SAINT ALPHONSUS
HEALTH ALLIANCE

PRACTICE AND PROVIDER INFORMATION SHEET

Email completed form to SAHS-Alliance@sarmc.org or fax to 208-367-8762

The information provided on this form is required for claims processing and payer directories. Please complete the entire form for new providers.

Start Date of Provider or Effective Date of Change:
SAHA is unable to guarantee an effective date. Some network payers assign their own effective date.

☐ Add Provider to Group ☐ Add a New Location ☐ Update Information ☐ Termination Reason:

PROVIDER INFORMATION (name as shown on license) Individual NPI:

Name:		Degree/Title:	Date of Birth:
Idaho Licensure	Oregon Licensure	Provider Email:	
State:	State:	Types of Insurance Accepted	
DEA:	DEA:	☐ Commercial ☐ Medicare Advantage ☐ Medicaid	
Controlled Substance:			

Does provider work at a practice/TIN other than that listed below? ☐ Yes ☐ No If yes, what percentage of provider's time is spent at practice listed below: %

PRACTICE LOCATION INFORMATION (place of service as billed on patient claims) TIN: (one per form)

Practice Web Address:	EMR System:
Primary Practice Name: (as it should appear in directories)	Group NPI: (CMS 1500 Box 33a or UB Box 56)
Office Address: (Street, City, State, Zip)	Ages Treated:
Office Phone: Office Fax:	Accepting New Patients: ☐ Yes ☐ No
Days and Hours of Operation:	Telehealth[2] Offered: ☐ Yes ☐ No
ADA Accommodations: ☐ Yes ☐ No Translation and/or Interpreter Services: ☐ Yes ☐ No	Publish Provider in Directories: ☐ Yes ☐ No
Provider Practicing Specialty:	Accepting Appointments: ☐ Yes ☐ No
Provider Type at Location: (only check 1) ☐ PCP ☐ Specialist ☐ Urgent Care ☐ Hospital Based[1]	
Credentialing Contact Name:	Credentialing Contact Email:
Practice Manager Name:	Practice Manager Email:

BILLING INFORMATION (as billed on CMS 1500 box 33a or UB box 2)

Remit Address: (Street, City, State, Zip)	
Billing Phone:	Billing Fax:
Billing Contact Name:	Billing Contact Email:

ADDITIONAL PRACTICE LOCATION INFORMATION Please list all locations at which the practitioner will be providing services under the listed TIN.

Additional Practice Name: (as it should appear in directories)	Group NPI: (CMS 1500 Box 33a or UB Box 56)
Office Address: (Street, City, State, Zip)	Ages Treated:
Office Phone: Office Fax:	Accepting New Patients: ☐ Yes ☐ No
Days and Hours of Operation:	Telehealth[2] Offered: ☐ Yes ☐ No
ADA Accommodations: ☐ Yes ☐ No Translation and/or Interpreter Services: ☐ Yes ☐ No	Publish Provider in Directories: ☐ Yes ☐ No
Provider Practicing Specialty:	Accepting Appointments: ☐ Yes ☐ No
Provider Type at Location: (only check 1) ☐ PCP ☐ Specialist ☐ Urgent Care ☐ Hospital Based[1]	

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Additional Practice Name: (as it should appear in directories)					Group NPI: (CMS 1500 Box 33a or UB Box 56)		
Office Address: (Street, City, State, Zip)					Ages Treated:		
Office Phone:		Office Fax:			Accepting New Patients:	☐ Yes	☐ No
Days and Hours of Operation:					Telehealth[2] Offered:	☐ Yes	☐ No
ADA Accommodations:	☐ Yes ☐ No	Translation and/or Interpreter Services:	☐ Yes ☐ No		Publish Provider in Directories:	☐ Yes	☐ No
Provider Practicing Specialty:					Accepting Appointments:	☐ Yes	☐ No
Provider Type at Location: (only check 1)	☐ PCP	☐ Specialist	☐ Urgent Care	☐ Hospital Based[1]			
Additional Practice Name: (as it should appear in directories)					Group NPI: (CMS 1500 Box 33a or UB Box 56)		
Office Address: (Street, City, State, Zip)					Ages Treated:		
Office Phone:		Office Fax:			Accepting New Patients:	☐ Yes	☐ No
Days and Hours of Operation:					Telehealth[2] Offered:	☐ Yes	☐ No
ADA Accommodations:	☐ Yes ☐ No	Translation and/or Interpreter Services:	☐ Yes ☐ No		Publish Provider in Directories:	☐ Yes	☐ No
Provider Practicing Specialty:					Accepting Appointments:	☐ Yes	☐ No
Provider Type at Location: (only check 1)	☐ PCP	☐ Specialist	☐ Urgent Care	☐ Hospital Based[1]			
Additional Practice Name: (as it should appear in directories)					Group NPI: (CMS 1500 Box 33a or UB Box 56)		
Office Address: (Street, City, State, Zip)					Ages Treated:		
Office Phone:		Office Fax:			Accepting New Patients:	☐ Yes	☐ No
Days and Hours of Operation:					Telehealth[2] Offered:	☐ Yes	☐ No
ADA Accommodations:	☐ Yes ☐ No	Translation and/or Interpreter Services:	☐ Yes ☐ No		Publish Provider in Directories:	☐ Yes	☐ No
Provider Practicing Specialty:					Accepting Appointments:	☐ Yes	☐ No
Provider Type at Location: (only check 1)	☐ PCP	☐ Specialist	☐ Urgent Care	☐ Hospital Based[1]			

SUMMARY OF CHANGES

Completed by:	Email:	Phone:

[1]Hospital-Based Provider Type - Practitioner is not required to credential with SAHA and is considered "Hospital-Based" if:

- Provides health care services within a facility (i.e. Hospital, Ambulatory Surgery Center, etc.) in which they are privileged by that facility,
- Does not accept appointments for health care services at the facility (will not appear in directories), and
- Exclusively sees patients who have been directed to the facility for health care services.

If the practitioner provides health care services at any other location not identified as Hospital-Based, credentialing is required.

[2]Telehealth - If only telehealth services are offered at a practice location, please add "Telehealth Only" at the end of the practice name.