McLaren Physician Partners

PROVIDER INFORMATION SHEET

GENERAL INFORMATION

Please Submit Current W-9

CAQH # _____
BOARD CERTIFIED ~ YES OR NO _____
Board Certified Specialty: _____
PROVIDER'S SOCIAL SECURITY NUMBER ~ _____

Last Name	First Name	MI	Degree
Practice/Group Name	Employer Name *(if applicable)*		
Federal Tax ID Number	License Number / NPI#		DEA Number
Do you bill under the group? (please circle one) YES or NO	Group NPI # *(if applicable)*		Date of Birth
Individual Medicare #	Individual Medicaid #		Gender Male / Female

In the following section, please list addresses as you want them to appear in the Provider Directory. These would include addresses where you typically see patients.

Primary Office Address

Street		Suite No., P.O. Box No.	
City	State	Zip	County
Telephone ( )		Fax ( )	
Federal Tax ID Number (if different than above)			

Secondary Office Address

Street		Suite No., P.O. Box No.	
City	State	Zip	County
Telephone ( )		Fax ( )	
Federal Tax ID Number (if different than above)			

Use additional sheet(s) of paper for other locations.

Billing Remittance Address (if different than primary address)

Billing Company Name (if applicable):			
Street		Suite No., P.O. Box No.	
City	State	Zip	County
Telephone ( )		Fax ( )	

CONTINUED ON NEXT PAGE

MEDICAL SPECIALTY ~ ❑ Primary Care Physician OR ❑ Specialist *(please check one)*

Hospitalist ~ YES or NO *(please circle one)*

Please place an "x" in the appropriate box to designate under which service you wish to be listed in the *MPP Membership Directory*.
More than one box can be checked.

❑Adolescent Medicine	❑Hand Surgery	❑Oncology/Gynecology	❑Psychiatry
❑ Allergy/Asthma	❑Hematology	❑Oncology/Hematology	❑Psychology
❑Allergy/Immunology	❑Infectious Disease	❑Ophthalmology	❑Pulmonary Disease
❑Anesthesiology	❑Internal Medicine	❑Ophthalmology/Neurology	❑Radiation Oncology
❑Cardiology	❑Internal Medicine/Pediatrics	❑Ophthalmology/Pediatrics	❑Radiology
❑Cardiovascular Disease	❑Maxillofacial Surgery	❑Optometry	❑ Rheumatology
❑Cardiovascular Surgery	❑Medical Genetics	❑Orthopedic	❑Sports Medicine
❑Cardiovascular/Thoracic Surgery	❑Medical Oncology	❑Orthopedic Surgery	❑ Technical Surgical Assist
❑Chiropractic	❑Neonatology	❑Otolaryngology	❑ Thoracic Surgery
❑Colon & Rectal Surgery	❑Nephrology	❑Outpatient Mental Health	❑Urgent Care
❑Critical Care Medicine	❑Neurological Surgery	❑Pain Management	❑Urology
❑Dental	❑Neurology	❑Pathology	❑ Vascular Surgery
❑Dermatology	❑Neurology/Pediatric	❑Pediatrics	❑ Optometry
❑Emergency Medicine	❑Neurology/Psychology	❑Pediatrics/Cardiology	❑ **OTHER** _____
❑Endocrinology	❑Neurology/Sleep Disorders	❑Pediatrics/Psychology	❑ **OTHER** _____
❑Family Practice	❑Neurology/Surgery	❑Pediatrics/Pulmonary	❑ **OTHER** _____
❑Gastroenterology	❑Nuclear Medicine	❑Physiatry	❑ **OTHER** _____
❑General Practice	❑Nuclear Radiology	❑Physical Medicine & Rehabilitation	❑ **OTHER** _____
❑General Surgery	❑Obstetrics/Gynecology – OB/GYN	❑Plastic Surgery	❑ **OTHER** _____
❑Geriatric Medicine	❑Occupational Medicine	❑Plastic Surgery/Facial	❑ **OTHER** _____
❑ Gynecology	❑Oncology	❑Podiatry	❑ **OTHER** _____

Are you accepting new patients: Yes _____ No_____

HOSPITAL AFFILIATION(s)

Please list hospital(s) where you have admitting privileges. (List those you routinely admit to first.) Attach a separate sheet, if necessary.

Primary Hospital Affiliation

Hospital Name: _____ ❑ Active ❑ Other _____

Hospital Name: _____ ❑ Active ❑ Other _____

Hospital Name: _____ ❑ Active ❑ Other _____

OFFICE CONTACT PERSON

The person identified below may be contacted for additional information regarding the above information or other information as needed.

Name _____ Title _____

Telephone (___)_____ Fax (___)_____

E-mail Address _____

Provider/Office Additional Information

Physician Email: _____ Disease Registry: Yes_____ No _____

Physician Cell Phone: _____ Disease Registry Product Name: _____

EMR / EHR: Yes _____ NO_____

EMR/HER Product Name: _____ E-Prescribe: Yes _____ No _____

Patient Portal: Yes _____ No _____ E-Prescribe Product Name: _____

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PROVIDER CERTIFICATION

I certify that the information contained herein is true and correct to the best of knowledge. I understand that misrepresentation may result in non-selection or, if discovered after selection, in termination as an MPP member. I understand that this application does not entitle participation in the MPP network. I authorize MPP to consult with and inspect all documents from individuals and organizations having information bearing on qualifications and authorize the copy of my signature on the application to be as binding as the original. I agree that MPP, its representatives, and any individuals or entities providing information to MPP in good faith shall not be liable for any act of occasion related to the evaluation or verification contained in this application. I further agree to notify MPP in a timely manner of any change to the information requested in this application. MPP will treat all information requested in this application that is not publicly available, as confidential.

_____

Print Name

_____ _____

Signature **Date**

(Original Physician Signature Required)

RETURN APPLICATION TO:

MPP
2701 Cambridge Court, Suite 200
Auburn Hills, MI 48326

EMAIL = MPP@mclaren.org
FAX: (248) 484-4999

FOR QUESTIONS CALL:

(248) 484-4933 – Nicolemarie Motyka
(248) 484-4913 – Marilyn Hester