Community
Partners
Health Plans

Preferred Provider Organization
Provider Manual

Community Partners Health Plans

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COMMUNITY PARTNERS HEALTH PLANS

Welcome to the Community Partners Health Plans, Inc. (Community Partners) network. Community Partners is a PPO Network and Third Party Administrator that is committed to the regional management of health care plans by bringing the providers of health care services together with the employer groups who purchase these services.

Provider Representatives

Provider Relations Representatives for Community Partners and its contracted payors provide assistance to the provider on operating policies and procedures. Please contact the provider representatives for questions beyond the information provided on the following pages. For further assistance, contact:

Marla Deval
marla@cphp.com
217-355-0055

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PROVIDER RESPONSIBILITIES

This section of the manual provides information concerning the provider's professional responsibilities relative to the Members and Payors.

Providers Have Agreed To:

- Provide health care services to Members using generally accepted standards of care.
- Maintain appropriate licensures and maintain appropriate medical staff privileges at a participating hospital.
- Comply with credentialing and re-credentialing polices and procedures.
- Inform Community Partners immediately of changes in licensure or changes in privileges at participating hospitals.
- Accept payment for Covered Services according to the agreement and not seek reimbursement from Members other than for co-payments, deductibles, or fees for non-covered services.
- Provide regular office hours and make provisions available for after-hour emergency service on a 24-hour per day, 365 days a year basis.
- Not discriminate in any manner between Members and non-Members.
- Maintain appropriate insurance coverage.
- Hold medical records confidential and obtain Member's authorization to release information in accordance with HIPAA guidelines.
- Refer and admit Members to participating providers, except when they are not available or in an emergency.
- Allow provider's name to be used in informational materials.
- Adhere to the polices, procedures and guidelines of Community Partners.
- Participate in quality assurance and utilization review programs.
- Be responsible for advice and treatment provided to Members.
- Accept the Negotiated Rate for Covered Services rendered after termination from the Community Partners, for up to ninety (90) days after termination, in accordance with the provisions governing continued treatment for patients under special circumstances, as set forth in your Network Participation Agreement
- Provide Covered Services without regard to participation in the preferred provider program, race, age, color, religion, sex, national origin, creed, ethnicity, ancestry, marital status, sexual preference, source of payment, health status or disability of any Member.
- Abide by the terms and language in the governing Network Participation Agreement

Confidentiality of Member Information and Records

Community Partners is committed to maintaining the privacy of Members health information and confidentiality between Members and Providers. Confidential information includes:

- Any communication between a Member and a Provider
- Any communication with other clinical persons involved in the Member's health, medical, and mental care.
- This includes all clinical data, diagnosis and treatments.
- Any other information designated as protected health information by HIPAA or applicable state statute.

All consultations or discussions involving the Member or his/her case should be conducted discreetly and professionally and should follow HIPAA guidelines. All Members have a right to confidentiality, and any healthcare professional or person who deals directly or indirectly with the Member or his/her medical record must honor this right. Information regarding the Member or his/her case, including medical, financial, or personal information is considered confidential and must be treated as such.

Access Standards

The purpose of these standards is to ensure that health services are available and accessible to Members. Community Partners recognizes that in some areas these standards may be difficult to obtain. By monitoring compliance with these guidelines over time, Community Partners can take action to improve Member service availability and access to medical services when necessary.

These access standards are:

- Emergent care appointments immediately.
- Urgent appointments within 24 hours.
- Symptomatic visits within 7 to 14 calendar days
- Preventative or Well Child appointments within 30 calendar days.

Credentialing Process

The credentialing process applies to all independent practitioners in which Community Partners Health Plans is qualified to do business. All independent practitioners are required to complete the credentialing process before being added to the provider network. MD's and DO's in the state of Illinois will be recredentialed in accordance with the Illinois Department of Public Health regulations on recredentialing.
The following provides credentialing criteria for providers.

