AlaMed
Workers' Compensation Medical Care Network

P.O. Box 361722 Birmingham, AL 35236 Phone: 205.451.1747
www.alamed.net

Provider Fact Sheet

Please complete one Provider Fact Sheet for Each Provider in the Group

1. **Provider's Name:** _____

2. **Physical Group/Practice Name to Appear in Directory**
   _____

3. **Physician's Specialty**
   Which specialty(s) would you like to be listed in the provider directory?
   _____ _____

4. **Treating Address**
   Street Address: _____
   City, State, Zip: _____
   County: _____
   Phone Number: _____ Fax Number: _____

5. **Medical Education**
   School Name: _____
   Address: _____
   City, State, Zip: _____
   Degree: _____ Date of Graduation: _____

6. **Licensure (Present)**

_____	_____	_____	_____
State or Province	Date Issued MM/DD/YY	Date Expires MM/DD/YY	State license No.

7. **License Status**: _____ **License Type**: _____

8. **Has your license to practice your profession in any jurisdiction ever been suspended or revoked**?
   Yes: _____ If yes, please give full details on separate sheet. No: _____

9. **UPIN Number:** _____

10. **NPI Number:** _____

11. Contact information

Phone Number: _____ Fax Number: _____
Website: _____ Contact Person: _____
E-mail Address: _____ Title: _____

12. Billing Address (if different from above)

Street Address: _____
City, State, Zip: _____
Billing Contact: _____
Phone Number: _____

13. Workers' Compensation/Occupational Medicine Coordinator

Name: _____
E-mail address: _____
Phone Number: _____
Practice Hours: _____

14. Is Provider Board Certified? Yes:___ No:___ **Is Provider Board Eligible?** Yes:____ No:___

15. Hospital Admitting Privileges

With what hospital(s) does the provider currently have admitting privileges?

_____ _____

16. Group Tax I.D. Number: _____
17. Group NPI Number: _____
18. Universal Medicare Number: _____

19. Status of any legal judgments: _____

AlaMed Holdings, Inc. will maintain a file of each participating provider's credentials. In order to do so, please attach the following documents:

- Copy of current license, registration or certificate
- Copy of current Board Certificate or eligibility
- Copy of current malpractice insurance policy
    - Minimum requirement: $1,000,000 single occurrence, $3,000,000 aggregate
- Copy of curriculum vitae
- Copy of the W-9 form that matches the facility name and Tax ID number

This documentation will need to be updated every year!

I represent that information provided in or attached to this application is accurate. I understand that a condition of this application is that any misrepresentation, misstatement, or omission from this application --whether intentional or not-- is cause for automatic and immediate rejection of this application and may result in the denial of panel appointment in the network. Upon subsequent discovery of such misrepresentation, misstatement, or omission, AlaMed Holdings, Inc., may have cause to terminate my panel appointment in the network.

I hereby authorize AlaMed Holdings, Inc. to collect verification of the above-noted credentials and insurance information on my behalf.

_____ _____
Signature Date

Please email your completed Fact Sheet to: jennifer.hall@alamed.net