Provider Interest Form

THIS IS NOT AN APPLICATION

Instructions:

Please provide the following information and attach a current Curriculum Vitae for each provider requesting consideration.

Personal Information

Last Name: _____ **First Name:** _____ **Middle Initial:**_____

Title: ☐ **MD** ☐ **DO** ☐ **DPM** ☐ **Other:** _____ **License #:**_____ **Date of Birth:**_____

Number of Years in Practice: _____ **DEA #:**_____ **NPI #:**_____

Are you a participating Medicare provider? ☐ **Yes** ☐ **No / Medicare #:**_____

Do you participate in Medi-Cal? ☐ **Yes** ☐ **No / Medi-Cal #:**_____

Do you participate in CAQH? ☐ **Yes** ☐ **No** **(If Yes) CAQH#:**_____

(Altais recognizes American Board of Medical Specialties)

Primary Specialty: _____ **Board Certified:** ☐ **Yes** ☐ **No**
☐ **PCP** ☐ **Specialist** **Board Eligible:** ☐ **Yes** ☐ **No**

Secondary Specialty: _____ **Board Certified:** ☐ **Yes** ☐ **No**
☐ **PCP** ☐ **Specialist** **Board Eligible:** ☐ **Yes** ☐ **No**
Area of Interest: _____

If not currently Board Certified, were you in the past? ☐ **Yes** ☐ **No**
If yes, when (Month/Year of expiration)? ___ / ___ **In what Specialty?**_____

Practice Information

Group Practice Name:_____

Name Associated with Tax ID: _____ **Tax ID:**_____

Number of Physicians in Practice: _____

Physician Total Weekly Hours: **In the Office:** _____ **(Hours)** **Hospital Work:** _____ **(Hours)**

Primary Practice Location:

Address:_____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Office Hours: _____

Covering Physicians: _____

Credentialing Contact Email:_____ **Credentialing Contact Phone:** _____

Contract Signor Name: _____ **Contract Signor Email:** _____

Secondary Practice Location:

Address:_____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Office Hours: _____

Covering Physicians: _____

Revenue Cycle Management

Contracted IPA(s): _____

Practice Management System: _____

Billing Software: _____

Billing Company: _____

Clearing House: _____

Monthly Revenues/Billings (Check One):

☐ **0-$10,000** ☐ **$10,000-$20,000** ☐ **$21,000-$30,000** ☐ **$31,000+**

Return Instructions

If approved for an application, send to: _____

_____

_____

Provider Signature:_____ **Date:** _____

Please submit this form on altais.com. Select Northern or Southern California and then complete the form accordingly, being sure to upload this Provider Interest Form and your Curriculum Vitae.

If you have any questions or concerns, please email the Credentialing Department.