ULTIMATE
HEALTH PLANS
Good health is where you live.

Provider Credentialing Application

Mail completed application to:

Ultimate Health Plans, Inc.
Attention: Provider Operations
1244 Mariner Blvd.
Spring Hill, FL 34609

Phone: (352) 835-7151
Fax: (352) 515-5976

If you have a CAQH #, please see instructions on next page.

Provider Name: _____ **Specialty:** _____

Group Name: Access Healthcare Physicians, LLC **Group NPI:** 1245529742

To initiate your request for participation as a provider for **Ultimate Health Plans, Inc.** the following information must be submitted to the **Provider Operations Department**. ***Please print clearly or type*** to ensure that we can process your request efficiently. Should your response(s) warrant the submission of additional detail, explanation or documentation, please attach such to the application and reference to which section/question it applies. Missing information may delay the credentialing process.

All information must be completed in full with the application signed and dated by applicant.
Please indicate any areas that do not apply with N/A.

CREDENTIALING APPLICATION CHECKLIST

Please include <u>all items below</u> in order for your credentialing package to be accepted. Please call the Provider Operations department if you have any questions about the required information.

If you are a provider participating in CAQH:

_____ **GROUP NPI #** 1245529742

_____ **CAQH #**_____ **SKIP TO PAGES 7 – 11**
***In order to accept, please make sure the CAQH application has been reattested in the last 120 days and all documents on file are current*.**

_____ Professional Historical Data Questionnaire ***All "Yes" answers must be accompanied by explanation(s).**

_____ For any pending malpractice cases, please provide a copy of Complaint Notice of Intent with Affidavit.

_____ Attestation, Consent and Release form

If you are a provider not participating in CAQH:

_____ Credentialing Application – Please complete ALL sections legibly.

_____ Current Curriculum Vitae **(Must account for 5 year work history, month/year format, any gaps 6 months or longer)**

_____ Professional Historical Data Questionnaire ***All "Yes" answers must be accompanied by explanation(s).**

_____ For any pending malpractice cases, please provide a copy of Complaint Notice of Intent with Affidavit.

_____ Attestation, Consent and Release form

_____ Current copy of your State Professional License

_____ Current copy of your Federal DEA Certificate and/or State Controlled Substance Certificates

_____ Copy of face sheet of Professional Liability Insurance Certificate with coverage of at least $250,000 / $750,000. ***If you do not carry Professional Liability insurance, please provide evidence of compliance with Florida Statute 458.320**

_____ Completed W9 Form **(Must Reflect Legal Entity & Address for Remittance)**

_____ Allied Health Professionals: Please complete addendum or attach collaborative protocols/ supervising physician agreement.

PROVIDER INFORMATION

Please print clearly or type.

Provider Name: _____ _____
Last First Middle Degree

Maiden Name (if applies) _____ Gender: Male ☐ Female ☐

Date of Birth: _____ Place of Birth: _____ Country: _____ US Citizen Y ☐ N ☐

SS #: _____ NPI #: _____ Tax ID #: _____

Office Mailing Address: _____
Street City State Zip

Telephone #: _____ Fax #: _____ Cell #: _____

Provider Email Address: _____ Back Line #: _____

FL Medicare #: _____UPIN #: _____ ECFMG #: _____

Accept FL Medicaid? YES☐ NO☐ FL Medicaid #: _____

Languages Spoken: _____ Ethnicity (optional): _____

AGE ACCEPTANCE/LIMITATIONS

Accept New Patients? YES☐ NO☐
Provider will accept membership under their care from age _____ to _____

List any restrictions here: _____

LICENSES

FL Medical License #: _____ Issue Date: ____/____/____ Expiration Date: ____/____/____

List Additional Medical State Licenses Below:

State	License Number	Issue Date	Expiration Date

DEA Number:_____ Expiration Date: ___/___/___ CDC Number: _____ Expiration Date: ___/___/____

CLIA Number:_____ Expiration Date: ___/___/___ CLIA Number: _____ Expiration Date: ___/___/____

BOARD CERTIFICATION

Name of Specialty Board	Certification Status	Certification Date	Expiration Date

If you are not Board Certified, on what date will you be (or were) first eligible to complete your Board examination? _____ ***Please attach evidence of eligibility.***

OFFICE DEMOGRAPHICS

Please attach a separate sheet for each additional location.

