

# MERCER FIRSTCHOICE PROVIDER ENROLLMENT FORM

All participating Physicians, Nurse Practitioners, Physician Assistants and all other health care providers in your group must be credentialed prior to Mercer FirstChoice participation. Each provider must complete a Provider Enrollment Form and forward copies of the following items:

1. Pennsylvania or Ohio Medical License
2. DEA Certificate
3. Current Malpractice Policy
4. Medical School Diploma
5. Specialty Board Certification and/or Recertification

## GENERAL INSTRUCTION

- Please complete the enrollment form in full.
- Group practices and partnerships should complete an enrollment form for each provider of services.
- Completed form and copies of the above items may be faxed to 724-983-3824 or sent via mail to Mercer FirstChoice, c/o Chris Golub, 740 East State St., Sharon, PA 16146. Once this is received, an agreement will be mailed for your signature.

\*Please note: participation will not be in effect until a signed agreement has been received along with the above items.

## PERSONAL INFORMATION:

Provider Name: \_\_\_\_\_  
(Last) (First) (Middle)

Medical Group Name: \_\_\_\_\_

Federal Tax ID Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ UPIN: \_\_\_\_\_

## SPECIALTY:

Primary Specialty (Directory Listing)	SubSpecialty
_____  Board Certified _____ Board Eligible _____	_____  Board Certified _____ Board Eligible _____

Has your Medical License ever been suspended or revoked? \_\_\_\_\_

## HOSPITAL AFFILIATIONS:

Hospital	Type of Privileges

## OFFICE ADDRESS:

Primary Office Location	Billing Address
<hr/> <hr/> <hr/> Phone: _____ Fax: _____	<hr/> <hr/> <hr/> Phone: _____ Fax: _____

Other Office Locations	Billing Address
<hr/> <hr/> <hr/> Phone: _____ Fax: _____	<hr/> <hr/> <hr/> Phone: _____ Fax: _____
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In recognition that Mercer FirstChoice has a valid interest in obtaining and verifying information concerning my professional competence in determining whether to enter into an agreement with me for the provision of medical services to members of its preferred provider organization,

I hereby affirm and represent that all statements, answers, and information contained in this form are true to the best of my knowledge and belief. I hold a valid and unrevoked license to practice medicine in the Commonwealth of Pennsylvania or the State of Ohio. I understand that misrepresentation or omission of any fact requested may be sufficient cause for immediate termination of my contract with Mercer FirstChoice.

**Signature:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_