



Request for a Proposal/Additional Information

1. Name of practice: _____
2. Address(es): _____

3. Primary Contact Name: _____
4. Primary Contact Phone #: _____ Email address: _____
5. What services are you interested in?:
 - Provider Enrollment – If so, please answer questions 6-13 below
 - Credentialing/Privileging – If so, please answer questions 8, 9, 10, 14 & 15 below
 - Licensing – If so, please answer questions 8, 16-19 below
 - Data Base Management – If so, what system do you use: _____
and please tell us a little about your project: _____

6. Does your practice need a Type 2 NPI #?: _____
 - a. **Type 2 NPI Info** - Health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.
7. Do you have a Tax ID # for your practice? _____
8. What is your primary specialty(s)?: _____
9. How many physicians practice at your location: _____
 - a. What are their specialties?: _____

10. How many Allied Health Professionals work at your location & what are their disciplines (NP, RN, PA): _____

11. Do your physicians have active CAQH profiles? _____
12. Is your practice/group currently contracted with any insurance plans, including Medicare or Medicaid? If so, please provide the list of plans: _____

13. Which plans are you interested in being contracted with?: _____

14. Are you a facility needing to credential medical staff? If so, is your facility accredited? If so, by which agency: _____

15. Are you an individual seeking hospital privileges, if so which hospital(s): _____

16. Which states would you like to become licensed in: _____

17. Which states are you currently licensed in: _____

18. Do you have an FCVS profile: _____ YES _____ NO

19. Which exam did you complete (USMLE, NBME, NBOME, FLEX, etc.): _____

a. How many attempts per step: _____

Notes: _____