Community Partners Health Plans

CREDENTIALING CRITERIA

I. INITIAL CREDENTIALING CRITERIA

A. Completed and signed State of Illinois Credentialing Application (unless there is an existing Agreement for Delegation of Credentialing). This form is available via the internet at http://www.idph.state.il.us/about/credentialing.htm If you do not have internet access, please call our office for a hard copy.

B. Applicants should have full, unrestricted active staff privileges at a minimum of one Community Partners Health Plans network hospital (Requirement of Active Staff Privileges and requirement that hospital(s) be in Network are both waivable under special circumstances)

C. Documentation required: (photocopies to help in primary source verification)
1. Medical School Diploma
2. All Internship/Residency/Fellowship/Preceptorship Training Completion certificates
3. All Currently Valid State Professional Licenses
4. Any Specialty Board Certificate or letter regarding status
5. Any Currently Valid Federal and State Controlled Substance Registration Certificate(s)
6. ECFMG Certificate (required of graduates of medical schools outside the United States and Canada)
7. Any Continuing Medical Education Certificate(s) (showing completion of at least 50 hours of Category I CME credits within previous 2 years)
8. Professional Liability Insurance Policy Face Sheet

II. RECREDENTIALING CRITERIA

B. Copy of completed State of Illinois “Health Care Professional Recredentialing and Business Data Collection Form. This form is accessible via the internet at http://www.idph.state.il.us/about/credentialing.htm. If you do not have internet access, please call our office for a hard copy.

C. Signed copy of the Community Partners Health Plans Inc. “Authorization and Certification” form.

D. Documentation required: (photocopies to help in primary source verification)
1. Copy of current malpractice insurance certificate.
2. Copy of current DEA license.
3. Copy of current physician state practitioner’s license.
4. Copy of current state controlled substance license.

REIMBURSEMENT

Compensation and Claims Payment

Compensation is on a fee for service basis. Providers can review their individual contracts for reimbursement rates. Providers should submit their normal billed charges to Community Partners Health Plans at the address indicated on each member's identification card (please note: this address will vary based on payor). They will be reimbursed at the lower of billed charges or contracted rate. For procedure codes without specified rates, payments will be based on a percentage of the submitted charge. When multiple surgical procedures are to be performed, the provider should verify benefit coverage for each procedure. A physician's reimbursement and the Member's benefits may be reduced for multiple procedures performed during a single admission.

For some types of treatment, Payors may require the Member's consent and possibly the consent of family members, to release medical information. These signatures should be kept on file with the Member's record.

Submitting Claims by Mail

Submit claims on a HCFA 1500, UB92, or their successor forms to the address found on the ID card. Claims must use current CPT procedure coding and two digit modifiers when appropriate. Use only the tax identification number on record with Community Partners. If a tax identification number is not recorded with Community Partners, the Member's benefits may be reduced and the provider's payment may be delayed.

Submitting Claims Electronically

Most claims can be submitted electronically through transaction networks and clearing houses. This method can promote faster and more accurate claims processing and is preferred to submitting paper claims by mail.

To facilitate electronic claims submission, please contact each payor as directed on the Payor Specifics page.

Required Claims Information

The information listed below is required on claims submissions. Omission of any of these items may delay claims processing.

- Patient's full name
- Patient's relationship to employee
- Group plan number
- Employee's member number
- Patient's date of birth
- Other insurance information (if the patient is covered by another plan)
- ICD-9 diagnosis codes
- Date of service
- CPT-4 procedure codes
- Amount charged for each service
- Name of physician and medical group supplying the service
- Name of referring physician authorization or referral number

Amounts Collectible from the Member

The provider may collect the Member's co-pay amount at the time of service. If the services being rendered have been verified as not covered under the Member's plan, these fees may also be collected at the time of service. Upon receipt of the Explanation of Benefits (EOB), the member may be billed for any deductible or coinsurance amounts indicated on the EOB.

Balance Billing

The Member may not be billed for the difference between the provider's standard fees and the contracted reimbursement amount.

