



EMI HEALTH HOSPITAL OR FACILITY-BASED PROVIDER FORM

EMI Health • 852 East Arrowhead Lane • Murray, Utah 84107-5298 • 801-262-7975

Group/Provider Name	Tax ID #	Billing NPI#
---------------------	----------	--------------

OFFICE CONTACT		
NAME	ADDRESS	
TELEPHONE	EMAIL ADDRESS	FAX

Please check your principal fields of specialization:

<input type="checkbox"/> Advanced Registered Nurse Practitioners (ARNP)	<input type="checkbox"/> Pathologists
<input type="checkbox"/> Anesthesiologists	<input type="checkbox"/> Physical Therapists
<input type="checkbox"/> Certified Registered Nurse Anesthetists (CRNA)	<input type="checkbox"/> Radiation Oncologists
<input type="checkbox"/> Emergency Room Physicians	<input type="checkbox"/> Radiologists
<input type="checkbox"/> Hospitalists	<input type="checkbox"/> Respiratory Therapists
<input type="checkbox"/> Neonatologists	<input type="checkbox"/> Registered Dietitians
<input type="checkbox"/> Occupational Therapists	<input type="checkbox"/> Speech Therapists

Please check that providers meet the following criteria:

_____ The providers are employees of a participating Joint Commission, HFAP, or DNVHC accredited hospital or facility.

OR

_____ The providers are active staff members of a participating Joint Commission, HFAP, or DNVHC accredited hospital or facility.

AND

_____ Participate with EMI Health only in their capacity as an employee or active staff member of the aforementioned hospital or facility.

AND

_____ The hospital or facility they are affiliated with can demonstrate Joint Commission, HFAP, or DNVHC accreditation is in good standing.

AND

_____ The provider's specialty is included on the above list of hospital providers exempted from the credentialing process.

AND

_____ The provider utilizes either the facility's Tax ID number or the exempted group's Tax ID number for billing purposes.

Please attach a roster including the following information:

- 1. Provider's Full Name
- 2. Practice and Billing Addresses (w/phone and fax numbers please)
- 3. Provider Type and Specialty (i.e. Anesthesia, Certified Nurse Anesthetist)
- 4. Individual NPIs
- 5. Hospital Affiliations
- 6. Medicare Number
- 7. Social Security Number
- 8. Date of Birth

All information is complete and accurate to the best of my knowledge. I understand that this application does not entitle the providers represented on this application to continued participation with EMI Health. On behalf of those providers, I authorize EMI Health to consult with, and inspect all documents from individuals and organizations having information bearing on our qualifications. We agree that EMI Health, its representatives, and any individuals or entities providing information to EMI Health in good faith pursuant to this release shall not be liable for any act or omission related to the evaluation or verification or information in this application. I further agree to notify EMI Health of any change to the information requested by this application.

Signature of Responsible Party

Date

EMI.FAC-PROV-APP.0311.0061



PLEASE NOTE THAT THIS INFORMATION WILL BE TREATED AS CONFIDENTIAL