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); Opticians; 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 and Ancillary 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 of the collaboration physicians. MVP requires the specialty of all registered mid-levels to be the same as their collaborating physicians, if the specialty on the form does not match the participating collaborating physician, the Mid-Level will not be able to be registered. 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 license to practice in the state for which they are applying.
4. 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.
5. 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.
6. Opticians are required to be contracted with MVP. After completing this form and submitting it to MVP with a copy of their license, they will receive a contract from MVP. They must sign the contract and return it to MVP. Opticians are not required to provide a collaborating physician.
7. Opticians are required to provide a W-9 with their license and contract.
8. Providers wishing to see MVP Medicaid Managed Care, Child Health Plus, and Harmonious Health Care Plan members must have an active New York State Medicaid Management Information System number (MMIS#). Providers are not required to see New York State Medicaid patients; however you must be registered with an MMIS#. Providers who do not have an active MMIS# will not be able to participate with MVP Medicaid Managed Care, MVP Child Health Plus, or MVP Harmonious Health Care Plan®. Providers wishing to obtain an MMIS# should visit **emedny.org/info/providerenrollment**.
9. Mid-Level and Ancillary providers who meet the registration requirements **must** not see MVP members until they have completed the registration process and have received a welcome letter from MVP confirming their participation status. MVP will not reimburse providers for services provided to an MVP member if the provider is not participating with MVP.
10. Email your completed form to **MVPPR@mvphealthcare.com**. Please include a copy or your DEA (if applicable) and License.

* Psychiatric Nurse Practitioners practicing in a group or practicing independently will be required to be contracted and credentialed with MVP. Nurse Practitioners and Certified Nurse Midwives in the state of New York who render services in an independent practice, not in an MVP participating physician's office, or would like to be listed in the directory are not eligible for registration with MVP. Such NPs and CNMs must be credentialed and have a completed contract with MVP.

** RNFAs who work independently must go through the contracting and credentialing process.

Mid-Level and Ancillary Practitioner Registration

Section 1: Demographic Information

Name *(Last, First)* | Date of Birth | Gender ☐ Male ☐ Female

Social Security No. | Area of Specialization | Licensure *(PA, NP, CNM, CRNA, etc.)*

Language(s) Spoken, Other than English *(check all that apply)*

☐ Spanish	☐ French	☐ Italian	☐ German	☐ Greek	☐ Portuguese
☐ Hungarian	☐ Polish	☐ Chinese	☐ Chinese-Cantonese	☐ Japanese	☐ Korean
☐ Vietnamese	☐ Armenian	☐ Russian	☐ Persian	☐ Arabic	☐ Hindi
☐ Sindhi	☐ Yiddish	☐ Hebrew	☐ Sign-Language	☐ Bengali-Bengla	☐ Twi
☐ Malayalam	☐ Tagalog/Filipino	☐ Samoan	☐ Haitian-Creole	☐ Marathi	☐ Urdu
☐ Pashto;pushto	☐ Gujarati	☐ Punjabi	☐ Afrikaans	☐ Other: _____	

Section 2: Education

Name of Graduate School | Degree | Year Graduated

Section 3: License Numbers

DEA No. | DEA State | Expiration Date | State License No. | State | Expiration Date

NPI No. *(Required for Registration)* | Medicaid Management Information System No.

Section 4: Insurance

Name of Current Professional Liability Carrier | Policy No.

Carrier Address | City | State | Zip Code

Amount of Coverage $ | From | To

Section 5: Practice Site Information

Practice Site 1

Effective Date | Group

Service Address | City | State | Zip Code

Phone Number ( ) | Fax Number ( ) | Employer/Practice Tax ID No. | Hours per Week at this Practice

Collaborating Physician | Collaborating Specialty

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Applicant Name: Social Security No.

Section 5: Practice Site Information *(continued)*

Practice Site 2

Effective Date	Group		
Service Address	City	State	Zip Code
Phone Number ( )	Fax Number ( )	Employer/Practice Tax ID No.	Hours per Week at this Practice
Collaborating Physician	Collaborating Specialty		

Section 6: Contact Information *(required)*

Contact Name	Contact Phone Number ( )
Contact Email	