Credentialing Application Request/ Provider Enrollment Form (CAR/PE FORM)

Practitioner Information

Last: ______ **First:** ______ **Middle:** ______ **Suffix:** ______

Degree/License: ______ **DOB:** ______ **Gender:** ____ **NPI#:** ______

Primary Specialty: ______ **Secondary Specialty:** ______

Additional Specialties: ______

Phone: ______ **Email Address:** ______

☐ **Curriculum Vitae – Submitted in Month/Year Format** *(MUST BE ATTACHED)*

☐ **Other Health Provider (OHP) Form completed and submitted**

Licensing Status: ☐ Applicant is licensed in New Mexico ☐ Application has been submitted to State Licensing Board

Credentialing Information

Select the entity applying to practice at:

☐UNMH	UNMH Department:	
☐UNMMG	UNMMG Clinic/Program:	
☐SRMC	SRMC Clinic Service Department:	

Credentialing Entry Point:

Anticipated Start Date: ______
*(If employed/contracted, indicate start date. *Please allow at least 60 days – or longer if not yet licensed)*

Employed By:

☐ **UNM** ☐ **SRMC** ☐ **UNMH** ☐ **UNMMG** ☐ **UNM LOCUMS**

If NOT Employed:

☐ **Contract / PSA Name:** ______

☐ **Community Provider**

Privilege Forms: *Note: required for Medical Staff and Allied Health Professionals (AHPs)*

UNMH			
SRMC			
UNMMG			

Credentialing Liaison: *(Person to be copied on all correspondence)*

Name: ______ **Position:** ______

Email: ______ **Phone:** ______

Enrollment Information

(1) Will applicant need to complete billing packet? ☐ Yes ☐ No (if no, further information not required)

(2) If yes, name of person assisting with billing packet: ______________________

(3) If billing packet previously completed, will there be a change in practice location? ☐ Yes ☐ No

(4) Please select: ☐ PCP ☐ Specialist

(5) Behavioral Health Provider? ☐ Yes ☐ No

Practice Locations:

Tax ID	Facility/Clinic Name and Address

NOTE: All practice locations will display on Find-A-Doc website excluding the following departments: Anesthesiology, Emergency Medicine, Emergency Department, Center for Reproductive Health, Pathology, Radiology.

Special Instructions for Provider Directory:

SECTION TO BE COMPLETED BY OCCS STAFF:

Has all sections been reviewed?

BH Confirmed: ☐ PCP Panel Confirmed: ☐ Specialty Excl Srvc Confirmed: ☐ Trauma Excl Srvc Confirmed: ☐

NO FAD ☐ Managed Care Ready ☐ Cactus Enter Date: ______________

1st Payer Notified Date: ______________ Entered By: ______________

Submit Completed form to:

CREDENTIALING Verification Office (CVO)
University of New Mexico Health System
Tel: 505.272.2526 Fax: 505.272.6055
Email: hsc-unmhs_cvo@salud.unm.edu