

**Maryland Physicians Care Participating
Health Provider Agreement
Attachment C**

**List of Health Professionals
And Acceptance of Terms**

PHP/Group Name _____

This Attachment C. must be completed if PHP is an entity, or if PHP is an individual, and a Health Professional other than PHP will perform Covered Services. This Attachment C, as may be amended from time to time, shall list the Health Professionals who (i.) own, are employed by, or under contract with, the PHP, including locum tenens; and (ii.) will perform Covered Services under this Agreement. . PHP may amend this Attachment C. by giving MPC at least thirty (30) days advance written notice of the Health Professional's addition to or deletion from the list below. PHP may only add a Health Professional that MPC has determined meets MPC credentialing criteria. Any addition and deletion requires PHP to deliver a new Attachment C.

Maryland Physicians Care Participating
Health Provider Agreement
Attachment C

List of Health Professionals
And Acceptance of Terms

Physician Address:	Clinic/Office Phone Number:	Days/Hours of Operation							
		Hour	Mon	Tue	Wed	Thur	Fri	Sat	Sun
	Fax Number:	From							
		Until							
Contact person/Office Manager Name: Direct Phone Number:		Email Address:							

Provider Information:	Specialty / Board Certification	Medical License #	Any Member Restrictions	EPSDT Certified
1. Name: _____ <input type="checkbox"/> MD <input type="checkbox"/> Other Add _____ Effective Date _____ Hospital affiliation: _____ Ethnicity* _____ Gender* _____ Languages* _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	1		Medicaid # _____	Age: _____ <input type="checkbox"/> Yes Other _____ <input type="checkbox"/> No PCP Panel Capacity: _____
	2		BNDD-DEA # _____	
	3		CDS # _____	
	4		TIN# _____	
	5		NPI # _____	
2. Name: _____ <input type="checkbox"/> MD <input type="checkbox"/> Other Add _____ Effective Date _____ Hospital affiliation: _____ Ethnicity* _____ Gender* _____ Languages* _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	1		Medicaid # _____	Age: _____ <input type="checkbox"/> Yes Other _____ <input type="checkbox"/> No PCP Panel Capacity: _____
	2		BNDD-DEA # _____	
	3		CDS # _____	
	4		TIN# _____	
	5		NPI # _____	
3. Name: _____ <input type="checkbox"/> MD <input type="checkbox"/> Other Add _____ Effective Date _____ Hospital affiliation: _____ Ethnicity* _____ Gender* _____ Languages* _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	1		Medicaid # _____	Age: _____ <input type="checkbox"/> Yes Other _____ <input type="checkbox"/> No PCP Panel Capacity: _____
	2		BNDD-DEA # _____	
	3		CDS # _____	
	4		TIN# _____	
	5		NPI # _____	
4. Name: _____ <input type="checkbox"/> MD <input type="checkbox"/> Other Add _____ Effective Date _____ Hospital affiliation: _____ Ethnicity* _____ Gender* _____ Languages* _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	1		Medicaid # _____	Age: _____ <input type="checkbox"/> Yes Other _____ <input type="checkbox"/> No PCP Panel Capacity: _____
	2		BNDD-DEA # _____	
	3		CDS # _____	
	4		TIN# _____	
	5		NPI # _____	

*Information will be used only to assist in the provider selection for our MPC Members

Provider Information:	Specialty / Board Certification	Medical License #		Any Member Restrictions	EPSDT Certified
5. Name: _____ <input type="checkbox"/> MD <input type="checkbox"/> Other Add _____ Effective Date _____ Hospital affiliation: _____ Ethnicity* _____ Gender* _____ Languages* _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	1		Medicaid # _____	Age: _____	<input type="checkbox"/> Yes
	2		BNDD-DEA # _____	Other _____	<input type="checkbox"/> No
	3		CDS # _____	PCP Panel Capacity:	
	4		TIN# _____		
	5		NPI # _____		
6. Name: _____ <input type="checkbox"/> MD <input type="checkbox"/> Other Add _____ Effective Date _____ Hospital affiliation: _____ Ethnicity* _____ Gender* _____ Languages* _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	1		Medicaid # _____	Age: _____	<input type="checkbox"/> Yes
	2		BNDD-DEA # _____	Other _____	<input type="checkbox"/> No
	3		CDS # _____	PCP Panel Capacity:	
	4		TIN# _____		
	5		NPI # _____		
7. Name: _____ <input type="checkbox"/> MD <input type="checkbox"/> Other Add _____ Effective Date _____ Hospital affiliation: _____ Ethnicity* _____ Gender* _____ Languages* _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	1		Medicaid # _____	Age: _____	<input type="checkbox"/> Yes
	2		BNDD-DEA # _____	Other _____	<input type="checkbox"/> No
	3		CDS # _____	PCP Panel Capacity:	
	4		TIN# _____		
	5		NPI # _____		
8. Name: _____ <input type="checkbox"/> MD <input type="checkbox"/> Other Add _____ Effective Date _____ Hospital affiliation: _____ Ethnicity* _____ Gender* _____ Languages* _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	1		Medicaid # _____	Age: _____	<input type="checkbox"/> Yes
	2		BNDD-DEA # _____	Other _____	<input type="checkbox"/> No
	3		CDS # _____	PCP Panel Capacity:	
	4		TIN# _____		
	5		NPI # _____		
9. Name: _____ <input type="checkbox"/> MD <input type="checkbox"/> Other Add _____ Effective Date _____ Hospital affiliation: _____ Ethnicity* _____ Gender* _____ Languages* _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	1		Medicaid # _____	Age: _____	<input type="checkbox"/> Yes
	2		BNDD-DEA # _____	Other _____	<input type="checkbox"/> No
	3		CDS # _____	PCP Panel Capacity:	
	4		TIN# _____		
	5		NPI # _____		
10. Name: _____ <input type="checkbox"/> MD <input type="checkbox"/> Other Add _____ Effective Date _____ Hospital affiliation: _____ Ethnicity* _____ Gender* _____ Languages* _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	1		Medicaid # _____	Age: _____	<input type="checkbox"/> Yes
	2		BNDD-DEA # _____	Other _____	<input type="checkbox"/> No
	3		CDS # _____	PCP Panel Capacity:	
	4		TIN# _____		
	5		NPI # _____		

PHP/Group Name: _____

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