Provider Grievance & Appeals Process

Please refer to Appendix II.

PLAN REQUIREMENTS, ELIGIBILITY AND SERVICES

Precertification, Referral and Medical Management Criteria

Payors may have adopted precertification and/or referral requirements as well as sets of medical criteria to support determination of medical appropriateness or care management interventions. These requirements and criteria may differ by Payor depending upon the utilization review agent contracted to provide services for each Plan. For a list of procedures requiring precertification, any plan referral requirements and/or for specific criteria used in making determinations of Medical Necessity, please call Community Partners at 217-355-0055 for Payor contact information

Verification of Eligibility and Benefits

To be a Covered Service, a service must be Medically Necessary and covered by the Member's plan. Services are determined to be Medically Necessary by the Plan, unless otherwise mandated by law. Coverage may vary by Payor and Plan. Coverage and eligibility for a Member and/or service must be verified directly with the Payor. However, due to administrative complexities and timing differences inherent in the process of administering health benefits, verification of eligibility is not a guarantee of coverage or payment. Members subsequently found to be ineligible for covered services may be billed directly by the provider.

Payors will issue identification cards to their members which will identify the Community Partners network by inclusion of our logo. Examples of these cards are included in Appendix I of this manual.

To verify benefits and eligibility, call the phone number listed on the back of the member's card.

After contacting the payer and determining the service being provided is not a covered benefit, the provider may bill the patient directly at the time of service without submitting a claim.

Community Partners Health Plans

GLOSSARY

Allowable Charges. The maximum amount that a Payor shall be obligated to pay for Covered Services rendered to Members

Clean Claim. A record of or a claim for payment for Covered Services provided to Covered Persons that is accurate, complete (i.e., includes all information necessary to determine the Payor's liability), not a claim on appeal, and not contested (i.e., not reasonably believed to be fraudulent, and not subject to a necessary release, consent, or assignment that has not yet been obtained).

Co-payments, Coinsurance and Deductibles. Charges, as determined under a Covered Person's Plan, for which the Covered Person is financially responsible and which should be collected by a Participating Provider directly from a Covered Person.

Covered Person. An individual who has an employment or other direct relationship with a Payor, meets eligibility requirements, and is enrolled in such Payor's Plan; and the dependents of such individuals who also meet eligibility requirements and are enrolled in such Payor's Plan. Also referred to as Member.

Covered Services. Those medical, hospital and ancillary services which are covered for payment under a Plan, including any expenses, payments or reimbursements which are to be paid by the Covered Person under such applicable Plan.

Medically Necessary. Medically Necessary Covered Services are those Covered Services which a Covered Person requires for the maintenance of good health and/or the treatment of sickness or injury as determined in accordance with generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment.

Member. An individual who has an employment or other direct relationship with a Payor, meets eligibility requirements, and is enrolled in such Payor's Plan; and the dependents of such individuals who also meet eligibility requirements and are enrolled in such Payor's Plan. Also referred to as Covered Person.

Negotiated Rate. The rate of payment for professional services that Provider has agreed to take as payment in full.

Non-Covered Services. Those healthcare services, equipment or treatments that, under the terms of the applicable Plan, are not the financial responsibility of the Payor of the Plan.

Participating Hospital. Any hospital contracted and participating as a preferred provider in the Community Partners network.

Payor/Payer: Any third party payor, including, but not limited to, an employer, a trust fund, an insurance company, a health maintenance organization, a governmental entity/agency or other entity that is financially responsible for providing benefits to Covered Persons under a Plan and that has contracted with Community Partners to access its network of Participating Providers.

Plan. Any benefit plan or benefit arrangement providing for the payment for Covered Services that is sponsored by a Payor for whom Community Partners has agreed to provide access to a network of Participating Providers and other services.

