



EMI HEALTH PROVIDER FORM

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

PERSONAL

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
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PRACTICE STATUS: INDIVIDUAL GROUP OTHER: _____

PLEASE CHECK BOX OF NPI NUMBER USED FOR BILLING: INDIVIDUAL: _____ GROUP: _____

PRINCIPAL OFFICE LOCATION			
STREET			
CITY	STATE	ZIP	COUNTY
TELEPHONE	TAX ID NUMBER		
FAX	EMAIL ADDRESS		

SECONDARY OFFICE LOCATION			
STREET			
CITY	STATE	ZIP	COUNTY
TELEPHONE	TAX ID NUMBER		
FAX	EMAIL ADDRESS		

Please indicate your mailing and billing address if it is different than your Principal Office Location. Attach addresses for any additional locations.

Membership in Professional Societies or Associations.

Name	Address

PRACTICE

Provider's Date of Birth (if applicable)	Office Manager's Name
Primary State of Licensure / License Number (please enclose copy)	Secondary State of Licensure / License number (please enclose copy)
DEA Number (please enclose copy, if applicable)	Medicare Number

SPECIALTY

Please check your principal fields of specialization (up to two):

<input type="checkbox"/> APRN, NP (Psych Services)	<input type="checkbox"/> Ambulatory Surgical Center	<input type="checkbox"/> Laboratory
<input type="checkbox"/> Psychologist	<input type="checkbox"/> Audiologist	<input type="checkbox"/> Licensed Professional Counselor
<input type="checkbox"/> Radiological Imaging Center	<input type="checkbox"/> Cancer Treatment Center	<input type="checkbox"/> Marriage and Family Counselor
<input type="checkbox"/> Residential Facility	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Respiratory Therapist	<input type="checkbox"/> Dialysis Center	<input type="checkbox"/> Optometrist
<input type="checkbox"/> Skilled Nursing	<input type="checkbox"/> Durable Medical Equipment	<input type="checkbox"/> Perfusionist
<input type="checkbox"/> Social Worker	<input type="checkbox"/> Genetic Counselor	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Speech Therapist	<input type="checkbox"/> Home Health Agency	
<input type="checkbox"/> Other _____		

LIABILITY

Liability Carrier	Policy Number
Amount of Coverage per Occurrence	Aggregate
<p>Malpractice Action</p> <p>Number of Malpractice Claims: _____ (if none, please write "none.")</p> <p>Number of prior malpractice judgements or settlements within the last ten years: _____ (if none, please write "none.")</p> <p style="text-align: center;">For each malpractice action, please attach an explanation to this application.</p>	

EDUCATION

School of Education	Location	Year Graduated
Internship	Location	Dates: From / to
Residency	Location	Dates: From / to
Fellowships		
Teaching Appointments	Name while attending school	
If Applicable: Foreign Medical Graduate Number	If you are fluent in languages other than English, please list:	

Do you have any other partners / associates in your practice? Yes No

Have you been subject to any of the following:

Suspensions or limitations to your practice? Yes No

Suspensions as a Medicare or Medicaid provider? Yes No

Professional liability insurance cancellation in the past five years? Yes No

Denied membership in any organization or health care institution, HMO, or PPO? Yes No

State licensing investigations or actions? Yes No

DEA licensing investigations or actions? Yes No

Conviction of a felony, fraud, moral, or ethical crime? Yes No

Chronic illness or physical defect that would impair your ability to practice your specialty? Yes No

Ownership in any facility or joint ownership of a facility to which you might refer patients? Yes No

Please attach an explanation of any questions answered "yes."

Are you accepting new patients? Yes No

Are you routinely available for patient care at least four full days per week? Yes No

If not, what are your office hours?: _____

What, if any, limitations do you have on the age range of your patients?

Approximately how many patients do you see per day, when you are in your office?

What, if any, limitations do you have on accepting new patients?

What arrangements do you have to provide 24-hour, 7-day-per-week coverage for your patients?

Briefly describe the general levels of care that you currently offer:

Please submit the following with your application:

- 1. A copy of your current state license(s)
- 2. Proof of malpractice coverage (the policy face sheet or certificate of insurance, with effective dates)
- 3. Any explanations requested elsewhere in this application
- 4. A copy of your education certificate(s)
- 5. Additional mailing, billing, or office addresses or additional active staff hospital affiliations
- 6. A copy of your DEA certificate (if applicable)
- 7. Release form
- 8. Five year work history
- 9. W-9 tax form
- 10. Accreditations / CMS 2567 (facility only)

All information is complete and accurate to the best of my knowledge. We understand that this application does not entitle us to continued participation with EMI Health. We 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. We further agree to notify EMI Health of any change to the information requested by this application.

Signature of Responsible Party

Date

EMI.PROV.PROV-APP.0111.0025



PLEASE NOTE THAT THIS INFORMATION WILL BE TREATED AS CONFIDENTIAL