COMMUNITY Health Options®

Provider Network Form

Email Completed Form to:
dataintegrity@healthoptions.org

Notes:
"Provider" identified sections are for updates related to the rendering practitioner. For updates related to the Practice/Group please use the sections identified as "Practice." Complete all applicable sections related to your update. If a section does not apply, please indicate with N/A.

Before submitting this form, ensure the CAQH "credentialing application" is current, complete, and includes all required supporting documentation. Community Health Options contracts with Verisys as our credentialing verification organization (CVO). If additional information is needed during the credentialing verification process, Verisys will reach out to the contact listed in CAQH.

Form Completion Information	
Form Completed By:	Form Completion Date:
Email:	Phone:

Provider Information				
Add Provider: ☐ Yes ☐ No Effective Date:	Change Provider: ☐ Yes ☐ No Effective Date: Reason:		Term: ☐ Yes ☐ No Effective Date:	
First Name:	MI:	Last Name:		Gender:
Date of Birth:	SSN:	Email:		License:
Primary Specialty:		Board Certified:		
Provider NPI:		CAQH Number:		
Locum Tenens: ☐ Yes ☐ No If yes, dates of coverage: Start: End: *Per NCQA: If <60 days, provider will be provisionally credentialed. If >60 days, will require full credentialing.				

Practice Information Location #1		
Add Practice: ☐ Yes ☐ No Effective Date:	Change Practice: ☐ Yes ☐ No Effective Date: Reason:	Term: ☐ Yes ☐ No Effective Date:
Contracted Entity Name:	Practice Name:	
Practice Email Contact:		
Address Line 1:	Address Line 2:	
City:	State:	Zip Code:
Phone:	Fax:	
Practice NPI:	Practice Tax ID:	
Practice As: ☐ PCP ☐ Specialist ☐ Hospitalist	Accepting New Patients: ☐ Yes ☐ No	
Languages Spoken by Office Staff:		
Are services provided via telehealth only? ☐ Yes ☐ No If no, do you offer telehealth? ☐ Yes ☐ No *Must be licensed in the state the Member is located in		

☐ Check if the address for Billing is the same as Practice Location #1
☐ Check if the Utilization Management (member auth contact) address is the same as Practice Location #

Billing Information		
Add Billing: ☐ Yes ☐ No Effective Date:	Change Billing: ☐ Yes ☐ No Effective Date: Reason:	
Name:	Email:	
Address Line 1:	Address Line 2:	
City:	State:	Zip Code:

Utilization Management (For Communication on Member Authorization)		
Add UM: ☐ Yes ☐ No Effective Date:	Change UM: ☐ Yes ☐ No Effective Date: Reason:	
Name:	Email:	
Address Line 1:	Address Line 2:	
City:	State:	Zip Code:
Authorization Phone:	Authorization Fax:	

Practice Information Location #2		
Add Practice: ☐ Yes ☐ No Effective Date:	Change Practice: ☐ Yes ☐ No Effective Date: Reason:	Term: ☐ Yes ☐ No Effective Date:
Contracted Entity Name:	Practice Name:	
Practice Email Contact:		
Address Line 1:	Address Line 2:	
City:	State:	Zip Code:
Phone:	Fax:	
Practice NPI:	Practice Tax ID:	
Practice As: ☐ PCP ☐ Specialist ☐ Hospitalist	Accepting New Patients: ☐ Yes ☐ No	
Languages Spoken by Office Staff:		
Are services provided via telehealth only? ☐ Yes ☐ No If no, do you offer telehealth? ☐ Yes ☐ No *Must be licensed in the state the Member is located in		

Note: If you need to add more than 2 locations, use the Roster Template located on our website https://healthoptions.org/providers/resources/

Please leave any additional comments or information below that may be relevant: