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 M F (circle one) _____ Title _____ NPI

Do you want to enroll as a Primary Care Provider for the Insure Oklahoma Program? ☐ Yes ☐ No

PROFESSIONAL PRACTICE

Section 2

Are you accepting new patients? ☐ Yes ☐ No

Do you accept Medicare patients? ☐ Yes ☐ No

Age of patients you wish to treat:_____- _____ Patients you wish to treat? ☐ Male ☐ Female ☐ Both

Are you enrolled in the Vaccine for Children (VFC) Program? ☐ Yes ☐ No VFC # _____

Will you provide OB/GYN care? ☐ Yes ☐ No

Do you have prescriptive authority? ☐ Yes ☐ No

INSURE OKLAHOMA

Section 3

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.)

☐ Any Age	☐ Age <1	☐ Age 0-5	☐ Age 0-14	☐ Age 0-18	☐ Age 0-20
☐ Age 0-21	☐ Age 0-45	☐ Age 1-4	☐ Age 1-5	☐ Age 1-99	☐ Age 4-99
☐ Age 6-99	☐ Age 10-99	☐ Age 14-99	☐ Age 16-99	☐ Age 18-99	☐ Age 21-99
☐ Age 45-99	☐ Age 55-99	☐ Age 6-14	☐ Age 12-20	☐ Age 15-20	☐ Age 21-44

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