elm & oak HEALTH

Formerly Known As
Monroe Plan for Medical Care

ENROLLMENT APPLICATION REQUIRED DOCUMENTATION CHECKLIST

Please submit current copies of ALL of the documentation listed below to PFMemails@elmandoakhealth.com. Any missing or inaccurate information will delay the enrollment process.

- W-9 form
- Disclosure and Ownership Form (Facility Credentialing ONLY)
- NYS License
- NYS MMID
- DEA
- Proof of Malpractice Insurance
- Group Roster
- Supervising/Collaboration physician form (midlevels only)

***If credentialing is required, the process will begin once the application is deemed complete and may take up to 60 days. You will not be considered in-network until formal approval is issued. Notification will be sent to the contract contact listed in CAQH upon completion.

***Providers designated as a PCP at a service location must maintain a minimum of 16 hours per week of on-site availability at that location.

Mail or Fax documents to:
Elm & Oak Health
1120 Pittsford Victor Road
Pittsford, NY 14534
Fax: 716-748-6987
Email: PFMemails@elmandoakhealth.com

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APPLICATION FOR PROVIDER ENROLLMENT

To begin the enrollment process, please complete the information appropriate to your specialty. Complete and return with the items on the attached checklist. All information must match NPPES.

***Please ensure that your CAQH information is completed and released to us with the most up-to-date information.

Today's Date:	**Requested Effective Date:**	**Group Name:**
Group TAX ID:	**Group NPI:**	**Provider Name:**
Individual NPI#:	**SSN#:**	**DOB:**
Gender: ☐ Male ☐ Female	**Provider License#/State:**	**DEA Certificate#:**
CAQH#: **MEDICAID #:**	**Accepting new patients?** ☐ YES ☐ NO **PCP?** ☐ YES ☐ NO **Panel?** ☐ OPEN ☐ CLOSE	**Language(s) other than English:**

Taxonomy Code (required). Circle One: MD ☐ DO ☐ PA ☐ NP ☐ Other: ☐ _____

Primary Specialty:	**Taxonomy Code:**
Second Specialty:	**Taxonomy Code:**
Third Specialty:	**Taxonomy Code:**

Please note: A correspondence street level address must be applied when a remittance address is a PO Box. Please use additional sheets when needed for multiple addresses.

Address A PCP at this location? Y or N	**Street:**_____ **STE:**_____ **City:**_____ **State:**_____ **ZIP Code:**_____	○ **Primary Office** ○ **Additional Office** ○ **Correspondence** ○ **Remittance** ○ **Medical Record**
Phone:_____ **Fax:**_____	**Office Hours:**	**Handicap accessible: Y or N** ☐ ☐ **Public Transportation: Y or N** ☐ ☐

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Address B **PCP at this location? Y or N**	**Street:**_____ **STE:**_____ **City:**_____ **State:**_____ **ZIP Code:**_____	○ **Primary Office** ○ **Additional Office** ○ **Correspondence** ○ **Remittance** ○ **Medical Record**
Phone:_____ **Fax:**_____	**Office Hours:**	**Handicap accessible: Y or N** ☐ ☐ **Public Transportation: Y or N** ☐ ☐
Address C PCP at this location ? Y or N	**Street:**_____ **STE:**_____ **City:**_____ **State:**_____ **ZIP Code:**_____	○ **Primary Office** ○ **Additional Office** ○ **Correspondence** ○ **Remittance** ○ **Medical Record**
Phone:_____ **Fax:**_____	**Office Hours:**	**Handicap accessible: Y or N** ☐ ☐ **Public Transportation: Y or N** ☐ ☐
Address D PCP at this location? Y or N	**Street:**_____ **STE:**_____ **City:**_____ **State:**_____ **ZIP Code:**_____	○ **Primary Office** ○ **Additional Office** ○ **Correspondence** ○ **Remittance** ○ **Medical Record**
Phone:_____ **Fax:**_____	**Office Hours:**	**Handicap accessible: Y or N** ☐ ☐ **Public Transportation: Y or N** ☐ ☐

All members can make an appointment and be treated at ***Address*: *A* ☐ *B* ☐ *C* ☐ *D* ☐**	Hospitalist at ***Address*: *A* ☐ *B* ☐ *C* ☐ *D* ☐**

Should provider be listed in directory? Yes or No

Reminder: Physician Assistants (PAs) are not listed in the directory.

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OFFICE CONTACT INFORMATION

Please use this space for indicating the best points of contact for each category. All email communications will also be sent to the email listed under "General Elm & Oak Updates"

Best contact (Please list name or N/A)	Email	Phone Number
General Elm & Oak Updates		
Credentialing-		
Office Manager-		
Quality-		
Clinical-		
Pharmacy-		
Billing-		

Authorized person completing form:

Name:	Phone:	Email:

Mail or Fax documents to:
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Supervising/Collaboration Physician Form

Name of Midlevel:	
NP/PA:	
NPI:	
Name of Supervising/Collab Physician:	
NPI of Physician:	
Effective date:	

Authorized person completing form:

Name:	Phone:	Email:

Mail or Fax documents to:
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Pittsford, NY 14534
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Email: PFMemails@elmandoakhealth.com