PPO Network. A network of contracted health care providers assembled to provide Covered Person's a choice of providers under a discounted arrangement in exchange for enhanced benefits. Generally, PPO Networks contract to bring Members to contracted providers, but make no guarantee of payment by the Payor.

Third Plan Administrator or TPA. An independent company contracted by the Payor to determine benefits, adjudicate claims and cut checks on the Payors behalf. Generally, the TPA performs administrative services only for a Plan, and makes no guarantee of payment by the Payor.

Wrap Network. Community Partners generally provides its network services within its service area (See Appendix II.) For providers outside of this service area, a national PPO network is contracted to ensure the availability of preferred providers to plan members who travel, who reside outside of the service area, or who require services not provided by providers within the Community Partners network. This secondary network is called a Wrap or Wrap-Around Network.

Community Partners Health Plans

APPENDIX I

Payor Specifics

The following pages are provided to provide an overview of administrative information unique to each Payor or Plan. This information is subject to change without notice. Community Partners strives to keep these reference pages up-to-date for your use. Please check our website **www.cphp.com** from time to time for periodic updates or call 217-355-0055 to verify current plan information.

APPENDIX I

Payer Information A

ADMINISTRATIVE INFORMATION

Plan:	Health Alliance Medical Plans
Administrator:	Health Alliance Medical Plans
Send Paper Claims to:	Health Alliance Medical Plans Attn: Claims Department P.O. Box 6003 Urbana, IL 61803
Electronic Claims:	If you are interested in electronic filing, please call the Health Alliance Audit & Configuration Management Department at 1-800-851-3379 ext. 8566
Primary Network Option:	
POS/ HMO, PPO, State of IL	Community Partners Health Plans and Health Alliance Medical Plans (please call Health Alliance Customer Service 1-800-851-3379 to confirm benefits)
Health Alliance Medicare	Contact Health Alliance directly to inquire.
Prescription Benefit Manager:	MedImpact (Medicare) Catamaran

Important Numbers:

Verification of Eligibility or Benefit	800-851-3379
Claim, Coding or Timely Filing or PSC@healthalliance.org	800-851-3379 x 4668
Precertification, Medical Management or Referrals	800-851-3379 x 8061
For information regarding Wrap Network Providers	800-851-3379
For questions regarding prescriptions call	800-851-3379 x 8078
For questions regarding your network contract call	217-355-0055
For information regarding Organ Transplant Benefits call	800-851-3379

BENEFIT AND PLAN REQUIREMENTS

(Call Health Alliance Customer Service to verify benefits 1-800-851-3379)

Referral required to see Specialist

Referral required to access Wrap Network:

Prescription Formulary:

Transplant Network — Yes, URN

List of Services requiring pre-certification

- All Inpatient Admissions
- Outpatient Surgical Procedures
- Emergency Room Visits (within 48 hours or as soon as reasonably possible)

Community Partners Health Plans

APPENDIX I

Payer Information B

ADMINISTRATIVE INFORMATION

Plan:	Christie Clinic Employee Health Plan
Effective Date:	October 1, 2003
Group #:	2003CCPC
Administrator:	WebTPA
Send Paper Claims to:	P.O. Box 99906 Grapevine, TX 76099-9706
Send Electronic Claims to:	Payer ID# 75261
Primary Network Option:	Community Partners Health Plans
Wrap Network Option:	AETNA Signature Administrators
Prescriptions:	Christie Clinic Pharmacy Walgreen's Health Initiatives

Important Numbers:

Verification of Eligibility or Benefit/Claim Information	1-800-459-2432
Precertification, Medical Management or Referrals	1-800-459-2432
For information regarding Wrap Network Providers	www.aetna.com/asa
For questions regarding prescriptions call:	
Walgreens Pharmacy	1-217-366-1278
Navitus	1-866-333-2757
For questions regarding your network contract call	1-217-355-0055
For information regarding Organ Transplant Benefits call	1-800-459-2432

BENEFIT AND PLAN REQUIREMENTS

PCP Required?	No
Referral required to see Specialist	No
Referral required to access Wrap Network:	No
Prescription Formulary:	Yes
Transplant Network	Yes

List of Services requiring pre-certification

All Inpatient Admissions, Cochlear Implants, Lap Band, Gastric Bypass
MRI/CT/PET Scan and Heart Catheterizations, Neurosurgery, Genetic Testing
Initial Therapy – PT (includes athletic training)/OT or ST
Emergency Room Visits (within 48 hours or as soon as reasonably possible) – Certification not required, notification only.

