McLaren HEALTH PLAN

PROVIDER INFORMATION FORM

McLaren HEALTH ADVANTAGE

Please complete this form to ensure accurate provider directory and payment information.
If needed, copy this form for additional sites.

Group Name (or Name of Practice): _____ **Fed Tax ID #:** _____

Hospital Affiliation(s): _____

Contact Name: _____

Email Address: _____ **How many physicians within practice?**_____

Service Location(s)

PRIMARY ADDRESS (NO PO BOX)	SUITE	CITY	STATE	ZIP- 9 DIGIT	PHONE	FAX	Hours
SECONDARY ADDRESS (NO PO BOX)	SUITE	CITY	STATE	ZIP- 9 DIGIT	PHONE	FAX	Hours

Please list additional service locations submitted on a separate sheet.

Billing Location

PRIMARY ADDRESS (NO PO BOX)	SUITE	CITY	STATE	ZIP- 9 DIGIT	PHONE	FAX	Hours

Is payment location the same as billing? ☐ **Yes** ☐ **No** **If No, please list payment address:**

PRIMARY ADDRESS (NO PO BOX)	SUITE	CITY	STATE	ZIP- 9 DIGIT

E-Prescribing: ☐ **Yes** ☐ **No** **Patient Portal:** ☐ **Yes** ☐ **No** **Certified Patient Centered Medical Home (PCMH):** ☐ **Yes** ☐ **No**

PLEASE RETURN ALL OF THE FOLLOWING DOCUMENTS:

- **THE PROVIDER DISCLOSURE INFORMATION FORM**
- **PROVIDER INFORMATION FORM**
- **COPY OF YOUR W-9**
- **THE SIGNED CONTRACT**

Mail to:
McLaren Health Plan, Provider Contracts
G-3245 Beecher Road
Flint, MI 48532

If you have any question please contact us at: (888) 327-0671

McLaren HEALTH PLAN

PROVIDER INFORMATION FORM

McLaren HEALTH ADVANTAGE

Please complete one form for each provider within the practice. Individual and group NPI is required for all providers.
If the provider does not use a group NPI, please signify with N/A.

Provider Information:

LAST NAME	FIRST NAME
TITLE	TYPE - CHECK ONE
	☐ PRIMARY CARE ☐ SPECIALIST
SPECIALITY	
INDIVIDUAL NPI #	GROUP NPI #
CAQH #	STATE LICENSE #
ALT LANGUAGE(S)	

RACE - CHECK ONE	ETHNICITY - CHECK ONE
☐ American Indian or Alaskan Native ☐ Asian ☐ White ☐ Other _____ ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander	☐ Hispanic or Latino ☐ Not Hispanic or Latino

DOES THE PROVIDER PRACTICE AT EACH LOCATION LISTED?	ARE YOU ABLE TO PROVIDE SERVICES TO PATIENTS WHO ARE HEARING IMPAIRED?
☐ YES ☐ NO	☐ YES ☐ NO

DOES YOUR OFFICE PROVIDE PHYSICAL ACCESS AND/OR REASONABLE ACCOMMODATIONS AND EQUIPMENT FOR PATIENTS WITH PHYSICAL OR MENTAL DISABILITIES?
☐ YES ☐ NO

MEANINGFUL USE PARTICIPATION	PLEASE CHECK THE APPROPRIATE BOX IF YOU HAVE RECEIVED INCENTIVE PAYMENTS FROM MEDICARE OR MEDICAID				
	MEDICARE	Stage 1 _____	Stage 2 _____	Stage 3 _____	
	MEDICAID	Stage 1 _____	Stage 2 _____	Stage 3 _____	