PrimeWest HEALTH™
3905 Dakota St | Alexandria, MN 56308
1-888-588-4420 | www.primewest.org

LEAVE NOTHING BLANK
Please print or type all information. If the question does not apply, enter N/A. ***Incomplete forms will be returned.***

PARTICIPATION REQUEST – CONTRACTED FACILITY

Please complete and submit this form if your facility is interested in becoming a PrimeWest Health network provider. Requests will be received and the listed contact person will be notified once a decision has been made. Submitting this form does not guarantee approval as a PrimeWest Health network provider.

1. Name of person completing this form:_____

2. Telephone:_____ 3. Email address: _____

4. What is the specific reason you are requesting to join the PrimeWest Health Network? _____

_____

5. Provider type (check one):

***Requires a Type 2 National Provider Identifier (NPI).**

- ☐ Adult Day Treatment 46 (also complete DHS-3868)
- ☐ Ambulatory Surgical Center* 22
- ☐ Birthing Center* B1
- ☐ Certified Registered Nurse Anesthetist Group (CRNA)* 67
- ☐ Chemical Dependency* 62 (also complete DHS-3491)
- ☐ Child and Teen Checkups Clinic* 16 (also complete DHS-4646)
- ☐ Children's Residential Treatment 06
- ☐ Chiropractic Group* 37
- ☐ Community Health Clinic* 58 (also complete DHS-5732)
- ☐ Community Mental Health Center* 10 (also complete DHS-5748)
- ☐ County Human Services 45
- ☐ Dental Clinic* 30
- ☐ Dental Hygienist group 31
- ☐ Early Intensive Developmental Behavioral Intervention (EIDBI)* EI
- ☐ Family Planning Agency* 54
- ☐ Federally Qualified Health Center* 52
- ☐ Home Care Nursing Agency* 64
- ☐ Home Health* 60 (if also providing PCA services, complete DHS-4022)
- ☐ Hospice* 02
- ☐ Hospital* 01
- ☐ Independent Diagnostic Testing Facility* 32
- ☐ Indian Health Services* 51
- ☐ Institution for Mental Disease* 03
- ☐ Intensive Residential Treatment* 50
- ☐ Laboratory, Independent* 80
- ☐ Medical Supply (DME)* 76
- ☐ Medical Transportation 82
- ☐ Mental Health Billing Entity* 34
- ☐ Nursing Facility* 00
- ☐ Optician/Optical Supplier* 75
- ☐ Pharmacy* 70
- ☐ Physician Billing Entity* 49
- ☐ Physician Clinic* 20
- ☐ Podiatry Clinic* 36
- ☐ Public Health Clinic* 57
- ☐ Public Health Nursing* 61
- ☐ Regional Treatment Center* 17
- ☐ Rehabilitation Billing Entity* 48
- ☐ Rehabilitation Agency – Medicare Certified* 11
- ☐ Renal Dialysis Center* 04
- ☐ Rural Health Clinic* 53
- ☐ Targeted Case Management* 44 (also complete applicable DHS-5638, DHS-5639, and DHS-5702)
- ☐ Waivered Services 18
- ☐ WIC 73
- ☐ X-Ray Services Provider 81

A. DEMOGRAPHIC INFORMATION

1. Legal name: _____

IMPORTANT: *This should be the business name you use to file income to the IRS. (This is also the first line of the **W-9 Form**.)*

2. DBA name: _____

*This should be the name you are doing business as. (This is also the second line of the **W-9 Form**.)*

3. Federal tax ID #: _____

4. Is this facility associated with a parent company? ☐ Yes ☐ No If yes, please indicate: _____

5. Physical address: _____

6. City, state, zip: _____

7. County: _____

8. Telephone: _____ 9. Fax: _____

*This is the number that will be listed in the **Provider Directory**.*

10. Email address: _____

11. Website address: _____

12. Mailing address: _____

Street Address or P.O. Box *City* *State* *Zip*

13. Billing name: _____

Billing address: _____

Street Address or P.O. Box *City* *State* *Zip*

Be sure your billing name and address are listed correctly below. This is the name and address to which remittances and correspondence will be sent. This should be the name and address that appear in Box 33 of the ***CMS 1500 form*** and Field 1 of the ***UB92 form***. **(If the information on your claim differs from the information you provide here, the claim may be delayed or denied.)**

14. Is this facility currently enrolled as a Medicaid provider with the State of Minnesota? ☐ Yes ☐ No

15. Is this facility currently enrolled as a Medicare provider with the Centers for Medicare & Medicaid Services (CMS)? ☐ Yes ☐ No