APPENDIX I

Payer Information C

ADMINISTRATIVE INFORMATION

Plan:	Humana
Administrator:	Humana
Send Paper Claims to:	Please refer to the address on the member's ID card
Send Electronic Claims to:	If you are interested in electronic filing, please call the Humana eCommerce consultant at 1-800-289 ext. 2329
Primary Network Option:	Choice Care Network
Prescription Benefit Manager:	Argus

Important Numbers:

Verification of Eligibility or Benefit/Claim Information	1-800-448-6262
Precertification, Medical Management or Referrals	1-800-448-6262
For questions regarding prescriptions call	1-800-448-6262
For questions regarding your network contract call	1-217-355-0055
For information regarding Organ Transplant Benefits call	1-800-448-6262

Health Care Providers may go to www.humana.com for administrative and informational needs pertaining to Humana.

BENEFIT AND PLAN REQUIREMENTS

PCP Required?	No
Referral required to see Specialist	No
Prescription Formulary:	Yes
Transplant Network	Yes, if plan allows transplant benefits

List of Services requiring pre-certification

All inpatient Admissions. In advance for non-emergency admits, within two working days for emergency admissions.

Some Outpatient Surgical Procedures and Treatments

Community Partners Health Plans

APPENDIX I – IF APPLICABLE

Payer Information D

ADMINISTRATIVE INFORMATION

Plan:	Humana Medicare **Only Includes Providers that have signed the CPHP Medicare Rider**
Administrator:	Humana
Send Paper Claims to:	Please refer to the address on the member's ID card
Send Electronic Claims to:	If you are interested in electronic filing, please call the Humana eCommerce consultant at 1-800-289 ext. 2329
Primary Network Option:	HumanaChoice-PPO, HumanaChoice – Regional PPO, Humana Gold Plus, Humana Gold Choice
Prescription Benefit Manager:	Argus

Important Numbers:

Verification of Eligibility or Benefit/Claim Information	1-800-457-4708
Precertification, Medical Management or Referrals	1-800-457-4708
For questions regarding prescriptions call	1-800-457-4708
For questions regarding your network contract call	1-217-355-0055
For information regarding Organ Transplant Benefits call	1-800-457-4708

Health Care Providers may go to www.humana.com for administrative and informational needs pertaining to Humana.

BENEFIT AND PLAN REQUIREMENTS

PCP Required?	No
Referral required to see Specialist	No
Prescription Formulary:	Yes
Transplant Network	Yes, if plan allows transplant benefits

List of Services requiring pre-certification

All inpatient Admissions. In advance for non-emergency admits, within two working days for emergency admissions.

Some Outpatient Surgical Procedures and Treatments

Community Partners Health Plans

APPENDIX I

Payer Information E

ADMINISTRATIVE INFORMATION

Plan:	Immergrun
Effective Date:	August 1, 2009
Administrator:	Immergrun
Send Paper Medical Claims to:	Immergrun PO Box 1538 Maumee, IL 43537
Send Paper Behavioral Health/ Substance Abuse Claims to:	PO Box 1538 Maumee, IL 43537
Send Electronic Claims to:	N/A
Primary Network Option:	Community Partners Health Plans
Prescription Benefit Manager:	N/A

Important Numbers:

Verification of Eligibility or Benefit/Claim Information call
1-800-333-3561 Fax: 419-535-1527

Precertification, Medical Management or Referrals FAX
Referrals/ Precertification not required

