

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 Na	me:		
Corporation/Group DB	A(if applicable):		
Type of Practice (Grou	p, Urgent Care, Surgery	Center, Etc.,):	
NPI Type II(Group:)		TIN:	
Practice/ Service Addre	ess(es): If additional spa	ace is needed, please attac	ch a separate sheet.
1			
2			
Office Phone:		Fax #:	
Hours:	Age Limitations:		
	<u>Authorized Offic</u>	ial/ Ownership Inforr	<u>mation</u>
Namo	DOP:	CCNI.	Pocontago
			Pecentage Percentage Percentage
			Percentage
			Percentage
		ent ID to Modio Secure Po	
	Point of C	Contact Information	
Contact Name:			
Email:			
Phone:		Fax:	



Additional Information

Specialties within the Group/Practice:	
1	_4
2	
3	
:	Secure Portal
Provider Name & Emails	
1	
9	
10.	



Provider Additional Information Needed For Each Provider

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



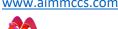
Electronic Signature Consent

By signing below, I	do herby give consent to use my signature,
provider below, for the purposes of provider of	
electronic signature is the legal equivalent of i	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 si	gnature applies only to materials related to
provider credentialing. I further agree that each	ch 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 t	the date of my e-signature. I do hereby
understand that I may withdraw my consent t	to use my electronic signature at any time.
•	notify us at the address below and provide your imber, and a description of the type of transaction t.
	Location In
Please Sign In The Center Of The Box	<u>Initials</u>
Print Name:	Date:
	signature. All documents that belong to you are located in
your secure cloud folder to which your Practice Admir	nistrator nas access at all times.

Alexis Daly 954-686-6577

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

cd@aimmccs.com providercredentialing@aimmccs.com





 Please provide 1 Signature and Initials in the Please upload to secure portal, fax or email b 	
ovider Name:	
Signature	Initials
ovider Name:	
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