15a. If "yes," provide the facilities Medicare number _____

16. NPI #*: _____ 17. UMPI #*: _____

***If you have more than one NPI/UMPI number, please use the NPI/UMPI request/verification form (section E). Please label what each NPI/UMPI number is for (e.g., clinic, swing bed, pharmacy, etc.).**

18. Special designations:

- ☐ Behavioral Health Home
- ☐ Critical Access Dental
- ☐ Critical Access Hospital
- ☐ Certified Community Behavioral Health Clinic
- ☐ CRNA Exemption
- ☐ Essential Community Provider
- ☐ Federally Qualified Health Center
- ☐ Health Care Home Certified
- ☐ Provider Based Billing
- ☐ Rural Health Clinic

B. CONTACT INFORMATION

Provide the following information for contact people at this facility.

TITLE	NAME	TELEPHONE	EMAIL ADDRESS
a. Administrator/ Facility Site Manager			
b. Business/Billing Office Manager			
c. Director of Nursing/ Nursing Supervisor			
d. Medical Director/ Chief of Staff			
e. Credentialing			
f. Compliance			

C. SERVICES AVAILABLE

1. Check any service that is provided at this facility. If the service is provided at the facility but billed by another entity, provide the name of the billing entity. If the service is not listed, please check "Other" and list.

☐ Chemotherapy
☐ Dialysis
☐ Diabetes Education
☐ Dietician/Nutrition
☐ Eyewear
☐ Language Interpreter (on-site)
Language(s) _____
_____
_____
☐ Mammography
☐ Mobile Lithotripsy

☐ Occupational Therapy
☐ Optometry
☐ Orthotics
☐ MTMS Certified*
☐ Physical Therapy
☐ Prosthetics
☐ Radiology
☐ Radiation Therapy
☐ Speech Therapy
☐ Swing Beds
☐ Telemedicine

☐ Transportation
- ☐ Ambulance Service
- ☐ Common Carrier Transportation
- ☐ Special Transportation Services
  - ☐ Volunteer Transport – mode 2
  - ☐ Unassisted Transport – mode 3
  - ☐ Assisted Transport – mode 4
  - ☐ Lift-equipped/Ramp transport – mode 5
  - ☐ Protected Transport – mode 6
  - ☐ Stretcher Transport – mode 7

Please list all Minnesota counties where you provide transportation services:
_____
_____
_____
_____
_____

☐ Other *(list below):*
a. _____
b. _____
c. _____

***You must provide a copy of the current Medication Therapy Management Services (MTMS) certification of the practitioner.**

2. Is this facility a primary care clinic? ☐ Yes ☐ No
If yes, which do you provide? ☐ OB/GYN ☐ Family Practice ☐ Internal Medicine ☐ Pediatrics

3. Does this facility have an age restriction in administering care to members or members? ☐ Yes ☐ No
If yes, what is the age restriction? (For example, 18 and under only.) _____

4. Does this facilty provide "in-house" laboratory services? ☐ Yes ☐ No
If yes, is the lab CLIA certified? **(If CLIA certified, you must provide a copy of the most current CLIA certificate.)**

D. CALL COVERAGE AND OFFICE HOURS – Facilities Only

1. Please indicate how members of this facility are instructed to access care when the primary clinic is not open. Check as many as apply.

- ☐ Answering machine directs members how to access care – no "live" person answering
- ☐ Answering service directs members call **911**
- ☐ After-hours message refers caller to another primary care provider or specialty care provider facility
- ☐ Members referred to hospital emergency room (ER) and seen by ER physician
- ☐ Live person answers phone (available 24 hours/day, 7 days/week)

2. Does this facility provide extended care hours? ☐ Yes ☐ No If yes, please fill out hours in section 5 in the grid below.

3. Does this facility provide urgent care? ☐ Yes ☐ No

4. REGULAR OFFICE HOURS		
Monday	FROM—TO –	☐ Closed
Tuesday	–	☐ Closed
Wednesday	–	☐ Closed
Thursday	–	☐ Closed
Friday	–	☐ Closed
Saturday	–	☐ Closed
Sunday	–	☐ Closed

5. EXTENDED CARE HOURS	
Monday	FROM—TO –
Tuesday	–
Wednesday	–
Thursday	–
Friday	–
Saturday	–
Sunday	–

6. Are there any practitioners that provide services at an outreach location? ☐ Yes ☐ No
If yes, please list:_____

7. Are there any practitioners at this facility who do not accept new members? ☐ Yes ☐ No
If yes, please list: _____

E. NPI/UMPI REQUEST/VERIFICATION FORM

If this facility has an NPI/UMPI for any of the following, please enter it in the appropriate area.