For questions regarding prescriptions call
N/A

For information regarding Organ Transplant Benefits call
1-800-333-3561

For questions regarding your network contract call
1-217-355-0055

BENEFIT AND PLAN REQUIREMENTS

PCP Required?	No
Referral required to see Specialist	No
Prescription Formulary:	Yes
Transplant Network	Yes

List of Services requiring pre-certification
N/A

APPENDIX II

Grievance & Appeals Process

APPEALS OF UNPAID CLAIMS OR DENIALS:

If the member, physician or hospital is dissatisfied with the processing of a submitted claim, the member, physician or hospital may appeal. This section outlines the procedure to follow, should such action become necessary.

Medical Necessity Denials

NOTE: Community Partners Health Plans is not an insurance company, HMO or utilization review agent. As such, Community Partners does not make determinations of medical necessity, covered services, or benefit coverage. Any contact with Community Partners regarding medical necessity is a service Community Partners provides to its contracted providers to facilitate interaction with the Plan or the Plan's designated utilization review agent, and will not result in a medical determination by Community Partners Health Plans.

A member, physician or hospital may appeal a claim that was denied because the medical service rendered was determined not to be medically necessary. Appeals may be submitted orally or in writing in accordance to the criteria set forth by a Plan or the Plan's designated utilization review agent.

Questions about the right to appeal or about how to file an appeal may be answered by calling the Provider Relations at or (217) 355-0055.

Other Denials

If a member, physician or hospital needs to inquire about an unpaid claim or claim denial other than for medical necessity, he/she should contact the claims center at the telephone number listed on the membership card.

If the problem is not resolved within a reasonable amount of time, the member, physician or hospital should appeal in writing to the payor/third party administrator with a copy to Community Partners in order that we may assist you. This copy of the written appeal should be sent to: Community Partners Health Plans, 1605 S. State, Suite 104; Champaign, IL 61820, Attn: Provider Relations

Community Partners will follow up on the initial appeal with the payor/third party administrator and respond in writing to the member, physician or hospital to acknowledge receipt of the appeal and to notify of problem resolution within 10 days.

