aetna COVENTRY

# PROVIDER CREDENTIALING REQUEST FORM

| Aetna Contracting Rep: | DATE: | Contract ID#: |
|---|---|---|

## GROUP INFORMATION

| W9 Legal Name: ACCESS HEALTH CARE PHYSICIANS LLC | | | | Tax ID# 451444883 | |
|---|---|---|---|---|---|
| Group Primary Address: ryfdfjkfhkg, yuifurf, oll, 346089 | | | | # of Locations | #Of Group Practitioners |
| Contract Group Type: | Group ☐ | Solo ☐ | Multi-Spec Group ☑ | Office Administrator: Diane Burkhardt | |
| Phone: | Fax: 5569477 | Email: dburkhardt@accesshealcarellc.net | | | |

**Individual Provider Profile:**

(Complete in it's entirety for **Each** Provider in the Group and/or to be credentialed even if using CAQH database)

(FOR OFFICE USE ONLY)

| PROVIDERS NAME: Pariksith Singh.MD | SPECIALTY (Primary): Internal Medicine | CPD # / EPDB # |
|---|---|---|
| NPI# 1417989625 | SOCIAL SECURITY # 052829007 | DATE OF BIRTH: 6/23/1968 12:00:00 AM |
| MEDICARE # 31545S | MEDICAID # 006385500 | WORKERS COMP # |
| CAQH#: *database info MUST be current 10721240 | MEDICAL LIC # MM29257 | DEA LIC # BS4971354 |
| LAST ATTESTATION DATE: | MD LIC EXPIRATION DATE: | BOARD CERTIFIED? ☐ Yes ☐ No<br>Name Board Below: American Board of Internal Medicine |

| HOSPITAL AFFILIATION (PRIMARY) | HOSPITAL AFFILIATION (2ND) |
|---|---|
| NAME: Oak Hill Hospital | NAME: Bayfront Health Spring Hill |

**Ambulatory Surgical Center Affiliation:**

| Name: | ZIP: |
|---|---|

| PATIENT AGE RANGE: 18 - 100 | OFFICE HOURS: | ADD'L LANGUAGES SPOKEN BY PRACTIONER: Malayalam,Afar,Akan, |
|---|---|---|

PROVIDER PRACTICING IN ALL OF THE GROUP'S LOCATIONS? ☐ YES ☑ NO IF NO, SPECIFY THE EXCEPTION

(FOR OFFICE USE ONLY) **CREDENTIALING STATUS?** ☐ **Approved** ☐ **Pending** ☐ **N/A**

[Information submitted is accurate and current] Signature: **X**_____

****PLEASE ATTACH A CURRENT COPY OF THE FOLLOWING DOCUMENTS WITH THIS FORM**

| | | | |
|---|---|---|---|
| ☑FL. Medical license | ☑FL DEA License | ☐FL Worker's Comp License | ☑W-9 Form |
| ☑Liability Insurance | ☐Financial Responsibility Form | ☐Practice Ownership Interest Form | ☑Contact Information for Credentialing |
| ☐Group's Roster | ☐Group's Location List | ☑Letter of Interest | |

**Completed forms should be faxed to (844) 228-0586**

******Please Note: Current CAQH information status is required to process request**