# Managed Medical Assistance Program (MMA)

Dear Provider:

Thank you for your interest in joining the MMA Plan Provider Network. To start the credentialing process, please send an email to credentialingdept@ccpcares.org and include the following information within the body of the email:

- Provider's First and Last Name
  - Provider's unique email address for each applicant
  - Email Address for Credentialing Contact
- Credentialing Contact Person
  - Name
  - Email Address
  - Phone Number
- Tax ID
- NPI
- W-9
- Communications preference
- Group Affiliation
  - Group Contracted Yes/No
- Populations Served
  - Children, adults, or both
- Specialty
- Other Services Provided
- Service Area (Please list counties served)
- Lines of business you are interested in:
  - Title 19 (Medicaid)
  - Title 21 (CHIP)
  - Both Title 19 and Title 21
- Are you a new provider?
- Are you part of a contracted provider?
- Do you have a Medicaid Provider ID? If yes, please provide.
- Provide Medical License Number and State

Once this information is received, you will be notified by CCP of next steps in the credentialing process. Credentialing connects you with a growing network of professionals across Florida, whose qualifications are carefully vetted and approved to distinguish the network as one that is committed to quality across all standards of care.

Should you have any questions or concerns, please call 1-844-618-5773 or email credentialingdept@ccpcares.org.

Thank you again for your interest and please know we are here to assist in the process and answer any questions you may have.

Sincerely,

CCP Credentialing Department

# Provider Demographic Form

*(Please complete one Demographic form per provider)*

## Group Information

| Group Name | | |
|---|---|---|
| | | |
| **Remit / Billing Address** | | |
| | | |
| **Contact Name** | **Contact Phone #** | **Contact Email** |
| | | |
| **TIN** | **NPI** | **FL Medicaid ID** |
| | | |
| **EMR** ❑ Yes ❑ No | **Gender Accepted** ❑ M ❑ F | |

## Provider Information

| Provider Name | | |
|---|---|---|
| | | |
| **Individual NPI** | **Provider Specialty** | **Taxonomy Code** |
| | | |
| **Individual FL Medicaid ID** | **FL Medical License #** | **Age Range** |
| | | |
| **Hospital Affiliations AHCA ID** | | **If Dental provider, Sedation Permit** ❑ Yes ❑ No |

## Location Information

*Use additional pages for multiple locations*

| Main Location Name | | Manager / Contact Name |
|---|---|---|
| | | |
| **Address** | | |
| | | |
| **City** | **State** | **Zip Code** |
| | | |
| **Phone #** | **Fax #** | **Location NPI** |
| | | |
| **Taxonomy Code(s)** | | **Wheelchair Access?** ❑ Yes ❑ No |
| | | |

| | | | |
|---|---|---|---|
| **Office Hours** | | **MPIP Y/N?** | |
| **Weekend/Holiday Hours** | | **MPIP Code** | |
| **Gender Accepted** | ❑ Female ❑ Male | **MPIP Start Date** | |
| **Languages Spoken** (Refer to AHCA's PNV File Specification - *Appendix C)* | | **MPIP End Date** | |
| | | (Refer to AHCA's PNV File Specification - *Appendix E)* | |

## FOR PLAN TO COMPLETE (Please do not complete form beyond this point)

| | | | |
|---|---|---|---|
| **Provider Application Received Date** | | | |
| **Credentialing Date** | | | |
| **Effective Date** | | | |
| **CRM Number** *Please be sure to request load for Provider, Group and POS- link providers to appropriate POS | | **PRPR Number or Date added to Load List** | |
| **Appear in Directory?** | ❑ Yes ❑ No | **Is Provider a PCP?** | ❑ Yes ❑ No |
| **PML Verification?** | ❑ Yes ❑ No | **NPPES Verification?** | ❑ Yes ❑ No |