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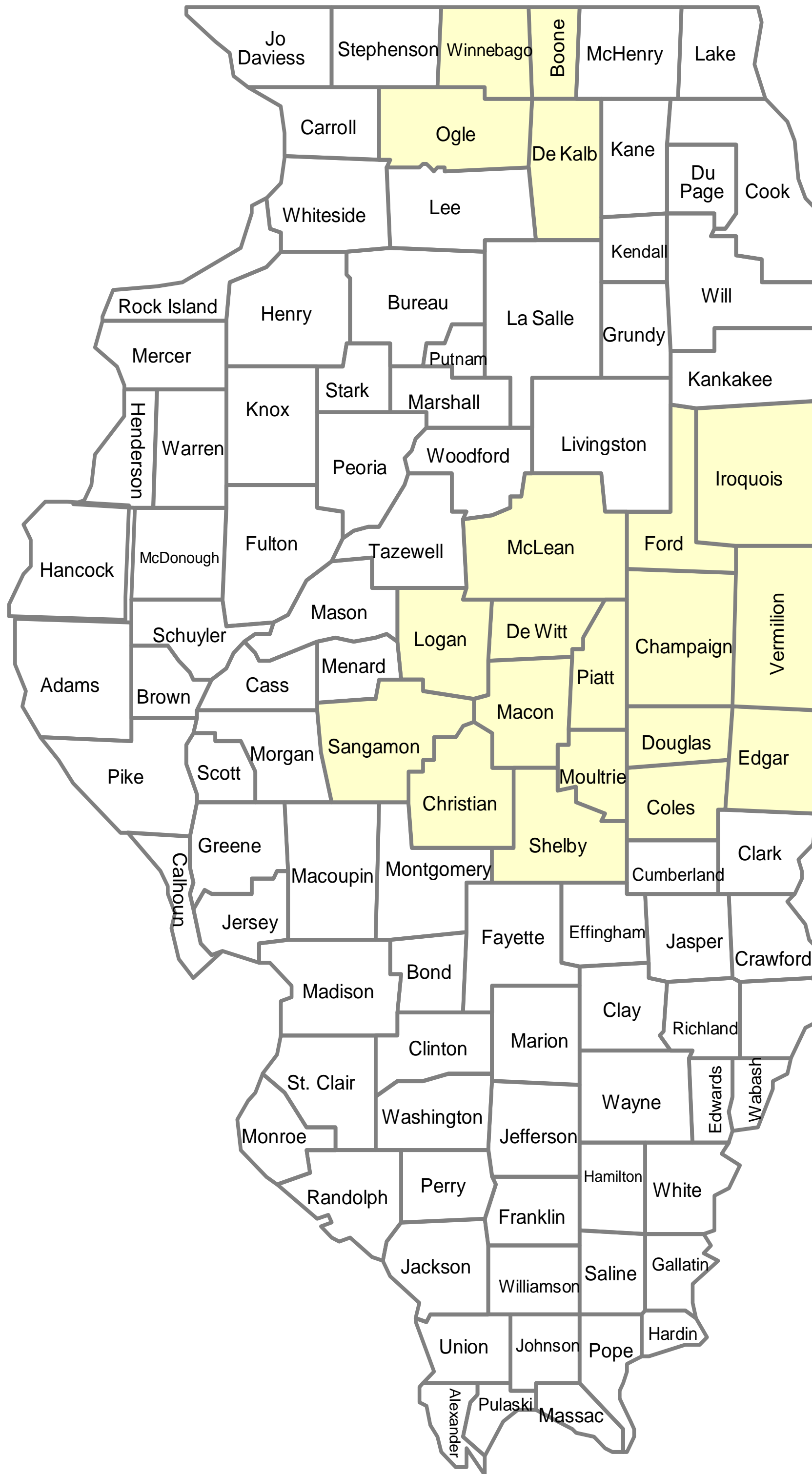
APPENDIX III – *Plan Service Area Map*



Community Partners Health Plans

Appendix IV Plan Forms

Community Partners Health Plans
Covering Provider Form

To comply with NCQA standards, and to provide continuity of care, Community Partners Health Plans requires that you provide coverage for your practice (your Community Partners members) in the case of your absence. We require that this covering provider information be **sent to us, by mail or fax, prior to** (whenever possible) **your absence.**

This information helps to facilitate the referral process and claims payment for our members, as well as for you, the providers.

YOUR NAME ____
(Community Partners Participating Provider)
OFFICE ____
ADDRESS ____
CITY ______________________ STATE ____________ ZIP ____________
COUNTY ______________________ PHONE ______________________
OFFICE CONTACT PERSON ______________________________________

....

COVERING PROVIDER INFORMATION

NAME ____
OFFICE ____
OFFICE ADDRESS ____
CITY ______________________ STATE ______________ ZIP __________
COUNTY ____________________ PHONE ________________________

BILLING ADDRESS ____
CITY ______________________ STATE ______________ ZIP __________
PHONE ____

DATE OF BIRTH ______________ TAX ID NUMBER __________________
DEA NUMBER ________________ UPIN NUMBER ____________________
LICENSE NUMBER ____
COVERAGE START DATE __________ COVERAGE END DATE ____________

MAIL OR FAX COMPLETED FORM TO:

Attention: Contract Coordinator
Community Partners Health Plans
1605 S. State, Suite 104
Champaign, IL 61820

or

Contract Coordinator
Fax # (217) 355-0044

Community Partners Health Plans Provider Addition/Change Form

PHYSICIAN/PROVIDER INFORMATION: □ ADD □ CHANGE □ TERM*

Illinois legislation requires contracted providers to give 90 days written notification of their intent to terminate their contract.

