



P.O. Box 969 • Lilburn, GA 30048
Phone 770.455.0040 • Toll free 866.374.9558 • Fax 770.455.6188
www.I-AHC.net

PLEASE RETURN THIS COMPLETED CHECKLIST WITH REQUESTED DOCUMENTATION TO THE P. O. BOX ABOVE.

PROVIDER NAME: _____ **PHONE:** _____ **FAX:** _____

___ STATE CREDENTIALING APPLICATION FOR HEALTHCARE PRACTITIONERS-
*CAQH printout can replace State Application.

___ PROVIDER INFORMATION FORM

___ LOCATION INFORMATION FORM

___ RELEASE AUTHORIZATION

___ I-AHC PROVIDER AGREEMENT (14 pages) – Signature page 14

___ I-AHC BUSINESS ASSOCIATE AGREEMENT (6 pages) – Signature page 6

___ COPY OF **CURRENT** STATE LICENSURES (with expiration dates)

___ NPI NUMBERS – INDIVIDUAL: _____ BUSINESS: _____

___ COPY OF CURRENT LIABILITY INSURANCE (valid insurance on building)

___ COPY OF CURRENT MALPRACTICE COVERAGE (1M/3M and NOT expired)

___ MALPRACTICE CERTIFICATE HOLDER REQUEST – **Please send this directly to your Malpractice Insurance carrier.**

___ COPY OF W-9 – INDIVIDUAL _____ CORPORATE _____ OTHER _____

___ CMS WORKSHEET

___ MEMBERSHIP FEE in the amount of \$ _____. Contact I-AHC at credentialing@I-AHC.net for the fee amount.

___ E-MAIL _____

___ Completed enrollment forms for **free** EDI with OFFICE ALLY. See the link from our website.

Thank you for applying to the Integrated-ActivHealthCare network.

Should you have any questions regarding your credentialing application, please contact the credentialing department at phone number listed above.