MVP Health Care Anesthesiology Registration Form

Physicians who have completed a fellowship in pain management, and will be providing pain management services, are required to undergo a full credentialing process prior to billing for outpatient services.

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: <u>NYS License, DEA certificate and proof of malpractice coverage</u>. 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
Network Management
220 Alexander Street
Rochester, NY 14607

Or you may fax the documents
585-327-2289

For office use only:

Effective Date_______________

Amisys Provider #__________