Hill Physicians Network Request Form

If you are interested in joining the Hill Physicians network, please **complete this form and fax it along with your current Curriculum Vitae (CV), a Letter of Intent, FAXBACK form and a current W9 to 855-644-4764 or via email to pdm@hpmg.com.** If you have questions regarding this form please contact Provider Data Management at PDM@hpmg.com

IF WE HAVE QUESTIONS ABOUT THE INFORMATION PROVIDED IN THIS FORM, WHO MAY WE CONTACT?

Name/Title:	
Phone: ( )	Email:
Credentialing Contact Email/Phone:	Date:

PERSONAL INFORMATION

First Name:	Middle Name:	Last Name:	Title:
Type I NPI:		CAQH ID:	TAX ID :
CA License No.:		Effective Date (MMDDYYYY):	Expiration (MMDDYYYY):
DOB:	Gender: ☐ Male ☐ Female	SSN:	Email:

PRACTICE GROUP INFORMATION

Practice Name:	Practice Type: ☐ Group ☐ Solo
List all Providers in Group (For FQHC clinics — List Supervising Physician (Required for N.P or P.A.):	

PRIMARY OFFICE LOCATION

Street Address:	City:	State:	Zip:
Phone: ( )	Fax: ( )	Office Hours:	
Type II NPI:	Tax ID:	Billing Phone: ( )	

SECONDARY OFFICE LOCATION

Street Address:	City:	State:	Zip:
Phone: ( )	Fax: ( )	Office Hours:	
Type II NPI:	Tax ID:	Billing Phone: ( )	
Correspondence Address, check box if same as: ☐ Primary office address ☐ Secondary office address			
Correspondence Address, if neither the primary or secondary office address: Street Address:	City:	State:	Zip:

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Will you accept Medi-Cal patients? ☐ Yes ☐ No If Yes, submit PAVE application approval ☐

Please check Medi-Cal Product Lines you participate in: ☐ CCS ☐ CPSP ☐ CHDP

SPECIALTY INFORMATION

CMS approved specialties applying for (e.g. Family Medicine or Endocrinology):

1. _____

2. _____

CERTIFICATION/EDUCATION

Board Certification(s):	Year Completed:	Year Expired:
1. _____	_____	_____
1. _____	_____	_____

If none, do you have plans to become board certified?

☐ Yes — When: Month _____ Year _____ ☐ No — Reason: _____

_____

HOSPITAL AFFILIATION(S) BY PRIORITY

Hospital Name:	Privilege Type:
1. _____	_____
2. _____	_____
3. _____	_____

DO YOU USE AMBULATORY SURGERY CENTERS? WHICH ONE(S)?

Center Name:

1. _____

2. _____

OTHER MEDICAL GROUP/IPA AFFILIATION(S)

Medical Group/IPA Name:

1. _____

2. _____

ADDITIONAL LANGUAGE(S) SPOKEN BY PHYSICIAN (OTHER THAN ENGLISH)

Language Name:

1. _____

2. _____

CALL GROUP (PLEASE NOTE THAT ON-CALL PHYSICIANS MUST ACCEPT HILL RATES)

Physician Name:	Par with Hill? Yes	No
1. _____	☐	☐
2. _____	☐	☐

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ELECTRONIC CAPABILITIES INFORMATION

Do you currently have an electronic health record?

☐ Yes ☐ No

If so, which EHR are you currently using?

_____

Do you currently submit claims electronically?

☐ Yes ☐ No

If yes, which clearinghouse do you use?

_____

You will be required to utilize the Provider Portal for electronic means of communication, access to Hill*Link* for authorizations and Hill*Metrics* for population health management (if applicable). Will you comply with this requirement?

☐ Yes ☐ No

Provide an email address(es) for general, non-HIPAA related provider communications:

_____

Hill Physicians requires the use of Electronic Funds Transfer (EFT) and electronic Explanation of Benefits (eEOB). Will you comply with this requirement?

☐ Yes ☐ No

Are you currently providing telehealth services to your patients?

☐ Yes ☐ No

If yes, please check the boxes that apply:

Telephone Visits ☐ Yes ☐ No
Video Visits ☐ Yes ☐ No
E-Visits/Email ☐ Yes ☐ No

REVIEW / APPROVAL PROCESS

Once the request is forwarded to our Membership Committee it takes **approximately 90 days** until a decision has been made, at which point written decision will be sent to your office.

Application requests are subject to review and approval by the Hill Physicians Membership Committee.