A La Carte Order Form - Please email this form and all required documents to: **orders@statcred.com**. Questions should be directed to our Billing Department at 877-887-1784, Ext. 403

Basic Information	Date Submitted:	Contact Name, Email & Phone #:		
	Client Name:			
Description of Requests				
Types of Requests	☐ Payor Enrollment Application For **Individual** Providers – Please include the names of your providers under each applicable request:		☐ New	☐ Recred
	☐ Medicare – 855I and/or 855R or both? Please include the names of your Providers:			Due Dates:
	☐ Medicaid – Please include the names of your Providers & the States:			Due Dates:
	☐ Commercial plans – Please include list of Plans & Providers:			Due Dates:
	Notes/Other Details to include PECOS logins and/or Medicaid portal logins:			

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STAT MedCare Solutions, LLC

Types of Requests Continued:	☐ Payor Enrollment application For **Groups/Facilities**, etc.: ☐ Medicare – 855B, 855S, etc.: ☐ Medicaid – please include the states: ☐ Commercial plans – Please include list of plans:	☐ New	☐ Recred Due Dates: Due Dates: Due Dates:
	Please include the names of the providers and also send any relevant data with your request: ☐ NPI Application: Type 1 or Type 2? If updating, provide details:	☐ New	☐ Update

Types of Requests Continued:	☐ State Medical License: Include name of Provider, state and license type. Please Note: STAT may also require the Providers Credentials with your Requests. Please confirm with your Account Manager or Specialist.	☐ New Licenses – If you need more room, please fill out multiple order forms Name of Provider, License Type (MD, DO, RN, NP, PA) & State: Name of Provider, License Type (MD, DO, RN, NP, PA) & State:	☐ Renewals – If you need more room, please fill out multiple order forms Name of Provider, License Type (MD, DO, RN, NP, PA) & State: Name of Provider, License Type (MD, DO, RN, NP, PA) & State:
	☐ FCVS Application – Please include the name of your provider(s):	☐ New	☐ Update
	☐ Demographic Changes: ☐ Medicare - 855B (Brief Explanation of Change): ☐ Medicare - 855I (Brief Explanation of Change): ☐ EFT Changes (Please provide a list plans, explain changes plus provide copy of bank letter, new w9 & voided check):		

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Types of Requests Continued:	☐ Add New Service locations - include list of plans & Brief Details of Change(s):		
	☐ Other Changes - Include List of Plans & Brief Explanation of Change:		
	☐ New EFT Requests - Please provide a list plans, provide a copy of your bank letter, w9 & voided check:		
	☐ CAQH	☐ New ☐ Update/Reattest CAQH ID: _____ USERNAME: _____ PASSWORD: _____	
Types of Requests Cont.	☐ Hospital/Facility Privileging - Select Provider Type & Include the names of your Providers: ☐ MD/DO ☐ Mid-Level ☐ Allied	☐ New Appointment Due Date: Rush Request:	☐ Reappointment Due Date: Rush Request:
	☐ Rate Negotiations - Please include list of Plans & Percentage of Increase requested:		
	☐ Maintenance & Monitoring (Please list the providers, items to be monitored & start date):		
	☐ Other Requests:		
Additional Notes:			

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REQUESTED BY:	NAME/E-SIGNATURE:

PLEASE SELECT/APPROVE THE PSV CRITERIA BELOW:

EXPENSES & FEES	☐ APPLICATION FEES (HOSPITAL, STATE BOARD, ETC.)	☐ NPDB
	☐ LICENSE VERIFICATION	☐ ABFAS
PLEASE SELECT PSV REQUIREMENTS	☐ BACKGROUND CHECK	☐ NCC
	☐ NATIONAL STUDENT CLEARING HOUSE	☐ AANP
	☐ AMA	☐ AOA
	☐ ECFMG VERIFICATION	☐ ANCC
	☐ FCVS	☐ USMLE
CLIENT APPROVAL	NAME/E-SIGNATURE:	DATE

PLEASE NOTE: THIS FORM MUST BE SUBMITTED, CLIENT INVOICED AND INVOICE PAID PRIOR TO ANY WORK BEING DONE FOR THESE REQUESTS.

THIS SECTION TO BE COMPLETED BY THE STAT BILLING DEPARTMENT				
INVOICE #:	☐ PAYMENT RECEIVED	☐ INVOICE DISPUTED	☐ INVOICE REJECTED	☐ MORE INFO NEEDED
DATE INVOICED:				
SPECIAL BILLING:				
COMMENTS:				

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