



Comprehensive Provider Application Request Form

This form is used for:

- New providers requesting to join the Alliance Health network
- Out-of-network providers submitting a single case application
- Contracted providers seeking to add new sites or service codes

Please note: Alliance Health operates a closed behavioral health network. If you are a new provider seeking to join the Alliance Health network, you must consult our service needs list prior to submitting this application.

All relevant information must be completed for your request to be processed.

NCTracks verification

If the provider is not enrolled in NCTracks, Alliance will not be able to process this request.

1

Is the provider enrolled in NCTracks?* Yes No

Request type

2

What is the nature of this request? (choose one)*

- New provider** requesting to join the Alliance Health network Provider has reviewed Alliance Health Service Needs list
- Out-of-network provider** submitting a single case agreement Requested effective date (mm/dd/yyyy) _____
- Contracted provider** seeking to add site(s) and/or service(s)

Provider information

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Today's date (mm/dd/yyyy):* _____

Provider full legal name (as it appears in NCTracks):* _____

Tax ID:* -

SSN if no Tax ID:* - -

National provider identifier (NPI):*

Provider Address Line 1* _____ Address line 2 _____
Street, P.O. Box, etc. Suite, Building, etc.

City* _____ State* _____ Postal code* _____

Associated entity type:*

- Hospital Agency Group Licensed Independent Practitioner/Solo Practice

Is this NPI and address registered in NCTracks?* Yes No

Contact information

Please include the contact information for the person submitting the request.

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Requester name:* _____ Title:* _____
Phone:* _____ Email:* _____

Service site(s) to be added

Please complete this section if you are a new provider, out-of-network provider or contracted provider requesting to add new site(s)

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Site name:* _____
Address Line 1* _____ Address line 2 _____
City* _____ State* _____ Postal code* _____
Site NPI number:* [] [] [] [] [] [] [] [] [] []
NCTracks Location Code:* [] [] []
Please identify the client population(s) served at this site:*
[] MH Adult [] SA Adult [] DD Adult [] TBI Adult
[] MH Child [] SA Child [] DD Child
Requested effective date (mm/dd/yyyy):* _____ Site registered in NCTracks* [] Yes [] No

Site name:* _____
Address Line 1* _____ Address line 2 _____
City* _____ State* _____ Postal code* _____
Site NPI number:* [] [] [] [] [] [] [] [] [] []
NCTracks Location Code:* [] [] []
Please identify the client population(s) served at this site:*
[] MH Adult [] SA Adult [] DD Adult [] TBI Adult
[] MH Child [] SA Child [] DD Child
Requested effective date (mm/dd/yyyy):* _____ Site registered in NCTracks* [] Yes [] No

Site name:* _____
Address Line 1* _____ Address line 2 _____
City* _____ State* _____ Postal code* _____
Site NPI number:* [] [] [] [] [] [] [] [] [] []
NCTracks Location Code:* [] [] []
Please identify the client population(s) served at this site:*
[] MH Adult [] SA Adult [] DD Adult [] TBI Adult
[] MH Child [] SA Child [] DD Child
Requested effective date (mm/dd/yyyy):* _____ Site registered in NCTracks* [] Yes [] No

If you need to include more than 3 addresses, please attached additional documentation to this application.

Service(s) to be added

Please complete this section if you are a new provider, out-of-network provider, or contracted provider seeking to add service(s).

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Requested title of service:* _____

Requested service code:* _____ Is service included on needs list?* Yes No

Requested effective date (mm/dd/yyyy): _____

Requested title of service:* _____

Requested service code:* _____ Is service included on needs list?* Yes No

Requested effective date (mm/dd/yyyy): _____

Requested title of service:* _____

Requested service code:* _____ Is service included on needs list?* Yes No

Requested effective date (mm/dd/yyyy): _____

Do you have an available prescriber?* Yes No


If yes, please select which kind:

MD

DO

PA

NP

 If you need to include more than 3 services, please attached additional documentation to this application.

Rationale for request

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Please provide any specialties as well as any other information to be considered in this application:*

Additional request details

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If you are a provider of services specifically for traumatic brain injury and/or intellectual and developmental disabilities for the following services: **Day Supports, Residential Supports, and Supported Employment**, you must submit a Home and Community Based Services (HCBS) Self-Assessment.

Have you submitted the Self-Assessment in the HCBS portal?* Yes No

Member information sheet

Please complete this section if you are new provider, out-of-network provider, or contracted provider making a member specific request.

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Member last name: _____ Member first name: _____

Date of birth mm/dd/yyyy: _____

Member address line 1 _____ Address line 2 _____
Street, P.O. Box, etc. Suite, Building, etc.

City _____ State _____ Postal code _____

Medicaid number: _____ Requested effective date: _____

Codes requested for member: _____

Are you working with care coordination for this member? Yes No

If yes, please provide care coordinator's name: _____


Member information sheet

Continuation

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Member last name: _____ Member first name: _____
Date of birth mm/dd/yyyy: _____
Member address line 1 _____ Address line 2 _____
Street, P.O. Box, etc. Suite, Building, etc.
City _____ State _____ Postal code _____
Medicaid number: _____ Requested effective date: _____
Codes requested for member: _____
Are you working with care coordination for this member? Yes No
If yes, please provide care coordinator's name: _____

Member last name: _____ Member first name: _____
Date of birth mm/dd/yyyy: _____
Member address line 1 _____ Address line 2 _____
Street, P.O. Box, etc. Suite, Building, etc.
City _____ State _____ Postal code _____
Medicaid number: _____ Requested effective date: _____
Codes requested for member: _____
Are you working with care coordination for this member? Yes No
If yes, please provide care coordinator's name: _____

 If you are including information for more than 3 members, please attach additional documentation to the application.

Authorization of person submitting request

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Print name:* _____
Signature (name or typed):* _____ Date (mm/dd/yyyy):* _____

x		
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Contract information

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Name and email where **contract** needs to be sent for authorized signature:
First name:* _____ Last name:* _____
Phone:* _____ Fax: _____
Website address (URL): _____ Email:* _____

Submission instructions

Please submit all completed applications and applicable attachments via email to Enrollment@AllianceHealthPlan.org.