Sandhills Physicians, Inc.
Submission of Uniform Application

To ensure timely credentialing of your providers, please provide the following:

Complete the attached "Data Form" and include with your submitted application.

All applications submitted to Sandhills Physicians, Inc. (SPI) **must** include everything that is listed on page 2 of the Uniform Application to Participate as a Health Care Practitioner.

In addition to the above instructions, you must also provide a current copy of the provider's Curriculum Vitae (CV), which includes the months as well as the years on all education and work history. (New NCQA standard effective July 2004) SPI require any gaps greater than 30 days in the education and work history be explained in writing and attached to the application.

The application must be **completely** filled out. There **should not** be any blank spaces. If it does not apply to the provider, **you must** write "not applicable" or "N/A" in that box. Months as well as years are mandatory within the application as well. "See CV" or "See Curriculum Vitae" **are not** acceptable within the application. All areas of the application should be completed.

The Attestation Statement that the provider has signed **should not** be greater than 30 days old.

There should be four (4) references provided with the complete address, phone number, fax number and email addresses.

Please note that all incomplete applications will be returned.

You may direct questions of concern to Sherry Yates, Provider Relations/Credentialing Specialist, 910-920-2507 Ext 224.

Please contact our office for the appropriate application fee before submitting.

Return Application and applicable fees to:
Sandhills Physician, Inc
354 Wagoner Drive, Suite 101
Fayetteville, North Carolina 28303
Attention: Sherry Yates

Personal Data Form

Please Print Clearly in Blue or Black Ink Only.

Personal Data: Part I

Name: ______________________________Title: ______ Specialty: _______________

Home Address: __________________________City:_____________State:_____Zip_____

Date of Birth: _______________ Place of Birth:_________________Sex: Male ☐ Female ☐

Primary Office Data: Part II

Name of Practice: ____

Physical Address: ________________________City:_____________State:_____Zip_____

Billing Address: ____________________________City:____________State:_____Zip_____
(If different from physical address)

Office Phone: ______________ Fax Phone: _____________ email: __________________

Administrative Contact: _________________________________Title: _______________

Claim/Carrier Information: Part III **(All numbers are required for enrollment)**

Federal Tax ID#:_________________ Medicare/Medicaid Number: __________________

Individual NPI#: ___________________ *Facility's NPI Number: ______________________
(Required unless you are a sole proprietor)

***A sole proprietor has the option of using one NPI to represent him or her as an individual or choose to have two different NPIs – one for the individual and one for the solo practice. Staff of the sole proprietor must include the facility's NPI, as well as their individual NPI.**