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Group Credentialing Intake Form

Group Document(s) Information Needed:

- IRS Document (CP575 Form) - Shows carriers proof of ownership, tax ID number and legal business name.
- Form W9 - Must have the group's pay-to/remittance address listed, signed and dated by an Authorized Official.
- Bank Letter/Voided Check - For submission to multiple carriers for EFT enrollment and proof of banking information.
- Certification Copies: JCHAO, AAAASF, AAAHC, etc.
- Copies of CLIA Certificates or Waivers.

Company Information

Corporation/Group Name:_____
Corporation/Group DBA(if applicable):_____
Type of Practice (Group, Urgent Care, Surgery Center, Etc.,):_____
NPI Type II(Group:)_____TIN:_____
Practice/ Service Address(es): If additional space is needed, please attach a separate sheet.
1._____
2._____
3._____
Office Phone:_____Fax #:_____
Hours:_____Age Limitations:_____

Authorized Official/ Ownership Information

Name: _____DOB:_____SSN:_____Pecentage_____
Name: _____DOB:_____SSN:_____Percentage_____
Name: _____DOB:_____SSN:_____ Percentage_____
Name: _____DOB:_____SSN:_____Percentage_____
(Please upload a copy of all owner's government ID to Modio Secure Portal)

Point of Contact Information

Contact Name:_____

Email:_____

Phone:_____Fax:_____

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Additional Information

Specialties within the Group/Practice:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Secure Portal

Provider Name & Emails

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

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Provider Additional Information Needed For Each Provider

- **Medicaid#**
- **Medicare#**
- **PECOS Login (Username & Password)**
- **Medicaid (Username& Password) ___**
- **CAQH Information**

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Electronic Signature Consent

By signing below, I _____ do herby give consent to use my signature, provider below, for the purposes of provider credentialing and re-credentialing. I agree my electronic signature is the legal equivalent of my manual signature. When used for provider credentialing, I understand that my electronic signature is legally binding; just as if I had signed a paper document. By signing, I consent to be legally bound by this Agreement's terms and conditions set forth. This consent to use my signature applies only to materials related to provider credentialing. I further agree that each use of my e-signature in obtaining provider credentialing constitutes my agreement to be bound by the terms and conditions of this electronic signature consent as they exist on the date of my e-signature. I do hereby understand that I may withdraw my consent to use my electronic signature at any time.

If you wish to withdraw your consent, please notify us at the address below and provide your name, mailing address, daytime telephone number, and a description of the type of transaction from which you are withdrawing your consent.

Please Sign In The Center Of The Box

Initials

Print Name: _____Date: _____

You have the right to all documents that contain your signature. All documents that belong to you are located in your secure cloud folder to which your Practice Administrator has access at all times.

We may be contacted at any time via the below information:

Alexis Daly
954-686-6577
cd@aimmccs.com
providercredentialing@aimmccs.com
www.aimmccs.com

Practice/ Group:_____

Date: _____

- Please provide 1 Signature and Initials in the middle of each box
- Please upload to secure portal, fax or email back to cd@aimmccs.com

Provider Name: _____

Signature

Initials

Provider Name: _____

Provider Name: _____

Provider Name: _____

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