☐ Solo Practice ☐ Group Practice

	Location 1	*Location 2*
County		
Group Name to Appear in Directory		
Street Address		
Suite #		
City, State, Zip		
Office Phone #		
Fax Number		
Office Hours		
Credentialing Contact		
Email Address		
Office Manager		
Email Address		
Group NPI #		

BILLING / REMIT LOCATION

Remit Name: _____

Billing Street Address: _____

City: _____ State: _____ Zip: _____

Billing Contact: _____

Billing Phone: _____ Billing Fax: _____

Billing Email Address: _____

PROFESSIONAL LIABILITY INSURANCE

Name of Carrier	Policy Number	Policy Limits	Effective Date	Expiration Date

EDUCATION

Please list all medical education and training.

	Name	State	Degree	Years	
Medical School:				From	To
Internship:				From	To
Residency:				From	To
Fellowship:				From	To

WORK HISTORY / PRACTICE EXPERIENCE

Please list employers since medical school graduation in chronological order. ***CV must include 5 year work history (month/year format) and account for any gaps of 6 months or more.***

Employer Name _____ From ____ To ____

Address _____ City _____ State _____ Zip _____

Employer Name _____ From ____ To ____

Address _____ City _____ State _____ Zip _____

Employer Name _____ From ____ To ____

Address _____ City _____ State _____ Zip _____

HOSPITAL AFFILIATIONS

Please list all hospitals at which you have Medical Staff Privileges. If you do not have privileges with any hospital, you must submit a letter signed by another physician or hospitalist accepting responsibility for the admission and follow-up care of your patients in a hospital setting.

Hospital Name and Location	Privilege Status

Please list ALL physicians and other professionals providing services at each location (include ARNP, PA, etc.)

Location 1 _____

_____

Location 2 _____

_____

COVERAGE

Every physician must arrange for twenty-four (24) hour coverage. It is required that your on-call coverage physician(s) be a participating provider fully credentialed or in the process of being credentialed with Ultimate Health Plans.

Name of Covering Physician: _____ Telephone:_____

PROFESSIONAL PEER REFERENCES

Please list two professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area.

1. Name: _____ Title: _____ Specialty: _____

Address: _____

Telephone #: _____ Fax: _____ Email: _____

2. Name: _____ Title: _____ Specialty: _____

Address: _____

Telephone #: _____ Fax: _____ Email: _____

CONFLICT OF INTEREST STATEMENT

Do you or any member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgery center, or other business dealing with the provision of ancillary health services, equipment or supplies? Y ☐ N ☐ **If yes, please provide the following:**

Name of Organization_____ Percent of Investment/Ownership _____

Address _____ Phone _____

Tax ID_____ Type of Organization _____

Nature of business interest (i.e., partner, owner, investor) _____ Size of Organization _____

AMBULATORY SURGICAL CENTERS/PROCEDURES

Are you affiliated with any Ambulatory Surgical Centers? Yes ☐ No ☐ If yes, please list below:

Facility Name Phone Number

Address City State Zip

Do you perform surgical or any other types of procedures in your office? Yes ☐ No ☐ **If yes, please list below:**

It is REQUIRED that you include a copy of the AHCA certificate indicating the level of surgical procedures authorized to perform.

PROFESSIONAL HISTORICAL DATA QUESTIONNAIRE

The following must be answered by Provider. Please circle Yes or No to the questions below.

Any "Yes" response will require a detailed explanation and must be submitted along with the Credentialing Application. Please use the enclosed "Malpractice Claims Information" form if applicable.

