Provider Credentialing Application Request

Request Date

Group Name | Group/Practitioner Tax ID No.

Practitioner Name *(Last, First, Middle Initial)* | Practitioner Degree *(e.g. MD, DO, PT)*

Practitioner NPI No. | Practitioner CAQH No. | Requested Specialty

License No. | License State ☐ NY ☐ VT ☐ PA ☐ CT ☐ MA

Medicaid Management Information System No. (MMIS#)* | Category ☐ PCP ☐ Specialist ☐ PCP and Specialist

*Providers wishing to see MVP Medicaid Managed Care, MVP Child Heath Plus, and MVP Harmonious Health Care Plan members in New York State must have an active Medicaid Management Information System number (MMIS#) with New York State. Providers are not required to see New York State Medicaid patients; however you must be registered with an MMIS number. Providers who do not have an active MMIS number will not be able to participate with MVP Medicaid Managed Care, MVP Child Heath Plus, and MVP Harmonious Health Care Plan. Providers wishing to obtain an MMIS number should visit **emedny.org** and select *Provider Enrollment*.

Primary Practice Location

Service Address

City | State | Zip Code+4 | County

Office Phone ( ) | Office Fax ( )

Does the Practice you are joining have an existing group contract with MVP? ☐ Yes ☐ No ☐ Do not know

Is the provider providing services in the inpatient setting only? ☐ Yes ☐ No

Is the provider providing urgent care services? ☐ Yes ☐ No

Contact Information

Name | Phone ( )

Email

Please email a copy of this completed form to **ProviderEnrollment@mvphealthcare.com** and include the county and state in which the provider is practicing in the subject line.

MVP Internal Use

SF No.	REMIT	FTR	LMT	ATTACH	DD	ASGN	RGN/FS	LOB