CovenantHealth Accountable Care Organization

CovenantHealth Covenant Health Partners

Participating Provider Application

INSTRUCTIONS

This form should be typed or legibly printed in black or blue ink. If more space for additional information is needed, please attach additional sheets and reference the section/question being answered.

Please email completed and/or future applications to marisa.fuentes@covhs.org or covhealthpartners@covhs.org

1. IDENTIFYING INFORMATION

First Name: _____	Middle Name: _____	Last Name: _____
Credentials: _____	Specialty/Scope of Care: _____	
NPI: _____	Taxonomy: _____	Supervising Physician: _____ ☐ N/A
Provider Cell: _____	Provider Email: _____	
Alternate Cell: _____	Alternate Email: _____	
Board Certified? ☐ Yes ☐ No	If not certified, is this provider Eligible for Board Certification? ☐ Yes ☐ No	Employment Date: _____

2. PRACTICE INFORMATION

Organization/Clinic Name : _____		Group TIN: _____ ☐ N/A
Clinic Address: _____	Clinic City, State & Zip: _____	
Clinic Phone: _____	Clinic Fax: _____	Clinic Email: _____
Primary Practice Location (if different from above): _____		Group NPI: _____ ☐ N/A
Mailing Address: _____ ☐ N/A	Clinic City, State & Zip: _____ ☐ N/A	
Clinic Manager: _____	Manager Phone: _____	Manager Email: _____
Please list any additional preferred contact information:		

3. ELECTRONIC HEALTH RECORD

EHR Name/Vendor: _____	EHR Version: _____	Can patients access a secure patient portal? ☐ Yes ☐ No
Is your current EHR version connected to a Health Information Exchange (HIE)? ☐ Yes ☐ No	If yes, what HIE? _____ ☐ N/A	

Is your current EHR version capable of producing a QRDA Type 1 and QRDA Type 3 file inclusive of the following metrics?	QRDA T1	QRDA T3
☐ CMS 2: Depression Screening & Follow-Up ☐ CMS 165: Controlling High Blood Pressure ☐ CMS 130: Colorectal Cancer Screening	☐ Yes	☐ Yes
☐ CMS 122: Glycemic Index Assessment (A1c) > 9% ☐ CMS 125: Breast Cancer Screening	☐ No	☐ No

4. BILLING INFORMATION

Business/Entity Name: _____	Billing TIN: _____	EIN: _____ - _____
Billing Address: _____ ☐ N/A	Billing City, State & Zip: _____ ☐ N/A	
Does this practice utilize a 3rd party billing software/vendor/platform? ☐ Yes ☐ No	Billing software/program name: _____	
Is your current billing software/program capable of producing either of the following exports?		
☐ CPT-level encounter report (Required for MSSP Participation) ☐ Yes ☐ No	☐ 837 Claim Files (Required for MSSP Participation)	☐ Yes ☐ No

Continue Application on Page 2.

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Participating Provider Application (Continued)

CERTIFY YOUR APPLICATION BELOW

☐ I have read and understood the contents of this application in its entirety and I certify that I am legally authorized to execute this document.

☐ By my signature, I certify that I have completed the attached membership questionnaire to the best of my ability and commit to supporting the administrative and contractual requirements set forth by Covenant Health Partners (CHP) and the Covenant Accountable Care Organization (ACO).
The information contained herein is true, correct and complete; I authorize CHP to verify the information provided and I understand and agree that CHP will share the content of this application, including any/all information and documents submitted with this application, with the CHP Board of Directors and physician committees.
If I become aware that any information in this application is not true, correct, or complete, I agree to notify CHP of this fact immediately and to provide the correct and/or complete information to the best of my ability.

SIGNATURE

Applicant Name:

Date:

Print Name (If different from Applicant):

Signature:

↓ CHP OFFICE USE ONLY ↓

Board Review Date: _____ ACO Effective Date: _____ CHP Effective Date: _____

Network Eligibility:	Yes	No
Aetna HRA/HSA	☐	☐
Aetna EPO	☐	☐
BSW Premier	☐	☐
EHN Network	☐	☐
Value-Based Care Plans	**Yes**	**No**
MSSP	☐	☐
Medicare Advantage	☐	☐
Medicaid	☐	☐
Commercial VBC	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

Notes: