beacon
health options

Practitioner Group Addition Form

This form is used to add any practitioner to a new group or to an already in-network group (including currently in-network individually contracted practitioners).

(Please check all boxes that apply)

Provider Name: _____

Provider Licensure: _____

Beacon Health Options provider number: _____ Provider NPI: _____

Provider CAQH#: _____

☐ I wish to be contracted under the group agreement for:

Group Name: _____

Group Tax ID: _____

Beacon Health Options Group provider number: _____

*Please indicate the **Group** Locations below (Please submit copies if additional locations needed)

Practice address: _____ Billing address: _____

Line 2: _____ Line 2: _____

City: _____ City: _____

State: _____ ZIP: _____ State: _____ ZIP: _____

Phone #: _____ Fax #: _____ Phone #: _____ Fax #: _____

M: _____ T: _____ W: _____ Th: _____ F: _____ Sa: _____ Su: _____

Practice address: _____ Billing address: _____

Line 2: _____ Line 2: _____

City: _____ City: _____

State: _____ ZIP: _____ State: _____ ZIP: _____

Phone #: _____ Fax #: _____ Phone #: _____ Fax #: _____

M: _____ T: _____ W: _____ Th: _____ F: _____ Sa: _____ Su: _____

Practitioner Group Addition Form

☐ I wish to terminate my Beacon Health Options individual practitioner agreement and no longer be in-network at any non-group service location.

☐ I will maintain my Beacon Health Options individual practitioner agreement and remain in-network at my private practice and/or individually contracted service locations at the following service locations:

*Please indicate your **Private Practice/Individually Contracted** locations below (Please submit copies if additional locations needed)

Practice address: _____	Billing address: _____
Line 2: _____	Line 2: _____
City: _____	City: _____
State: _____ ZIP: _____	State: _____ ZIP: _____
Phone #: _____ Fax #: _____	Phone #: _____ Fax #: _____
M: _____ T: _____ W: _____ Th: _____ F: _____ Sa: _____ Su: _____	

Practice address: _____	Billing address: _____
Line 2: _____	Line 2: _____
City: _____	City: _____
State: _____ ZIP: _____	State: _____ ZIP: _____
Phone #: _____ Fax #: _____	Phone #: _____ Fax #: _____
M: _____ T: _____ W: _____ Th: _____ F: _____ Sa: _____ Su: _____	

Name (please print): _____

Signed: _____ Date: _____

*** Attention group administrators: Please submit this form with an updated group roster. ***

Please submit your completed form to: Beacon Health Options, PO Box 989, Latham, NY, 12110
Fax: 866-612-7795.