2018 HMCC NEW PROVIDER APPLICANT QUESTIONNAIRE

Date: _____ **Group Tax ID#:** _____

Physician Name: _____ **Degree:** _____ **NPI#** _____

Please Check One: Solo Provider ☐ New Group ☐ Joining Existing Group ☐ Change ☐

Physician Specialty and Clinical Interest: _____

Is Physician Part-time of Locum Tens? Yes ☐ No ☐

Are you currently accepting new patients? Yes ☐ No ☐ Age Limits? _____

Who covers for you in your absence? _____

Date Joining Group _____ **Effective Date:** _____

Group: _____

Primary Address: _____

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

Telephone No: _____ **Fax No:** _____

Office Manager: _____ **E-mail:** _____

Days of the week at this Location: _____

Billing Address: _____

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

Telephone No: _____ **Fax No:** _____

Billing Manager: _____ **E-mail:** _____

Please fill out attached sheet with ALL additional locations where you practice.

Previous Group Affiliated With: _____

Primary **HCA** Hospital: _____

Please check other hospital staff memberships:

- ☐ Allen County Hospital
- ☐ Belton Regional Medical Center
- ☐ Cass Regional Medical Center
- ☐ Centerpoint Medical Center
- ☐ Children's Mercy Hospital
- ☐ Lafayette Regional Health Center
- ☐ Lee's Summit Medical Center
- ☐ Menorah Medical Center
- ☐ North Kansas City Hospital
- ☐ Overland Park Regional Medical Center
- ☐ Research Medical Center

Signature: _____ Date: _____

Print Name: _____

Please fax completed form(s) to Provider Relations: 816-823-0755 – Attn: Terri

HMCC Office Use Only:

☐ **New to HCA Database** ☐ **New to HMCC Database** ☐ **Changes in existing Databases**

☐ **to CVO Date:** _____ ☐ **Date File Completed** _____

FILL OUT FOR ALTERNATE LOCATIONS (if applicable)

Physician Name: ______________________________

Group Name: ______________________ **TIN#** ______________

Effective Date: ______________ **Specialty:** ______________

Alternate Address: Office ☐ **Billing** ☐ ______________________

City: ______________ **State:** ________ **Zip:** ________

Telephone No: ______________ **Fax No:** ______________

Office Manager: ______________ e-mail ______________

Days of the week at this Location: ______________________

Group Name: ______________________ **TIN#** ______________

Effective Date: ______________ **Specialty:** ______________

Alternate Address: Office ☐ **Billing** ☐ ______________________

City: ______________ **State:** ________ **Zip:** ________

Telephone No: ______________ **Fax No:** ______________

Office Manager: ______________ e-mail ______________

Days of the week at this Location: ______________________

Group Name: ______________________ **TIN#** ______________

Effective Date: ______________ **Specialty:** ______________

Alternate Address: Office ☐ **Billing** ☐ ______________________

City: ______________ **State:** ________ **Zip:** ________

Telephone No: ______________ **Fax No:** ______________

Office Manager: ______________ e-mail ______________

Days of the week at this Location: ______________________

Group Name: ______________________ **TIN#** ______________

Effective Date: ______________ **Specialty:** ______________

Alternate Address: Office ☐ **Billing** ☐ ______________________

City: ______________ **State:** ________ **Zip:** ________

Telephone No: ______________ **Fax No:** ______________

Office Manager: ______________ e-mail ______________

Days of the week at this Location: ______________________