



MVP Health Care Locum Tenens Registration Form

Physicians are required to undergo a full credentialing process if physician becomes a full-time employee at the facility/office.

Last name: _____ First name _____ MI ____

Date of birth: _____ Gender: M F

Name of Medical School: _____

Your Specialty: _____ Degree: _____

NYS License #: _____ Effective Date: _____

DEA #: _____ Provider NPI # _____

Medicaid #: _____ Medicare #: _____

Languages you speak: _____

Social Security # _____

Primary office address: _____

Practice Name: _____

City: _____ State: _____ Zip: _____

Phone : (____) _____ Answering service phone: _____

Fax: (____) _____ E-mail address: _____

Employer/Practice Tax ID number: _____

Please attach a copy of the following required documents with this form: NYS License, DEA certificate and proof of malpractice coverage. Failure to submit these documents will result in delay of your registration.

Physician signature _____ Date: _____

Mail the completed form and documents to:

**MVP Health Care
Credentialing Dept.
259 Monroe Avenue
Rochester, NY 14607**

**Or you may fax the documents to:
585-327-2289**

<p>For office use only:</p> <p>Effective Date _____</p> <p>Amisys Provider # _____</p>
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