Credentialing Application Request/ Provider Enrollment Form (CAR/PE FORM)

Practitioner Information

Last: ____________ **First:** ____________ **Middle:** ____________ **Suffix:** ________

Degree/License: ____________ **DOB:** ________ **Gender:** ___ **NPI#:** ____________

Primary Specialty: ____________ **Secondary Specialty:** ____________

Additional Specialties: ____________________________

Phone: ____________ **Email Address:** ____________________

☐ **Curriculum Vitae – Submitted in Month/Year Format** *(MUST BE ATTACHED)*

Licensing Status: ☐ Applicant is licensed in New Mexico ☐ Application has been submitted to State Licensing Board **(receipt attached)**

Credentialing Information

Select the entity applying to practice at:

☐UNMH	UNMH Department:	
☐UNMMG	UNMMG Clinic/Program:	
☐SRMC	SRMC Clinic Services:	

Credentialing Entry Point:

Anticipated Start Date: ____________________

*(If employed/contracted, indicate start date. *Please allow at least 60 days – or longer if not yet licensed)*

Employed By:

☐ **UNM** ☐ **SRMC** ☐ **UNMH** ☐ **UNMMG** ☐ **UNM LOCUMS**

If NOT Employed:

☐ **Contract / PSA Name:** ____

☐ **Community Provider**

☐ **UNMH Children's Hospital** *(Clinical Service Chief invitation form attached)*

☐ **Pure Volunteer** *(MOU approved by Legal must be attached)*

Privilege Forms:

UNMH			
SRMC			
UNMMG			

☐ **Other Health Provider (OHP) Form completed and submitted**

Credentialing Liaison: *(Person to be copied on all correspondence)*

Name: ______________________ **Date:** ______________________

Email: ______________________ **Phone:** ______________________

Enrollment Information

(1) Will applicant need to complete billing packet? ☐ Yes ☐ No (if no, further information not required)

(2) If yes, name of person assisting with billing packet: ______________________

(3) If billing packet previously completed, will there be a change in practice location? ☐ Yes ☐ No

(4) Please select: ☐ PCP ☐ Specialist *(Please do not leave unchecked)*

(5) Behavioral Health Provider? ☐ Yes ☐ No *(Please do not leave unchecked)*

(6) Provider on a MOU? ☐ Yes ☐ No

(7) Telemedicine Provider ONLY? ☐ Yes ☐ No **If, yes, State:** ______________________

Practice Locations:

Tax ID	Facility/Clinic Name and Address	(Check Primary Location – PCP Only)
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐

NOTE: All practice locations will display on Find-A-Doc website excluding the following departments: Anesthesiology, Emergency Medicine, Emergency Department, Center for Reproductive Health, Pathology, Radiology.

Special Instructions for Provider Directory:

SECTION TO BE COMPLETED BY OCCS STAFF:

Has all sections been reviewed?

BH Confirmed: ☐ PCP Panel Confirmed: ☐ Specialty Excl Srvc Confirmed: ☐ Trauma Srvc Confirmed: ☐

NO FAD ☐ Managed Care Ready ☐ Cactus Enter Date: ______________________

1st Payer Notified Date: ______________________ Entered By: ______________________

Returning Notified Date: ______________________

Submit Completed form to:

CREDENTIALING Verification Office (CVO)
University of New Mexico Health System
Fax: 505.272.6055
Email: hsc-unmhs_cvo@salud.unm.edu

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Submission Date