Hospital:_____ Clinic: _____

Durable Medical Equipment (DME): _____

Skilled Nursing Facility (SNF): _____

Long-Term Care/nursing home: _____

Swing bed:_____ Emergency room: _____

Hospice:_____ Home Health services: _____

Pharmacy: _____ Dental: _____

Anesthesia: _____ Behavioral health: _____

Chiropractor: _____ Transportation: _____

Home and Community Based Service (HCBS): _____

Vision: _____

Other: _____

_____

F. REFERRAL PATTERNS

Clinic Referral Patterns: It is PrimeWest Health's goal to allow practitioners to retain as many usual referral patterns as possible and to encourage referral to PrimeWest Health participating providers. To assist us in contracting efforts, we are asking that you please provide names of the organizations/providers where you refer members for services you are not able to provide at this facility. You may list more than one provider and/or organization in each section.

Specialty	Name	City
Hospital used by most physicians at clinic		
Tertiary services (Hospital)		
Trauma		
Burns		
Preterm Labor		
Complicated pregnancies		
Preterm infants		
Cardiology		
Rheumatology		
Pulmonology		
Gastroenterology		
Oncology		
Urology		
Dermatology		
Orthopedics		
Ophthalmology		
ENT		
Neurology		
Surgery		
Radiology		
Dialysis		
PT, OT, ST		
Home Health services		
Long-Term Care/SNF		
DME		
Mental health treatment		
Substance Use Disorder treatment		
Other		

G. ADDITIONAL LOCATION(S)

Copy pages 6 – 7 and complete for each additional practice location associated with the primary facility.

1. Legal name:_____

__IMPORTANT:__ This should be the business name you use to file income to the IRS. (This is also the first line of the __W-9 Form__.)

2. DBA name: _____

This should be the name you are doing business as. (This is also the first line of the __W-9 Form__.)

3. Federal tax ID #: _____

If different from Section A, #2

4. Physical address: _____

5. City, state, zip: _____ 6. County: _____

7. Telephone: _____ 8. Fax: _____

This is the number that will be listed in the __Provider Directory__.

9. Billing address: _____

This is the address to which remittances and correspondence will be sent. This should be the address that appears in Box 33 of the __CMS 1500__ and Field 1 of the __UB92__.

10. Mailing address: _____

11. Email address: _____ 12. Website address: _____

13. Is this facility currently enrolled as a Medicaid provider with the State of Minnesota? ☐ Yes ☐ No

14. Is this facility currently enrolled as a Medicare provider with the Centers for Medicare & Medicaid Services (CMS)? ☐ Yes ☐ No

14a. If "yes," provide the facility's Medicare number _____

15. NPI #:_____ 16. UMPI #:_____

H. CALL COVERAGE AND OFFICE HOURS FOR ADDITIONAL LOCATION(S)

1. Please indicate how members of this facility are instructed to access care when the primary clinic is not open. Check as many as apply.

- ☐ Answering machine directs members how to access care – no "live" person answering
- ☐ Answering service directs members call **911**
- ☐ After-hours message refers caller to another primary care provider or specialty care provider facility
- ☐ Members referred to hospital emergency room (ER) and seen by ER physician
- ☐ Live person answers phone (available 24 hours/day, 7 days/week)

2. Does this facility provide extended care hours? ☐ Yes ☐ No If yes, please fill out hours in section 5 in the grid below.

3. Does this facility provide urgent care? ☐ Yes ☐ No

4. REGULAR OFFICE HOURS		
Monday	FROM—TO –	☐ Closed
Tuesday	–	☐ Closed
Wednesday	–	☐ Closed
Thursday	–	☐ Closed
Friday	–	☐ Closed
Saturday	–	☐ Closed
Sunday	–	☐ Closed

5. EXTENDED CARE HOURS	
Monday	FROM—TO –
Tuesday	–
Wednesday	–
Thursday	–
Friday	–
Saturday	–
Sunday	–

6. Are there any practitioners that provide services at an outreach location? ☐ Yes ☐ No
If yes, please list:_____

7. Are there any practitioners at this facility who do not accept new members? ☐ Yes ☐ No
If yes, please list: _____

I. CONTACT INFORMATION FOR ADDITIONAL LOCATION(S)

Provide the following information for contact people at this facility.

