Accountable Healthcare Advantage

An affiliate of Accountable Healthcare Alliance

Application

Please complete this form indicating your interest in applying for membership in Accountable Healthcare Advantage (AHA). Your request will be reviewed by AHA leadership. Once approved, a membership packet will be routed to the party you select below. If you have questions, please call Loraine Stewart at (517) 324-2520.

Physician Name: _____ Date: _____

Physician Title (e.g. MD, DO): _____ Specialty: _____

Are you functioning as a PCP? YES ☐ NO ☐ Are you Board Certified? YES ☐ NO ☐

If so, what is your Board Certification? _____

Please specify what are you functioning as (i.e., Family Practice, Internal Medicine, ER Physician, etc.):

_____

Legal Practice Name: _____

Practice dba (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-mail Address: _____

Enrollment packet should be routed to (check one box below, but please provide information for both):

☐ Billing Contact Name: _____

Email: _____ Phone: _____

☐ Office Manager Name: _____

Email: _____ Phone: _____

Please indicate the health plans/programs in which you would like to participate through Accountable Healthcare Advantage:

- ☐ *Health Alliance Plan*
- ☐ *Molina*
- ☐ *Blue Care Network*
- ☐ *BCBSM Physician Group Incentive Program (PGIP)*
- ☐ *Meridian Health Plan*
- ☐ *Priority Health*

There will be a $500.00 nonrefundable subscription fee to join Accountable Healthcare Advantage. Please do <u>not</u> include a subscription fee with your application. Payment of your subscription fee will be requested when you have been approved for membership and a full enrollment packet is provided to you for completion.

Please list all physicians who are members of the above listed practice (attach more paper if needed):

Physician Name	AHA Member
_____	YES ☐ NO ☐
_____	YES ☐ NO ☐
_____	YES ☐ NO ☐
_____	YES ☐ NO ☐
_____	YES ☐ NO ☐
_____	YES ☐ NO ☐

Are you new to the practice listed above? YES ☐ NO ☐

How many years have you been in practice? _____

Please list all area hospitals where you are on staff: _____

_____

Do you provide inpatient care to your hospitalized patients? YES ☐ NO ☐

Who referred you to AHA? _____

PCPs Only – Please Complete the Following:

Please indicate your current health plans and the Physician Organization(s) through which you participate:

Health Plan	***Physician Organization***
☐ *Health Alliance Plan*	_____
☐ *BCBSM Physician Group Incentive Program (PGIP)*	_____
☐ *Molina*	_____
☐ *Meridian Health Plan*	_____
☐ *Blue Care Network*	_____
☐ *Priority Health*	_____
☐ *Other:* _____	_____

Please attach quality and utilization reports from any health plans or Physician Organizations from the past two years. If these documents are not available, please state why. _____

_____

****PCPs often will not be considered if quality and/or utilization reports are not submitted with this application****

Please fax your response to (866) 306-1027 or email lstewart@medadvgrp.com