NURSE PRACTITIONER / PHYSICIAN ASSISTANT REGISTRATION FORM

This Form is accepted by Aetna/RCIPA, Excellus, Monroe Plan, and MVP Health Care.

This form has been developed by the Monroe County Medical Society, in conjunction with area hospitals, managed care organizations and other health care facilities.

Applicant Name:______________________________ **DOB:**________________ **Effective Date of Registration:** ____________________
(Last, First, MI) (mm/dd/yyyy) (mm/dd/yyyy)

Social Security #:________________________________

Gender: ❑ **Female** ❑ **Male**

Please check one of the following and complete the form below:

❑ **Nurse Practitioner** ❑ **Physician Assistant** ❑ **CDE** ❑ **CRNA** ❑ **Nutritionist**

DEMOGRAPHIC INFORMATION

Primary Office Address:____ **City**:______________ **ST**:_____ **Zip**:_________

Office Phone: ___________________**Cell:**____________________**Fax**:_____________________**Pager**:____________________

Add'l Office Address:____**City**:______________ **ST**:_____ **Zip**: _________

Office Phone: ____**Fax:** ____

Correspondence Address:____**City**:______________ **ST**:_____ **Zip**: _________

Remittance Address:____**City**:______________ **ST**:_____ **Zip**: _________

NPI Billing No: ____**Remittance Phone**: ____________________________

Medical Records Address:____**City**:______________ **ST**:_____ **Zip**: _________

IMPORTANT INFORMATION REGARDING DEMOGRAPHIC INFORMATION

Primary Office Address: A Provider (ID) is only allowed one Primary Location Address. This address MUST be identified by street level information with corresponding City, ST and ZIP. PO Box data is NOT allowed.

Add'l Office Address: A Provider (ID) is allowed additional office location addresses. These addresses MUST be identified by street level information with corresponding City, ST and ZIP. PO Box data is NOT allowed.

Correspondence Address: A Provider (ID) is only allowed one Correspondence Address. This address MUST be identified as a valid USPS mailing address. ***If PO Box information is provided,*** the corresponding City, ST and ZIP for the PO Box must be provided. Do not include street level information.

Remittance Address: A Provider (ID) is only allowed one Remittance Address *(checks and remittances*). This address MUST be identified as a valid USPS mailing address. ***IF PO Box information is provided,*** the corresponding City, ST and ZIP for the PO Box must be provided. Do not include street level information.

Medical Records Address: A Provider (ID) is only allowed one Medical Records Address. This address MUST be identified as a valid USPS mailing address. ***If PO Box information is provided,*** the corresponding City, ST and ZIP for the PO Box must be provided. Do not include street level information.

EDUCATION/LICENSES

(Please attach copies of your diploma and licenses as listed below.)

Graduate School:__________________________ **Graduation Date**:_____________**Degree**: ___________________
(mm/dd/yyyy)

License No:____ **Expiration Date**:___________________
(mm/dd/yyyy)

DEA #:____ **Expiration Date**:___________________
(mm/dd/yyyy)

Medicaid #: ______________________ **Medicare #**:_____________________**NPI No**: _________________________

LIABILITY INSURANCE

(Please attach copy of current certificate.)

Policyholder Malpractice Insurance *(choose one)*: ❑ **Self** ❑ **Collaborating Physician** ❑ **Other**

APPLICANT'S SIGNATURE

Applicant's Signature:____**Date**:___________________

COLLABORATING PHYSICIAN INFORMATION AND AGREEMENT

Collaborating Physician Name:___________________________________ **Specialty**: ______________________

Physician's NPI No: _______________________________**Group NPI No**:_______________________________

(If physician is part of a group)

Medical Practice Group Name: ____

Billing Tax ID No: _________________________________ ***(Please attach copy of current W9 Form.)***

I, the undersigned, hereby verify and attest that I am the collaborating physician for the above-named applicant. As required by applicable laws, I have satisfied myself as to the ability and competency of this applicant and that the functions that the applicant will carry out are performed under my collaboration and oversight.

Collaborating Physician's Name *(print name)*: ____

***Collaborating Physician's Signature*:** ____

Date: ______________________