NHealth
Norman Regional Health System

Provider Membership Application
NHealth Care Network

Thank you for your interest in becoming a participating member of the NHealth Clinically Integrated Network (CIN). Consideration for membership is based upon a provider's commitment to improve the health of patients, qualifications, practice history in the community, and the geographic and specialty needs of NHealth at the time of enrollment. Membership in NHealth will become effective only after credentials verification and approval of the NHealth Board of Directors. If you are a member of a medical group, please note that all members of your group practice must be eligible for membership and that all members must participate in NHealth in order for you to participate.

Step 1- Participating Provider Requirements (All Applicants) - Please review the following participation requirements and attest to your eligibility.

- I am currently credentialed and a member in good standing on the Medical Staff of Norman Regional Health System, or
    - I have begun the credentialing process with Norman Regional Health System Medical Staff Services
    - I currently am not a member of the Medical Staff of Norman Regional Health System, I understand that I must complete the secondary NHealth credentialing process prior to full acceptance to NHealth. Every effort will be made to submit information within 60 days.
- I am committed to improving quality of care and clinical outcomes, improving coordination and continuity of care, improving efficiency of care, eliminating unnecessary clinical care variation, applying evidence-based medical interventions, and supporting comprehensive clinical care with use of an information integration technology platform.
- I will meet and abide by the terms outlined in the NHealth Participation Agreements
- I agree to participate in all of the contracts of NHealth
- I agree to comply with the clinical performance standards, guidelines, and objectives to be defined by the NHealth Committees.
- I agree to actively promote, gather and report evidence-based clinical outcome measures as required by NHealth with third party payers and NHealth policies and procedures
    - Upon request of NHealth, I agree to provide information in a timely manner in order to allow for analysis of clinical outcomes by NHealth.
    - I agree to comply with all requirements and deadlines as defined by NHealth for aggregation and reporting of clinical outcomes.

By my signature, I attest that I meet, or that I will meet, the Participating Provider Requirements listed above. I further agree that, if I am accepted as a Participating Provider, I will continue to meet all the participating Provider Requirements during the term of my membership.

Provider Signature: _____

Provider Printed Name: _____ Date: _____

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Step 2- Applicant Information (All Applicants)

Please Indicate What Type of Provider You Are:

- ☐ **Physician**
- ☐ **Physician's Assistant**
- ☐ **Advanced Practice Nurse**
- ☐ **Physical Therapist**
- ☐ **Occupational Therapist**
- ☐ **Psychologist**
- ☐ **Licensed Professional Counselor**
- ☐ **Licensed Clinical Social Worker**
- ☐ **Licensed Marital and Family Therapist**
- ☐ **Licensed Behavioral Practitioner**
- ☐ **Dentist**
- ☐ **Optometrist**
- ☐ **Podiatrist**
- ☐ **Audiologist**
- ☐ **Other (Please Specify):_____**

General Information: Enter all information, when applicable, EXACTLY as it appears in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). All fields marked with an asterisk (*) are required.			
*Last Name	*First Name	M.I.	Birth Date
*Primary Practice Specialty (Board Certification)		Supervising Physician (If Applicable)	
*Tax ID # (TIN)	*Individual NPI#	*Group NPI #	EMR Product/ Version
*Practice Name (If more than one practice site, please report additional site information on a separate page)			
*Practice Street Address		Suite #	
*City	*State	*Zip	*Practice Phone #
Practice Fax #	Personal Phone #	Preferred Email	
In-Office Contact Name	Title	Email	

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Step 3- Credentialing Pre-Questionnaire- Complete only if you are currently NOT a member of the Medical Staff of Norman Regional Health System

As a prerequisite to completing the Credentialing Application for Membership in the NHealth CIN, the following information must be answered. Please note that additional information may be requested in order to complete the application process. If it is discovered that the information you supplied on the pre-application questionnaire or application form is false, this may result in ineligibility for membership.

Please answer the questions listed below. NHealth will send you a comprehensive credentialing application upon receipt of your completed application request and pre-application questionnaire.

Questions	**Yes**	**No**
Do you currently hold an Oklahoma State License in one of the provider disciplines listed at the top of page 2?		
Are you currently eligible to participate in federally funded health care programs such as Medicare and Medicaid?		
Are you currently participating in Medicare?		
Are you currently board certified in your primary area of expected specialty practice?		
Do you have a current, unrestricted DEA registration? (If you are a practitioner who is ineligible based on a non-medical staff specialty or in a specialty not requiring/utilizing a DEA, answer "Yes".)		
Do you currently have malpractice liability coverage with minimum coverage of $1,000,000 per occurrence/ $3,000,000 aggregate?		

Comments:

Please Send Completed Form to Rachel Minatee Email: rminatee@nrh-ok.com Fax: (405) 515-5043

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*Practice Street Address		Suite #	
*City	*State	*Zip	*Practice Phone #
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