**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: | |

STATMedCare, LLC
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**Types of Requests Continued:**

☐ Payor Enrollment application For **Groups/Facilities**, etc.: ☐ New ☐ Recred

☐ Medicare – 855B, 855S, etc.:

Due Dates:

☐ Medicaid – please include the states:

Due Dates:

☐ Commercial plans – Please include list of plans:

Due Dates:

Please include the names of the providers and also send any relevant data with your request: ☐ New ☐ Update

☐ NPI Application: Type 1 or Type 2?

If updating, provide details:

**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):<br><br>☐ 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<br>☐ New<br>☐ Update/Reattest<br>CAQH ID: USERNAME: PASSWORD: |
| Types of Requests Cont. | ☐ Hospital/Facility Privileging - Select Provider Type & Include the names of your Providers:<br>☐ MD/DO ☐ Mid-Level ☐ Allied<br>☐ New Appointment<br>Due Date:<br>Rush Request:<br>☐ Reappointment<br>Due Date:<br>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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