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aetna COVENTRY Health Care

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: 3480 Deltona Blvd., Spring Hill, Florida, 34606, United States				# of Locations	#Of Group Practitioners
Contract Group Type:	Group ☐	Solo ☐	Multi-Spec Group ☑	Office Administrator:	
Phone:	Fax:	Email:			

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	SPECIALTY (Primary): Advanced Subspeciality Resident in Infectious and Tropical Diseases	CPD # / EPDB #
NPI# 1417989625	SOCIAL SECURITY # 052829007	DATE OF BIRTH: 07-05-1968
MEDICARE #	MEDICAID #	WORKERS COMP #
CAQH#: *database info MUST be current 10721240	MEDICAL LIC #	DEA LIC #
LAST ATTESTATION DATE:	MD LIC EXPIRATION DATE:	BOARD CERTIFIED? ☐ Yes ☐ No Name Board Below: American Board of Dermatology

HOSPITAL AFFILIATION (PRIMARY)	HOSPITAL AFFILIATION (2ND)
NAME:	NAME:

Ambulatory Surgical Center Affiliation:

Name:	ZIP:

PATIENT AGE RANGE:	OFFICE HOURS:	ADD'L LANGUAGES SPOKEN BY PRACTIONER:

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**