICENSE? <input type="checkbox"/> YES <input type="checkbox"/> NO
TAX IDENTIFICATION NUMBER		WILL YOU BILL UNDER THIS NUMBER? <input type="checkbox"/> YES <input type="checkbox"/> NO		SPECIALTY (PRIMARY)		BOARD CERTIFIED (PROVIDE COPY) <input type="checkbox"/> YES <input type="checkbox"/> NO	YEAR
SOCIAL SECURITY NUMBER		WILL YOU BILL UNDER THIS NUMBER? <input type="checkbox"/> YES <input type="checkbox"/> NO		SPECIALTY (SECONDARY)		BOARD CERTIFIED (PROVIDE COPY) <input type="checkbox"/> YES <input type="checkbox"/> NO	YEAR
DOES THE PROVIDER SPEAK MORE THAN ONE LANGUAGE? IF YES, LIST LANGUAGES <input type="checkbox"/> YES <input type="checkbox"/> NO				IF YOU ARE NOT BOARD CERTIFIED, ARE YOU ELIGIBLE TO TAKE A BOARD EXAMINATION? <input type="checkbox"/> YES <input type="checkbox"/> NO			
BILLING ADDRESS	STREET			BOARD FOR WHICH YOU ARE ELIGIBLE		DATE ADMISSIBILITY EXPIRES	
	CITY		STATE	ZIP CODE			
	TELEPHONE NUMBER ( )		FAX NUMBER ( )		<b>PLEASE COMPLETE BELOW INFORMATION AND ATTACH CV</b>		
PRIMARY OFFICE ADDRESS	OFFICE MANAGER			MEDICAL EDUCATION (SCHOOL)		CITY, STATE	YEAR
	STREET		STATE	ZIP CODE		TYPE OF INTERNSHIP	DATES
	CITY		STATE	ZIP CODE		NAME OF INSTITUTION	CITY, STATE
	TELEPHONE NUMBER ( )		FAX NUMBER ( )		TYPE OF RESIDENCY		DATES
SECOND OFFICE ADDRESS	OFFICE MANAGER			NAME OF INSTITUTION		CITY, STATE	
	STREET		STATE	ZIP CODE		TYPE OF FELLOWSHIP	DATES
	CITY		STATE	ZIP CODE		NAME OF INSTITUTION	CITY, STATE
	TELEPHONE NUMBER ( )		FAX NUMBER ( )		<b>LIST ALL HOSPITALS AT WHICH YOU CURRENTLY HAVE ADMITTING PRIVILEGES</b>		
THIRD OFFICE ADDRESS	OFFICE MANAGER						
	STREET		STATE	ZIP CODE			
	CITY		STATE	ZIP CODE			
	TELEPHONE NUMBER ( )		FAX NUMBER ( )		IF YOU ARE NOT BOARD CERTIFIED IN YOUR PRIMARY OR SECONDARY SPECIALTY (LISTED ABOVE) AND NOT ELIGIBLE TO TAKE EITHER EXAMINATION, PLEASE ATTACH AN EXPLANATION OF ANY RELEVANT TRAINING AND EXPERIENCE.		
NAME OF PROFESSIONAL LIABILITY INSURANCE CARRIER (PROVIDE A COPY OF COVERAGE)				AMOUNT OF PROFESSIONAL LIABILITY INSURANCE (PER OCCURRENCE/AGGREGATE) \$		POLICY RENEWAL DATE	
DO YOU HAVE FULL TIME COVERAGE FOR YOUR PATIENTS <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, PHYSICIAN				
ADDRESS			CITY		STATE	ZIP CODE	
TELEPHONE NUMBER			TIN/SSN		SPECIALTY		
PROVIDER ACCEPTS MEDICARE ASSIGNMENT <input type="checkbox"/> YES <input type="checkbox"/> NO		AGE RANGE OF PATIENTS		ARE YOU ACCEPTING NEW PATIENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO		WILL THE PHYSICIAN GIVE SECOND SURGICAL OPINIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**PLEASE DO NOT SEPARATE**  
WHITE-COMP1ONE / PINK-PROVIDER COPY