Group Application and Release Form

New Jersey | Medicaid

Provider identification

P.O. box is not acceptable.

Group name:

Street address:

City: **State:** **ZIP:** **County:**

Phone: **Fax:**

You are a/an:
- ☐ Federally qualified health center (Y8)
- ☐ Rural health clinic (YO)
- ☐ Urgent care (ZK)
- ☐ Nontraditional provider
- ☐ State-approved nonprofit health corporation
- ☐ Other:

Claim payments are made to: ☐ Group (fill out payment box below) ☐ Individual

Your group consists of: ☐ PCPs ☐ Specialists ☐ Both PCPS and specialists ☐ Doula ☐ Other:

Number of physicians, other practitioners, and nontraditional providers in this group:

Payment information (if group was selected above)

Billing name:

Street/P.O. Box:

City: **State:** **ZIP:**

Phone: **Fax:**

Tax ID: **NPI:**

Are subgroups covered by this group contract? If so, list them:

Group name: Tax ID: NPI:

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For additional groups, list the names, tax IDs, and NPIs on a separate sheet.

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Enclosures

Submit the following with your completed and signed application:

- A copy of your state facility license(s)
- A copy of your liability insurance policy face sheet with expiration dates and amounts
- A copy of your NPI confirmation notice for each NPI listed
- For urgent care centers: a copy of facility accreditation or recent (within 24 hours) Health Care Financing Administration or state review if not accredited
- A copy of certificate(s)

Attestation and information release authorization

All information provided in this or in connection with this application is complete and accurate to the best of my knowledge, and I shall immediately notify Wellpoint of any changes thereto. I understand that this application does not entitle the provider to participate in the Wellpoint network. By applying to be a Wellpoint participating provider, the plan, its Medical Director, and appropriate representatives may consult with other institutions, including past and present malpractice carriers. I hereby further consent to the inspection by Wellpoint, its Medical Director, and appropriate representatives of all records and documents that may be material to an evaluation of professional qualifications and competence. I hereby release Wellpoint and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating this provider's application, credentials, and qualifications. I hereby release any individuals and organizations from any liability that provide information to Wellpoint or its staff in good faith and without malice concerning competence and other qualifications, and I hereby consent to the release of such information.

_____ _____

Signature **Date**

_____ _____

Name (print) Title

Unless a *Credentialing Delegation Addendum* has been executed, please also submit an *Individual Provider Application and Information Release Form* for each group participant.