TITLE	NAME	TELEPHONE	EMAIL ADDRESS
a. Administrator/ Facility Site Manager			
b. Business/Billing Office Manager			
c. Director of Nursing/ Nursing Supervisor			
d. Medical Director/ Chief of Staff			
e. Credentialing			
f. Compliance			

J. SERVICES AVAILABLE AT ADDITIONAL LOCATION(S)

1. Check any service that is provided at this facility. If the service is provided at the facility but billed by another entity, provide the name of the billing entity. If the service is not listed, please check "Other" and list.

☐ Chemotherapy
☐ Dialysis
☐ Diabetes Education
☐ Dietician/Nutrition
☐ Eyewear
☐ Language Interpreter (on-site)
Language(s) _____
_____
_____
☐ Mammography
☐ Mobile Lithotripsy

☐ Occupational Therapy
☐ Optometry
☐ Orthotics
☐ MTMS Certified*
☐ Physical Therapy
☐ Prosthetics
☐ Radiology
☐ Radiation Therapy
☐ Speech Therapy
☐ Swing Beds
☐ Telemedicine

☐ Transportation
- ☐ Ambulance Service
- ☐ Common Carrier Transportation
- ☐ Special Transportation Services
  - ☐ Volunteer Transport – mode 2
  - ☐ Unassisted Transport – mode 3
  - ☐ Assisted Transport – mode 4
  - ☐ Lift-equipped/Ramp transport – mode 5
  - ☐ Protected Transport – mode 6
  - ☐ Stretcher Transport – mode 7

Please list all Minnesota counties where you provide transportation services:
_____
_____
_____
_____
_____

☐ Other *(list below):*
a. _____
b. _____
c. _____

***You must provide a copy of the current Medication Therapy Management Services (MTMS) certification of the practitioner.**

2. Is this facility a primary care clinic? ☐ Yes ☐ No
If yes, which do you provide? ☐ OB/GYN ☐ Family Practice ☐ Internal Medicine ☐ Pediatrics

3. Does this facility have an age restriction in administering care to members or members? ☐ Yes ☐ No
If yes, what is the age restriction? (For example, 18 and under only.) _____

4. Does this facilty provide "in-house" laboratory services? ☐ Yes ☐ No
If yes, is the lab CLIA certified? **(If CLIA certified, you must provide a copy of the most current CLIA certificate.)**

K. ACCOMMODATIONS – To be completed by ALL facilities

Does this facility have:

☐ Yes ☐ No Is this office, including parking, entryways, and other relevant spaces, accessible for people with disabilities?
☐ Yes ☐ No Are this office's exam rooms accessible for people with disabilities?
☐ Yes ☐ No Does this office have equipment accessible for people with disabilities?
☐ Yes ☐ No Does this facility meet ADA accessibility requirements?
☐ Yes ☐ No Does this parking lot include handicap parking spots?
☐ Yes ☐ No Does this facility have automatic doors?
☐ Yes ☐ No Does this facility have adjustable exam, X-ray tables?
☐ Yes ☐ No Does this facility have scales for people with disabilities (rails)?
☐ Yes ☐ No Does this facility have bariatric scales?
☐ Yes ☐ No Have staff in this facility completed cultural competency training within the past 12 months?
If yes, what type of cultural competency training does your organization provide?

_____

In addition, what types of cultural competency trainings and specialties do you identify as being important to the patient population you serve? *List any experiences, trainings, or personal cultural experiences/ backgrounds you feel are important:*

_____

_____

_____

L. DOCUMENTATION

Please attach the following documents:

☐ **State Facility License**

☐ **General Liability Certificate of Insurance, showing coverage amount and dates**
Refer to the PrimeWest Health Provider Manual for coverage requirements.

☐ **W-9 form**

☐ **Ownership Disclosure**

☐ **EFT/ERA**

☐ **Minnesota Uniform Facility Credentialing Application**
Only required for the following provider types: Behavioral Health, SUD, LTC, Ambulatory Surgical Center, Hospital, and Home Care

☐ **Other miscellaneous documents that were requested throughout the form, if applicable (e.g., CLIA Certificate)**

M. CONTRACT SIGNOR STATEMENT

I certify that the information provided on this form is true and correct. I will notify the PrimeWest Health credentialing and network department with any additions/changes to the information.

Contract signor name (print)	Title
Contract signor signature	Date
Telephone number	Email address

Submit