Wellstar

Ambulatory Practices Directory

2021

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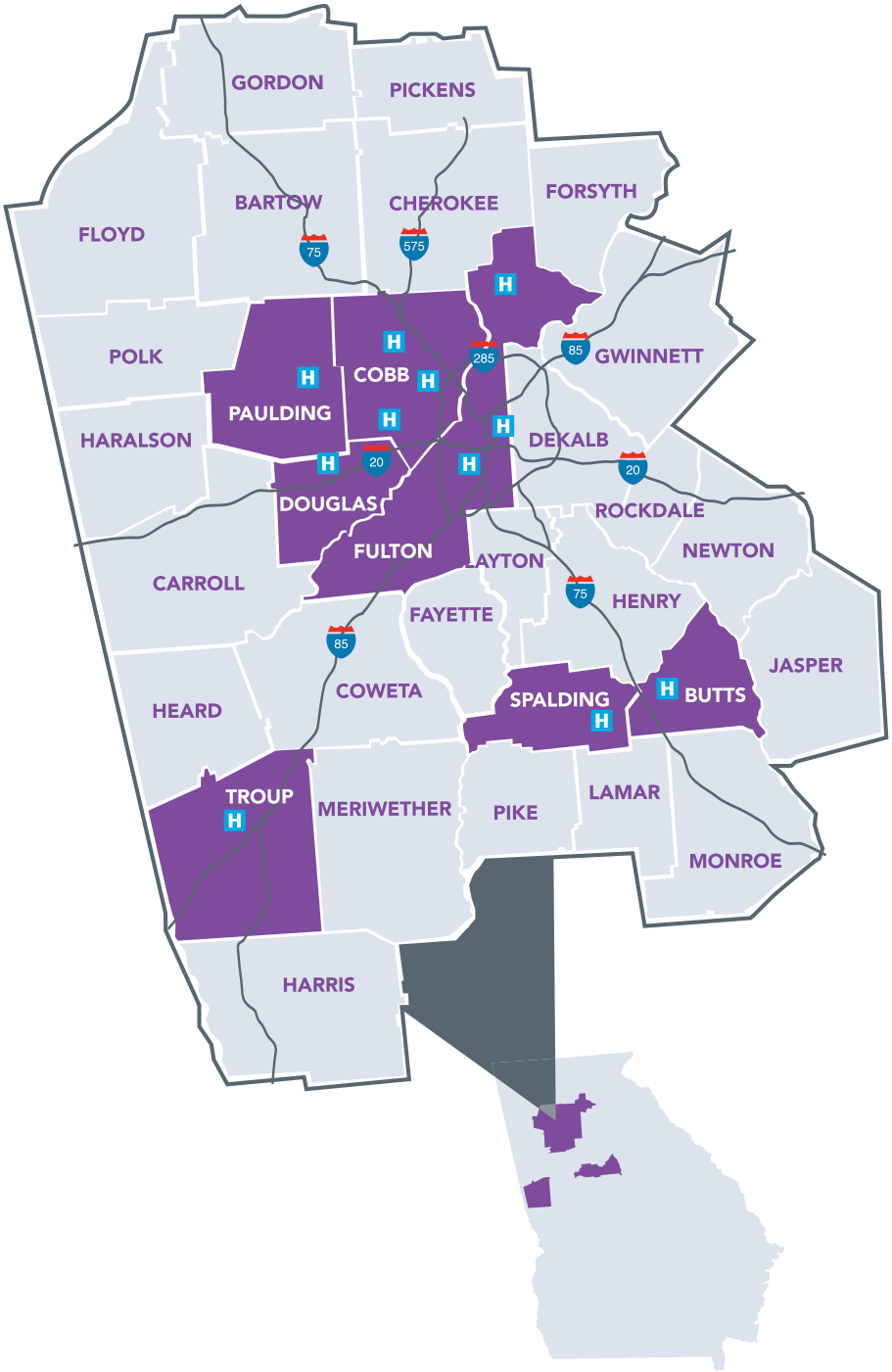

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(404) 265-4000

Wellstar Atlanta Medical Center South
1170 Cleveland Avenue
East Point, GA 30344
(404) 466-1170

Wellstar Cobb Hospital
3950 Austell Road SW
Austell, GA 30106
(470) 732-4000

Wellstar Douglas Hospital
8954 Hospital Drive
Douglasville, GA 30134
(770) 949-1500

Wellstar Kennestone Hospital
677 Church Street
Marietta, GA 30067
(770) 793-5000

Wellstar North Fulton Hospital
3000 Hospital Boulevard
Roswell, GA 30076
(770) 751-2500

Wellstar Paulding Hospital
2518 Jimmy Lee Smith Parkway
Hiram, GA 30141
(470) 644-7000

Wellstar Spalding Regional Hospital
601 South 8th Street
Griffin, GA 30114
(770) 228-2721

Wellstar Sylvan Grove Hospital
1050 McDonough Road
Jackson, GA 30233
(770) 775-7861

Wellstar West Georgia Medical Center
1514 Vernon Road
LaGrange, GA 30240
(706) 882-1411

Wellstar Windy Hill Hospital
2540 Windy Hill Road
Marietta, GA 30067
(770) 644-1000

Wellstar
Clinical Partners

PROVIDER DEMOGRAPHIC DATA CHANGE FORM

Practice Name:

PLEASE SELECT YOUR APPROPRIATE WELLSTAR AFFILIATION(S)

☐ WellStar Medical Group (WMG)	☐ WellStar Clinical Partners (WCP)	☐ Accountable Care Organization (ACO)	☐ WellStar Employee Plan ONLY

Provider type: ☐ MD ☐ DO ☐ DPM ☐ Other: _____

PRACTICE DEMOGRAPHIC CHANGE ONLY

Please include updated practice W9s for any respective changes and send along with completed form

Previous Practice Name:	New Practice Name:
Previous Practice TIN:	New Practice TIN:
Practice Billing Address:	
Previous Practice Address:	New Practice Address:
Changes to Phone, Fax, or Email:	

PROVIDER DEMOGRAPHIC CHANGE ONLY

Please include updated provider W9s for any respective changes and send along with completed form

Provider Previous Last Name:	Provider Previous First Name:	Provider Previous Middle Name:
Provider New Last Name:	Provider New First Name:	Provider New Middle Name:
Previous Provider NPI:	New Provider NPI:	
Changes to Phone, Fax, or Email:		

NEW PROVIDER JOINING PRACTICE

HAS A WELLSTAR HOSPITAL CREDENTIALING APPLICATION BEEN COMPLETED FOR THIS PROVIDER?

☐ YES | Please provide date of submission or effective date of committee approval _____/_____/_____

☐ NO | Please send an email to Medical Staff Services at medstaffapp@wellstar.org to request an application for hospital membership/privileges. Please indicate in the email if you are requesting basic hospital affiliation for WCP membership purposes only or if you require clinical privileges.

HAS A WELLSTAR MANAGED CARE CREDENTIALING APPLICATION BEEN COMPLETED FOR THIS PROVIDER?

☐ YES | Please provide date of submission or effective date of committee approval _____/_____/_____

☐ NO

IS THE PROVIDER BOARD CERTIFIED?

☐ YES | Please provide date of certification ____/_____/_____ and expiration date ____/_____/_____
| Please indicate the certifying body _____

☐ NO | Please indicate date of residency/fellowship completion _____/_____/_____

DOES THE PROVIDER PARTICIPATE IN AN SIGNIFICANT JOINT VENTURE OR MANAGEMENT, CONSULTING OR SERVICE ARRANGEMENT WITH A HOSPITAL OR HEALTH SYSTEM OTHER THAN WELLSTAR HEALTH SYSTEM OR ITS AFFILIATES? FOR EXAMPLE, PROVIDER HAS A SERVICE ARRANGEMENT/AGREEMENT WHERE YOU PROVIDE MEDICAL SERVICES AT A COMPETING HOSPITAL. ☐ YES | If yes, please explain each arrangement and identify the other party _____ ☐ NO

DOES THE PROVIDER SERVE AS AN EMPLOYEE, INDEPENDENT CONTRACTOR, TRUSTEE, DIRECTOR, PARTNER, GENERAL MANAGER, OFFICER, AGENCT, A DVISOR IN ANY OTHER SIMILAR LEADERSHIP/GOVERNANCE ROLE OR CAPACITY (OTHER THAN AS A MEDICAL STAFF LEADER) WITH ANY HEALTHCARE PROVIDER, SYSTEM, NETWORK, HEALTH PLAN, INSURER OR OTHER ORGANIZATION WHICH IS OR MAY BE A COMPETITOR OF WELLSTAR HEALTH SYSTEM OR ITS SUBSIDIARIES OR AFFILIATES? FOR EXAMPLE, AN EMPOYEE/DIRECTOR RELATIONSHIP AT A COMPETING HOSPITAL. ☐ YES | If yes, for each such relationship, please identify the entity and describe the role played by the member of your group _____ ☐ NO

HAS THE PROVIDER EVER BEEN SUSPENDED OR EXCLUDED FROM PARTICIPATON IN A FEDERAL OR STATE GOVERNMENTAL HEALTHCARE PROGRAM IN THE LA ST FIVE (5) YEARS? ☐ YES | if yes, please provide specific information regarding such suspension or exclusion ☐ NO

Provider Last Name:	Provider First Name:	Provider Middle Name:
Provider NPI:	Primary Specialty:	Secondary Specialty:

EXISTING PROVIDER LEAVING PRACTICE (TERM REQUEST)

ACO PROVIDERS, PLEASE EMAIL A SIGNED TERM LETTER TO provider.relations@wellstar.org

Provider Last Name:	Provider First Name:	Provider Middle Name:
Provider NPI:	REASON FOR TERM: ☐ Leaving Service Area/Relocation ☐ Joining Another Practice ☐ Retiring ☐ Deceased ☐ OTHER: _____	

PLEASE CONFIRM AND NOTE THE REQUESTED EFFECTIVE DATE OF TERMINATION ____/_____/_____

AUTHORIZED SIGNATURE

Person Authorized to Make Changes (Print Name & Title):	Signature:	Email:	Date:

Please complete one form for EACH provider in the practice. Once completed, please email to provider.relations@wellstar.org or wellstarclinicalpart@wellstar.org. To fax, please send to (770) 563-0736.

Please use this Provider Demographic Data Change Form to submit all changes.
Once completed, please email to provider.relations@Wellstar.org or Wellstarclincalpart@Wellstar.org.
To fax, please send to (770) 999-2387.

Wellstar
Clinical Partners

PROVIDER DEMOGRAPHIC DATA CHANGE FORM

Practice Name:

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PRACTICE DEMOGRAPHIC CHANGE ONLY

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Previous Practice TIN:	New Practice TIN:
Practice Billing Address:	
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Previous Provider NPI:	New Provider NPI:	
Changes to Phone, Fax, or Email:		

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☐ YES | Please provide date of submission or effective date of committee approval _____/_____/_____

☐ NO

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| Please indicate the certifying body _____

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To fax, please send to (770) 999-2387.


Wellstar
HEALTH SYSTEM