4350 E. Cotton Center Boulevard • Building D • Phoenix, AZ 85040 • (602) 263-3000 • (800) 624-3879

INITIAL REQUEST FORM- PROFESSIONAL

Mercy Care Plan (MCP) contracting and credentialing standards require that Mercy Care obtain personal information such as your name, address, and social security number. Personal information is maintained in contracting and credentialing databases at Mercy Care for in-house tracking, reporting purposes, contracting, credentialing and payment of claims. Providing the required personal information is voluntary; however, failure to provide it will delay the contracting and credentialing process and may preclude a contract.

IN ORDER TO BE CONTRACTED, YOU MUST HAVE: AN NPI NUMBER, BE REGISTERED WITH AHCCCS, HAVE NOT OPTED OUT OF MEDICARE, SUBMIT CLAIMS ELECTRONICALLY, HAVE INTERNET ACCESS AND PARTICIPATE WITH ALL MERCY CARE LINES OF BUSINESS. TO CONTINUE PROCESSING, ALL FIELDS MUST BE COMPLETED.

EDI and Internet:	Electronic Claim Submissions: ☐ Y ☐ N Does your Business have internet Access: ☐ Y ☐ N If no, please explain: ______
Provider Name:	______, ______ ______ ______ (Last) (First) (MI) (Degree) Gender: ☐ M ☐ F DOB: ___/___/___ SSN: ___/___/___ Corporate Name: ______ Joining Existing Group: ☐ Y ☐ N DBA Name: ______ Employment Start Date: ___/___/___
Practicing Specialties	
Primary: ______ Board Certified ☐ Y ☐ N	Secondary: ______ Board Certified ☐ Y ☐ N
If not Board Certified, are actively pursuing Board Certification: ☐ Y ☐ N	

Administrative Contact: (MCP's contact)	Contact Name: ______ Email: ______ Phone Number: ( ) ______ Fax Number: ( ) ______	
NPI:	Pay To NPI: ______ Eff. Date: ___/___/___ Individual NPI: ______ Eff. Date: ___/___/___	
Tax ID: **Other ID's:**	Pay To Tax ID #: ______ Eff. Date: ___/___/___	DEA#: ______ Eff. Date: ___/___/___ Medicare #: ______ Eff. Date:___/___/___ Medicare Opt Out? ☐Yes ☐No AHCCCS # ______ Eff. date: ___/___/___ CAQH#______
AZ License:	AZ License#: ______ Date First issued: ___/___/___ Exp date: ___/___/___	

Please list other services or important information you want Mercy Care Plan to know that is unique or different from your peers.

Language(s) spoken other than English: ______, ______
Cultural Heritage:______ Is this a Minority or Female-owned Business? ☐ Y ☐ N

4350 E. Cotton Center Boulevard • Building D • Phoenix, AZ 85040 • (602) 263-3000 • (800) 624-3879

Hospital / Free Standing Surgery Facilities: (Indicate Affiliations on a separate attached sheet)

________________________________ ☐ Active ☐ Courtesy ☐ Delivery ☐ Provisional
________________________________ ☐ Active ☐ Courtesy ☐ Delivery ☐ Provisional
________________________________ ☐ Active ☐ Courtesy ☐ Delivery ☐ Provisional
________________________________ ☐ Active ☐ Courtesy ☐ Delivery ☐ Provisional

Call Coverage Practice(s)/ Physician Name(s) (must be registered with AHCCCS)**:** Please list additional names on separate sheet.

________________________________ ________________________________
________________________________ ________________________________

Conscious Sedation: GENERAL ANESTHESIA AND SEDATION /Dental Providers only need to complete this portion:

☐ I do not administer any type of sedation (including nitrous oxide) in my practice. (No permit required)
☐ I only administer nitrous oxide in my practice (No permit required)
☐ I administer general anesthesia and semi-conscious sedation in my practice 1301 Permit #______________
☐ I administer conscious sedation in my practice 1302 Permit #______________
☐ I administer oral conscious sedation in my practice 1303 Permit #______________

IF A PERMIT IS REQUIRED INCLUDE A COPY OF THE CERTIFICATE WITH THIS INITIAL REQUEST FORM

Primary Address: (Main location where provider offers services)	Street: ______________________ Suite: ________ Office hours: __________ City: ____________________ State: __________ Zip: ______________ Phone: (____) _______________ Fax: (____) _______________ County:______________

Additional Office (if applicable) (Indicate other offices on separate sheet)	Street: ______________________ Suite: ________ Office hours:__________ City: ____________________ State: __________ Zip: ______________ Phone: (____) _______________ Fax: (_____) _______________ County: ______________

Contract will be mailed to this address unless otherwise specified

Mailing/ Billing Address: (All correspondence, checks, remits, contracts & credentialing info will be sent to this address)	Street: ______________________________ Suite: __________ City: ____________________ State: ____________ Zip: ______________ Phone: (____) _______________ Fax: (_____) ____________________

The completion of this form does not guarantee network participation. The Provider may not bill Mercy Care or be paid for services rendered until the Credentialing process is fully completed and approved.

Please allow approximately five business days to evaluate the current network need. If approved as a network need and MCP can verify that a CAQH application has been completed, please allow approximately ninety business days to complete the credentialing process.

I am _____________________ of ______________________ and authorized to submit this application on behalf of ______________________________. I affirm that all of the information on this form is accurate and complete to the best of my knowledge, information, and belief. I Promise to keep confidential any information that Mercy Care Plan shares with me during this process.

Authorized Signature: ____ Date: _____/_____/_______

Please mail or fax completed form to the attention of Network Development & Contracting Department - (860)-975-3201

4350 E. Cotton Center Boulevard • Building D • Phoenix, AZ 85040 • (602) 263-3000 • (800) 624-3879

Please Do Not Write Below This Line –Mercy Care Plan Representative Only

☐ Specialist ☐ Dentist ☐ PCP* ☐ FP/OB* ☐ Allied Provider ☐ Mercy1Source Form ☐ Request Approved by ND&C ☐ EFT

Please Remember: Site Visit/MRR are required for all PCP & OB Practitioners

MCP Representative Signature____ **Date**____/______/_____