**If provider is terming please note reason in comments below.*

NAME_______________________________________SPECIALTY____________________

NPI________________UPIN_____________DEA#_____________LICENSE#____________

EFFECTIVE DATE____

MIDLEVEL PRACTITIONER/ELIGIBLE BILLER INFORMATION: □ ADD □ CHANGE □ TERM*
(additional space on next page)

NAME_______________________________________SPECIALTY____________________

DOB________________UPIN______________DEA#______________LICENSE___________

EFFECTIVE DATE__________________________SUPERVISING PHYSICIAN________________

GENERAL OFFICE/BILLING INFORMATION: □ ADD □ CHANGE □ TERM*
(additional space on next page)

PHYSICAL PRACTICE LOCATION: OFFICE NAME_____________________________________

ADDRESS________________________________CITY__________STATE_____ZIP________

PHONE__________________________________FAX_________________________________

EMAIL ADDRESS___________________________TAX ID#**___________________________

EFFECTIVE DATE____

BILLING LOCATION: COMPANY NAME____

ADDRESS_________________________________CITY__________STATE______ZIP_______

PHONE___________________________________FAX________________________________

EMAIL ADDRESS_____________________________TAX ID#**__________________________

EFFECTIVE DATE____

***If you have a Tax ID# change, please remember to submit a new W-9 Form to Community Partners Health Plans. If claims are filed electronically, list the vendor and contact person.*

VENDOR_________________CONTACT PERSON____________________PHONE______________

If Community Partners Health Plans has questions about the addition/change of a provider, who can we contact?

NAME______________________________PHONE_____________________________________

COMMENTS____

Please mail or fax copies of DEA certificate (if applicable) and state licenses for all providers.

Mail to: Attention: Contracting Department
Community Partners Health Plans
1605 S. State, Suite 104
Champaign, IL 61820

or

Fax to: Contracting Department
(217) 355-0044

Illinois legislation requires contracted providers to give 90 days written notification of their intent to terminate their contract.

Community Partners Health Plans

**If provider is terming please note reason in comments below.*

ADDITIONAL MIDLEVEL PRACTITIONER/ELIGIBLE BILLER INFORMATION: □ADD □CHANGE □TERM*

NAME____________________SPECIALTY____________

DOB__________UPIN__________DEA#__________LICENSE__________

EFFECTIVE DATE____________________SUPERVISING PHYSICIAN____________

NAME____________________SPECIALTY____________

DOB__________UPIN__________DEA#__________LICENSE__________

EFFECTIVE DATE____________________SUPERVISING PHYSICIAN____________

NAME____________________SPECIALTY____________

DOB__________UPIN__________DEA#__________LICENSE__________

EFFECTIVE DATE____________________SUPERVISING PHYSICIAN____________

NAME____________________SPECIALTY____________

DOB__________UPIN__________DEA#__________LICENSE__________

EFFECTIVE DATE____________________SUPERVISING PHYSICIAN____________

ADDITIONAL GENERAL OFFICE/BILLING INFORMATION: □ ADD □ CHANGE □ TERM*

PHYSICAL PRACTICE LOCATION: OFFICE NAME____________________

ADDRESS____________________CITY__________STATE______ZIP________

PHONE____________________FAX____________________

EMAIL ADDRESS____________________TAX ID#**____________________

EFFECTIVE DATE____

PHYSICAL PRACTICE LOCATION: OFFICE NAME____________________

ADDRESS____________________CITY__________STATE______ZIP________

PHONE____________________FAX____________________

EMAIL ADDRESS____________________TAX ID#**____________________

EFFECTIVE DATE____

PHYSICAL PRACTICE LOCATION: OFFICE NAME____________________

ADDRESS____________________CITY__________STATE______ZIP________

PHONE____________________FAX____________________

EMAIL ADDRESS____________________TAX ID#**____________________

EFFECTIVE DATE____

COMMENTS____

***If you have a Tax ID# change, please remember to submit a new W-9 Form to Community Partners Health Plans.*