vibra HEALTH PLAN

For NEW GROUP Use Only

Provider Data Form

For Credentialing and New Group Setup

To begin the credentialing process, please use this simple, standardized form. Please **email** the completed form to Vibra Health Plan at providersupport@vibrahealthplan.com.

Note: Anything marked with an asterisk (*) is a required field.

Section 1—Provider Group Information

*Date:							
*Legal Entity Name:							
Group Name (DBA, *if different from Legal Entity Name*):							
*Group NPI Number:							
*Group Tax ID Number:							
*Primary Office Street Address:				Suite Number:		Medicare Number:	
*Primary Office City:		*State:		*County:		*ZIP:	
*Appointment Phone Number:				Primary Fax Number:			
Group Email Address:				*Print in Directory? ☐ Yes ☐ No			
*Primary Office Hours:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Additional Office Location Street Address (affiliated with NPI/Tax ID listed above):				Suite Number:			
Additional Office City:		State:		County:		ZIP:	
Additional Office Appointment Phone Number:				Additional Office Fax Number:			
Additional Office Email Address:				Print in Directory? ☐ Yes ☐ No			
*Correspondence Address:							
*Correspondence Phone:				Correspondence Fax:			

Vibra Health Plan is a PPO with a Medicare contract. Enrollment in Vibra Health Plan depends on contract renewal.

*Remit Address:	
*Remit Phone: (If applicable)	Remit Fax: (If applicable)
*Medical Records Address:	
*Medical Records Phone:	Medical Records Fax:
*Medical Records Contact Person:	*Medical Records Email:
Please list those who are authorized to sign contracts on behalf of the practice:	
*Name:	*Title:
*Phone:	Fax:
*Email:	**Note:** This email address is used to communicate important information. It is the group's responsibility to notify Vibra Health Plan of any changes.
Name:	Title:
Phone:	Fax:
*Group Contact Name:	*Group Contact Phone:
*Name and Title of Individual Completing this Form:	
*Email Address: ☐ Do not have an email address	*Taxonomy Code:

Please complete Page 3—Section 2 of this form for each individual practitioner that is part of the group in Section 1.

Note: If the group has already completed the practitioner's application with CAQH, please ensure that the group has authorized all applicable organizations to access the practitioner's data. Using the CAQH Universal Provider DataSource does not grant participation or constitute applying for participation with any of the above organizations. If the practitioner is already listed with CAQH this form will allow us to pull the necessary information to begin contracting and credentialing.

Section 2—Individual Practitioner Information

It is important that the group notifies us promptly when a practitioner's status changes.

*Last Name:	*First Name:	Middle Initial:
*Date of Birth:		
*Practitioner Type (e.g., MD, DO, DC, DDS, DMD, DPM):		
*Specialty:	*Applying As: ☐ Primary Care Physician ☐ Specialist ☐ Allied Health Professional	
*Languages:		
*Date Joined/Opened Group:	**Note:** Does not mean that this will be the effective date.	
*CAQH ID Number:	**Note:** Vibra Health Plan requires practitioners to be registered with CAQH. So, if the practitioner is not already registered, please do so prior to submitting the Provider Data Form.	
*Social Security Number:		
*State License Number:	*Licensed State:	
*Individual NPI Number:	*Taxonomy Code:	
*Will the practitioner be practicing at all locations? ☐ Yes ☐ No (If the practitioner will be at some, but not all locations, please list the locations below)		

Service Locations	Primary:	
	Other:	
	Other:	
	Other:	
	Other:	
	Other:	

Note: If adding multiple practitioners to a group, the group will need to complete Section 2 for each practitioner being added.