



Aspirus Network, Inc. (ANI) NEW Practice Demographic or Location Form

If your practice plans to add any of the following, please complete this NEW Practice Demographic or Location Form in its entirety and submit to ANI's Customer Service at Customerservice-ANI@aspirus.org:

- Taxpayer Identification Number (TIN);
- National Provider Identifier (NPI);
- A Licensed or Credentialed Facility, Clinic, or Service (i.e., ambulatory surgery center, comprehensive inpatient/outpatient behavioral health mental treatment program, federally qualified health center (FQHC), hospital, hospice/home health, residential health center (RHC), senior nursing facility (SNF), etc.); or
- Clinic

IF adding a licensed or credentialed facility or clinic, the practice should complete the facility credentialing process with each of ANI's contracted payors prior to submitting this Form to ANI. A complete list of ANI's contracted payors, along with a payor contact list, can be found on ANI's website in the Payor Information section. Once a practice has completed a majority of the contracted payors' facility credentialing process, the practice should complete and submit this Form, along with a W-9 form, to ANI's Customer Service. For awareness, the NEW location may require ANI Board approval and please allow up to one hundred and eighty (180) days for ANI to amend its payor contracts accordingly.

IF adding a clinic location that is not licensed or credentialed, the practice should complete and submit this Form to ANI's Customer Service. The Form should be submitted ninety (90) days in advance of the requested effective date. Please include a list of providers for that location (a list in Excel format works best) and whether this New location is the provider's primary or an additional location.

For Durable Medical Equipment (DME) practices and/or an Orthotics & Prosthetics (O&P) practice, if the NEW location is licensed or credentialed, please include a copy of the most current certification.

Aspirus Network, Inc. (ANI)
NEW Practice Demographic or Location Form

Please complete the Form below:

*All fields are required. If it does not apply, please enter N/A. Attach any supporting documentation, including a W-9, along with the completed Form.
Please include a list of providers (Excel format preferred) for the NEW location and note whether it is the provider's primary or an additional location.*

ANI Member
Member Organization: <input type="checkbox"/> CIN Member <input type="checkbox"/> Affiliate Member
Type of NEW Location <input type="checkbox"/> Tax ID Number <input type="checkbox"/> NPI <input type="checkbox"/> Licensed or Credentialed Facility, Clinic, or Service <input type="checkbox"/> Clinic <input type="checkbox"/> DME <input type="checkbox"/> O&P
<input type="radio"/> Is this request the result of a merger/acquisition? Yes No
<input type="radio"/> Is this an outreach location only? Yes No
<input type="radio"/> Is this location a <input type="checkbox"/> Primary Care Clinic or <input type="checkbox"/> Specialty Care Clinic?
<input type="radio"/> Is this a Behavioral Health location? Yes No
Description of NEW Location:
Has your practice completed the state required licensing, accreditation, and/or credentialing for the NEW Facility or Clinic? Yes No N/A. If no, please provide explanation:
If yes to the above question, has your practice reached out to ANI's contracted payors to complete facility credentialing? Yes No. If no, please provide explanation:
Requested <u>effective date</u> to add the NEW Facility or Clinic:
DO NOT PROCEED UNTIL THE ABOVE IS COMPLETE

Are the following documents included:

- W-9
- License
- Provider list

Member Organization to Complete

NEW LOCATION INFORMATION

Legal Entity Name:

DBA Name:

Primary or Specialty:

Address:

Tax ID:

NPI:

Group Medicare #:

Group Medicaid #:

Check most applicable: Inpatient/Outpatient FQHC RHC SNF Hospice/Home Health Psych Inpatient/Outpatient
 Comprehensive Inpatient/Outpatient Rehab/BH Mental Treatment Program Non-Licensed or Credentialed Location Other _____

Will the NEW location be Provider Based to a hospital? Yes No

Location Contact Name and Phone Number:

Phone Number for Appointments:

Fax Number:

Are providers accepting new patients? Yes No (If no, please explain)

Please indicate general day hours of operation below:

Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

MEMBER ORGANIZATION CONTACT AND BILLING INFORMATION

Please use N/A if not applicable.

Organization Practice Administrator:

Organization Practice Administrator Email:	
Practice Main Address:	
City, State, Zip Code, County:	
Billing Contact Representative:	Physician/Medical Director Name:
Billing Contact Representative Email:	Physician/Medical Director Email:
Billing Contact Representative Phone:	Physician/Medical Director Phone:
Billing Address:	
Billing City, State, Zip:	Organization Credentialing Contact:
Billing County:	Organization Credentialing Contact Email:
Billing Phone:	Organization Credentialing Contact Phone:
Billing Fax:	Organization Credentialing Contact Fax:
Office use only: ANI Contract Type	
Office use only: ANI Class	

Form Completed by: _____
 Email Address: _____

Phone: _____ Date: _____

****Please submit this Form and supporting documentation to: CustomerService-ANI@aspirus.org**

**ANI will review and forward to ANI Credentialing and Provider Enrollment upon approval.

ANI Initials: _____ Date: _____