Mid-Level and Ancillary Practitioner Registration

Instructions

MVP Mid-Level and Ancillary Practitioners who provide services in an MVP Health Care-participating physician’s practice must be registered with MVP. Mid-Level and Ancillary Practitioners subject to this registration requirement include all office-based physician extenders, including but not limited to: Nurse Practitioners (NP)*; Physician Assistants (PA); Certified Nurse Anesthetists (CRNA); Certified Nurse Midwives (CNM); Registered Nurse First Assistants (RNFA) who work exclusively in the hospital and are credentialed and privileged by the hospital.**

The information below will assist with completing the Mid-Level Registration. All Mid-Level Practitioners should refer to **Section 4: Provider Responsibilities of the MVP Provider Resource Manual** for all policies related to Mid-Level registration and contracting requirements.

1. This form should be completed only by Mid-Level and Ancillary Practitioners who have not previously been registered with MVP. If you are currently registered or were previously registered with MVP and wish to update information related to your registration, please submit such changes in writing utilizing the Provider Change of Information form.

2. When completing the Area of Specialization field on line 3 of the registration form, provide the specialty in which you were trained. Example: OB/GYN or Cardiology. Do not show NP, PA, CNM, etc. in this field.

3. Mid-Level and Ancillary Practitioners must provide a copy of their DEA if they will be prescribing controlled substances. Mid-Level and Ancillary Practitioners who do not prescribe controlled substances do not need to provide a copy of a DEA. If Mid-Level Practitioners indicate that they do not have a DEA, they must supply documentation in writing confirming that they do not have a DEA, and the DEA field on the form must indicate N/A.

4. Mid-Level and Ancillary Practitioners who have opted out of Fee-for-Service (FFS) Medicare may not render services to MVP Medicare Advantage patients. This is regardless of whether the MVP-participating physician with whom they practice has opted in to FFS Medicare and is a participating provider with MVP Medicare Advantage products.

5. Email your completed form to the Regional MVP office in your area (see email addresses below). Please include a copy or your DEA (if applicable) and License.

   East/Massachusetts Region
   Central Region/Mid-State/Southern Tier Region
   Vermont Region
   Rochester Region
   Mid-Hudson Region
   eastpr@mvphealthcare.com
   centralprdept@mvphealthcare.com
   vpr@mvphealthcare.com
   RocProviderChanges@mvphealthcare.com
   MidHudsonprdept@mvphealthcare.com
## Section 1: Demographic Information

<table>
<thead>
<tr>
<th>Name (Last, First)</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Social Security No.</th>
<th>Area of Specialization</th>
<th>Licensure (PA, NP, CNM, CRNA, etc.)</th>
</tr>
</thead>
</table>

**Language(s) Spoken, Other than English** *(check all that apply)*
- [ ] Spanish
- [ ] Hungarian
- [ ] Vietnamese
- [ ] Sindhi
- [ ] Malayalam
- [ ] Pashto/Pushto
- [ ] French
- [ ] Polish
- [ ] Armenian
- [ ] Yiddish
- [ ] Tagalog/Filipino
- [ ] Gujarati
- [ ] Italian
- [ ] Chinese
- [ ] Russian
- [ ] Hebrew
- [ ] Samoan
- [ ] Punjabi
- [ ] Afrikaans
- [ ] German
- [ ] Chinese-Cantonese
- [ ] Persian
- [ ] Sign-Language
- [ ] Haitian-Creole
- [ ] Other: ____________
- [ ] Greek
- [ ] Japanese
- [ ] Arabic
- [ ] Bengali-Bengla
- [ ] Marathi
- [ ] Other: ____________
- [ ] Portuguese
- [ ] Korean
- [ ] Hindi
- [ ] Twi
- [ ] Urdu
- [ ] Armenian
- [ ] Russian
- [ ] Persian
- [ ] Arabic
- [ ] Hindi
- [ ] Urdu

## Section 2: Education

<table>
<thead>
<tr>
<th>Name of Graduate School</th>
<th>Degree</th>
<th>Year Graduated</th>
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</thead>
</table>

## Section 3: License Numbers

<table>
<thead>
<tr>
<th>DEA No.</th>
<th>DEA State</th>
<th>Expiration Date</th>
<th>State License No.</th>
<th>State</th>
<th>Expiration Date</th>
</tr>
</thead>
</table>

**NPI No.** *(Required for Registration)*

**Medicaid Management Information System No.**

## Section 4: Insurance

<table>
<thead>
<tr>
<th>Name of Current Professional Liability Carrier</th>
<th>Policy No.</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Carrier Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Amount of Coverage</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Section 5: Practice Site Information

<table>
<thead>
<tr>
<th>Practice Site 1</th>
<th>Group</th>
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<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Group</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Service Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone Number ( )</th>
<th>Fax Number ( )</th>
<th>Employer/Practice Tax ID No.</th>
<th>Hours per Week at this Practice</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Collaborating Physician</th>
<th>Collaborating Specialty</th>
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</thead>
</table>

*Continued on page 2*
### Section 5: Practice Site Information (continued)

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Address</td>
<td>City</td>
</tr>
<tr>
<td>Phone Number ( )</td>
<td>Fax Number ( )</td>
</tr>
</tbody>
</table>

| Practice Site 2 | Collaborating Physician | Collaborating Specialty |

### Section 6: Contact Information (required)

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Contact Phone Number ( )</th>
</tr>
</thead>
</table>

Contact Email