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/yyy) _____

○ **Contracted provider** seeking to add site(s) and/or service(s)

Provider information

3

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* _____ (Street, P.O. Box, etc.) Address line 2 _____ (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.

4

Requester name:* _____ Title:* _____

Phone:* _____ Email:* _____

Service site(s)

Please complete this section identifying the site(s) where you will be providing the service(s).

5

Site name:* _____

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

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

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Site name:* _____

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

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

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Site name:* _____

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

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) requested

Please complete this section identifying the service(s) you are requesting to provide.

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

6

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

Rationale for request

7

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

Additional request details

8

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.

9

Member last name: _____ Member first name: _____

Date of birth mm/dd/yyyy: _____

Member address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (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

9

Member last name: _____ Member first name: _____

Date of birth mm/dd/yyyy: _____

Member address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (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 _____ (Street, P.O. Box, etc.) Address line 2 _____ (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

10

Print name:* _____

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

x		

Contract information

11

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 secure email to Enrollment@AllianceHealthPlan.org.