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)*

☐ **Letter of Offer or Letter of Academic Title (LAT)** *(MUST BE ATTACHED)*

Licensing Status: ☐ Applicant is licensed in New Mexico ☐ Application has been submitted to State Licensing Board **(receipt attached)**

Credentialing Information

Select the entity applying to practice at:

☐**UNMH**	**UNMH Department:**	
☐**UNMMG**	**UNMMG Clinic/Program:**	

Credentialing Entry Point:

Anticipated Start Date: _____

*(If employed/contracted, indicate start date. *Please allow up to 90 days after submission of application – or longer if not yet licensed)*

Employed By:

☐ **UNM SOM** ☐ **UNM HR** ☐ **UNMH** ☐ **UNMMG** ☐ **UNM GME** **(Moonlighting Fellows Only)**

If NOT Employed:

☐ **Contract / PSA Name:** _____

☐ **Community Provider**

☐ **Pure Volunteer** (*MOU approved by legal must be attached)*

Privilege Forms:

UNMH	UNMH Privileges	UNMH Privileges	UNMH Privileges
UNMMG	UNMMG Privileges	UNMMG Privileges	UNMMG Privileges

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

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

Name: _____ **Date:** _____

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 *(Please do not leave unchecked)*

(5) Behavioral Health Provider? ☐ Yes ☐ No *(Please do not leave unchecked)*

(6) Provider on a MOU? ☐ Yes ☐ No

(7) Telemedicine Provider ONLY? ☐ Yes ☐ No **If, yes, State:** _____

Practice Locations:

Tax ID	Facility/Clinic Name and Address	Check Primary Loc. (PCP Only)	Load to Provider Directory (FAD)
Select Tax ID	Select a Practice Location	☐	☐Yes ☐No
Select Tax ID	Select a Practice Location	☐	☐Yes ☐No
Select Tax ID	Select a Practice Location	☐	☐Yes ☐No
Select Tax ID	Select a Practice Location	☐	☐Yes ☐No
Select Tax ID	Select a Practice Location	☐	☐Yes ☐No
Select Tax ID	Select a Practice Location	☐	☐Yes ☐No
Select Tax ID	Select a Practice Location	☐	☐Yes ☐No
Select Tax ID	Select a Practice Location	☐	☐Yes ☐No

NOTE: All practice locations will be displayed in contracted Health Plan Provider Directories and on Find-A-Doc website excluding the following departments: Anesthesiology, Emergency Medicine, Emergency Department, Center for Reproductive Health, Pathology, and Radiology or unless you select no above.

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 Srvc Confirmed: ☐

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

1st Payer Notified Date: _____ Entered By: _____

Returning Notified Date: _____

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

_____
Submission Date

Revised: 02/08/2024