POLK HEALTHCARE PLAN
PROVIDER ENROLLMENT FORM

Indigent Health Care Division
2135 Marshall Edwards Drive – Bartow, FL 33830
Telephone (863) 533-1111 / Provider Services Fax (863) 519-2045

Provider Type

Group____ Individual ____ Hospital ____ Radiology ____ Other _____

Please copy this form and submit one for each group member, including any allied health care professionals

Group or Individual Practice Information

PHP use only ID#_____

Practice Name (d/b/a): _____

Tax ID #: _____ (***Must submit copy of W9 Form***)

Group NPI #:_____ (***Must have NPI #***)

Address 1:_____ Address 2:_____

City: _____ State: _____ Zip Code: _____

Phone: _____Ext:_____ Fax:_____

Office Manager:_____ Answering Service:_____

E-Mail Address:_____ Owner:_____

Do you operate another facility? ☐ Y ☐ N

(If yes, please provide information on a separate sheet for each location)

Number of physicians/ allied health care professionals at this location_____

Are you a Medicaid Provider? ☐ Y ☐ N

Do you accept Medically Needy Share of Cost (MNSOC) ☐ Y ☐ N

Provider Information Effective Date:_____

Name:_____ Title (i.e. MD, DO,Etc)_____

Are you an Independent Physician? ☐ Y ☐ N

Medical Specialty (Primary/Secondary)_____

Any Board Certifications? ☐ Y ☐ N (If yes, please specify) _____

_____

Hospital Affiliation:_____

Individual NPI #:_____ (***Must have for each physician***)

A copy of each of the following certificates must be attached:

Curriculum Vitae - Certificate of Insurance - DEA Certificate - Medical License

Billing Information

Contact Name:_____ Phone: _____

Pay to Name (d/b/a):_____(***Must be same as CMS 1500, Block 33***)

_____

Pay to Address:_____

City:_____ State:_____ Zip Code:_____

Do you use a computer for billing? ☐ Y ☐ N

Billing Software Used: _____

Do you currently file claims electronically? ☐ Y ☐ N

Is this a billing service? ☐ Y ☐ N

(If Yes) Billing Agent Name _____Effective Date_____

Address_____ City_____ State_____ Zip_____

Service bureau/claims clearinghouse used: _____

The PHP will reimburse for services rendered by all physicians and allied health care professionals (ARNP, CRNA & PA) based on the rates listed in the fee schedule as it applies to the provider of service. An enrollment form MUST be completed and on file with the PHP for all providers whether individual or within a group.

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Referral Information

Contact Name: _____
Phone: _____
Fax: _____

Equipment Information

Radiology? ☐ Y ☐ N EKG? ☐ Y ☐ N
Audiology? ☐ Y ☐ N Treadmill? ☐ Y ☐ N

Other Information

Handicap Access? ☐ Y ☐ N
Languages Other than English_____
Age Limits of Patients_____

Hours of Operation

Office Hours
M: _____ T: _____ W: _____ Th: _____ F: _____ SA: _____ Su:_____

Miscellaneous

Office Manager
Name: _____
Phone: _____
Fax: _____
Email: _____

Diversity Information Survey

Although the following information is **not mandatory**, it is requested to aid the Polk Healthcare Plan offer our members a diverse option in selecting their future provider.

SEX: ☐ FEMALE ☐ MALE

RACE (Check Only One):

☐ ASIAN ☐ HISPANIC ☐ NATIVE AMERICAN
☐ BLACK (Non-Hispanic) ☐ PACIFIC ISLANDER ☐ WHITE (Non-Hispanic)
☐ OTHER (Specify) _____

Provider or Authorized Representative

Name	Title
Signature	Date