

For Current SoonerCare Choice Primary Care Providers Only*

NOTICE – ALL FIELDS MUST BE COMPLETED OR YOUR APPLICATION WILL BE RETURNED

(PLEASE INDICATE N/A IF A FIELD ISN'T APPLICABLE)

PERSONAL INFORMATION

Section 1	Provider Type _____ Specialty(ies) _____				
	Last Name _____		First Name _____		Middle Initial _____
	Suffix _____		SSN _____		
	Gender <input type="radio"/> M <input type="radio"/> F (circle one)	Title _____	NPI _____		
Do you want to enroll as a Primary Care Provider for the Insure Oklahoma Program? <input type="checkbox"/> Yes <input type="checkbox"/> No					

PROFESSIONAL PRACTICE

Section 2	Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you accept Medicare patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Age of patients you wish to treat: _____ - _____		Patients you wish to treat? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both		
	Are you enrolled in the Vaccine for Children (VFC) Program? <input type="checkbox"/> Yes <input type="checkbox"/> No VFC # _____				
	Will you provide OB/GYN care? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Do you have prescriptive authority? <input type="checkbox"/> Yes <input type="checkbox"/> No				

INSURE OKLAHOMA

If you answered YES to participate in Insure Oklahoma programs in Section 1, this section is required.

Which age of Insure Oklahoma members do you wish to treat? (Please only select one age range.)

Section 3	Any Age <input type="checkbox"/>	Age <1 <input type="checkbox"/>	Age 0-5 <input type="checkbox"/>	Age 0-14 <input type="checkbox"/>	Age 0-18 <input type="checkbox"/>	Age 0-20 <input type="checkbox"/>
	Age 0-21 <input type="checkbox"/>	Age 0-45 <input type="checkbox"/>	Age 1-4 <input type="checkbox"/>	Age 1-5 <input type="checkbox"/>	Age 1-99 <input type="checkbox"/>	Age 4-99 <input type="checkbox"/>
	Age 6-99 <input type="checkbox"/>	Age 10-99 <input type="checkbox"/>	Age 14-99 <input type="checkbox"/>	Age 16-99 <input type="checkbox"/>	Age 18-99 <input type="checkbox"/>	Age 21-99 <input type="checkbox"/>
	Age 45-99 <input type="checkbox"/>	Age 55-99 <input type="checkbox"/>	Age 6-14 <input type="checkbox"/>	Age 12-20 <input type="checkbox"/>	Age 15-20 <input type="checkbox"/>	Age 21-44 <input type="checkbox"/>

Insure Oklahoma

Desired total # Insure Oklahoma patient capacity? _____

What gender Insure Oklahoma patients do you wish to treat? Male Female Both

What percentage of your total office hours are available for serving members at this location? _____

*All other providers interested in becoming PCPs should go to the OHCA website at okhca.org.

CONTACTS

Section 4

Enrollment Contact

First Name _____ Last Name _____ Phone (____) _____ ext _____ Fax (____) _____
Email _____

Clinical Services Contact (if different from Enrollment)

First Name _____ Last Name _____ Phone (____) _____ ext _____ Fax (____) _____
Email _____

Electronic Payment Contact (if different from Enrollment)

First Name _____ Last Name _____ Phone (____) _____ ext _____ Fax (____) _____
Email _____

Do you have a website you want listed in a provider directory? If yes, include the web address.

Provider Website _____

OHCA will provide a directory of providers on a public website. If you do not want to be listed in the directory, check the following box:

Print Provider Name **Provider Signature** **Date**

*This form is for current SoonerCare Choice PCPs only: all other providers interested in becoming PCPs should go to the OHCA website at okhca.org.

Please return the completed form to:

Oklahoma Health Care Authority
Attn: Provider Contracting
P.O. Box 54015
Oklahoma City, OK 73154