



### Recruitment Request Form

This form is intended to be used for inquiring participation in the Virginia Premier network. Completion of this form does not constitute that a provider/vendor is contracted with Virginia Premier. Please complete this form, when requesting a provider/vendor to be recruited or when receiving a call from an interested provider/vendor. Please complete and fax form to: Network Development Department at (804) 819-5366. Should you have any questions or concerns, call (800) 727-7536 extension 5204.

Date Call Received: \_\_\_\_\_ Staff Member Receiving Call: \_\_\_\_\_

Provider Information: \_\_\_\_\_ Individual / Solo Practice \_\_\_\_\_ Group Practice

# of Providers: \_\_\_\_\_ Are there any panel restrictions? Yes  No

If applying to be a Primary Care Physician(s). Do you wish to have an open panel? Yes  No

Name of Group Practice: \_\_\_\_\_

Provider Name or Names: \_\_\_\_\_

\_\_\_\_\_

Physical Location: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

Phone #: \_\_\_\_\_ Facsimile #: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

Specialty or Services Provided: \_\_\_\_\_ Hours of Operation: \_\_\_\_\_

If applicable, do you currently have active hospital privileges? Yes  No  If yes, where \_\_\_\_\_

\_\_\_\_\_

Do you offer after-hours services? If so, please provide information on after-hours: \_\_\_\_\_

\_\_\_\_\_

Are you receiving referrals to see VPHP Members? If yes, what is the frequency? \_\_\_\_\_

Do you treat children with special needs? Yes  No

INDV NPI #: \_\_\_\_\_ GROUP NPI# \_\_\_\_\_ EIN # \_\_\_\_\_

Medical Management Recommendation: Yes  No  Date: \_\_\_\_\_

Network Development Committee Decision: Approved  Not Approved  Date: \_\_\_\_\_

Resolution / Actions Taken: Sent Recruitment  Rejection Letter  Date: \_\_\_\_\_

**VIRGINIA PREMIER HEALTH PLAN, INC.  
RECRUITMENT REQUEST FORM CAQH INFORMATION**

CAQH number only applies to the following provider types (MD, DDS, DO, DPM, DC, DMD, and DDS).

Provider CAQH#: _____	Provider Name: _____
VA License#: _____	Degree Type: _____
VA Medicaid Number: _____	Specialty: _____
Provider CAQH#: _____	Provider Name: _____
VA License#: _____	Degree Type: _____
VA Medicaid Number: _____	Specialty: _____
Provider CAQH#: _____	Provider Name: _____
VA License#: _____	Degree Type: _____
VA Medicaid Number: _____	Specialty: _____
Group Name: _____	TIN#: _____
Main Location: _____	
Phone: _____	Fax: _____
Secondary Location: _____	
Phone: _____	Fax: _____
Remittance Location: _____	
Contact Person/Title: _____	Phone: _____

Network Development Comments/Recommendation: \_\_\_\_\_

Recruitment Package Mailed: _____	Contracting Staff: _____
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