		Y	N
1.	Have you ever been convicted of a felony or do you have any pending misdemeanor and/or felony charges?		
2.	Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned, or otherwise limited?		
3.	Have you ever been publicly reprimanded or disciplined by a professional licensing agency or Board?		
4.	Has your DEA certification and/or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?		
5.	Have any of your privileges or memberships at any hospital or institution ever been denied, suspended, reduced, revoked, not renewed or otherwise limited?		
6.	Has your participation in Medicare, Medicaid or any other government program ever been limited, expelled, excluded or have you voluntarily excluded yourself from any of these programs?		
7.	Have you ever been convicted or pled "nolo contendere" to a criminal offense related to Medicare, Medicaid or any other Federal program?		
8.	Has your participation in an HMO and/or an Insurance Company network ever been limited, restricted, suspended or terminated?		
9.	In the past five years, up to and including the present, have you had any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?		
10.	Considering the essential function of a practitioner in your area of practice, in the past five years, up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients?		
11.	In the past five years and up to and including the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?		
12.	Are you currently participating or under supervision of a Physician or Recovery Network or applicable program?		
13.	Has any malpractice carrier made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf in the past 5 years or are any medical malpractice suits pending against you?		
14.	Are you currently uninsured for professional liability (malpractice insurance) coverage?		
15.	Has your malpractice/professional liability insurer placed conditions or restrictions on your coverage or ability to obtain coverage in the past 10 years?		

I certify that I have answered the questions listed on this questionnaire truthfully, correct and complete to the best of my knowledge.

Applicant's Signature: _____ Date: _____

Printed Name: _____

ATTESTATION, CONSENT AND RELEASE FORM

I understand that:

Any misrepresentations, misstatement or omission of a relevant fact in connection with this application, whether intentional or not, may result in denial of my application or termination of my participation with Ultimate Health Plans. I agree that information provided in or attached to this application is correct and complete. By applying for provider participation, the following conditions are accepted as legally binding. These conditions shall remain in effect for the duration of any term of provider participation. To the extent permitted by law, applicant shall release and hold harmless from liability, the Plan, its authorized representatives and any third parties, as defined below, for any actions, recommendations, reports, statements, communications, or disclosures, that are made, taken or received by the Plan or its authorized representatives relating to the following:

It is my responsibility to promptly advise Ultimate Health Plans in writing within 30 days of any changes or additions to the information contained in this application. All of the information contained in this application, or its attachments, is subject to Ultimate Health Plans investigation and review and; this is an application only and my submission of this application does not automatically result in participation with Ultimate Health Plans.

Ultimate Health Plans will query the National Practitioner Data Bank for each applicant. If your application is rejected by Ultimate Health Plans for reasons relating to professional conduct or professional competence, the rejection may be reported to the National Practitioner Data Bank and/or appropriate state licensing board.

I authorize Ultimate Health Plans to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been or am currently associated, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications, to additionally include all past employers, schools, Provider Recovery Network, persons, financial institutions and organizations having relevant information to provide it to Ultimate Health Plans and its affiliates for its use in making a decision on this application.

I further consent to the inspection by agents, employees, contractors, affiliates or other representatives of Ultimate Health Plans of all documents that may be material to an evaluation of my professional competence, character, and ethical qualifications. I further understand that an investigative report may be made as to my professional abilities, character, and general reputation. I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension or curtailment of participation status, membership and/or participation of any type to or from Ultimate Health Plans.

I hereby release from liability all individuals and organizations that provide information to Ultimate Health Plans and its affiliates or its staff, in good faith and without malice, concerning my professional competence, ethics, character credentials and other qualifications for provider status, and I hereby consent to the release of such information.

I, the undersigned, hereby acknowledge that the information submitted on this application is correct and complete to the best of my knowledge and belief. I fully understand that any significant misstatements or omissions on this application constitute cause for denial of participation. I understand and agree that I, as a Potential Provider*, have the responsibility of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and resolving any doubts about such qualifications. If I am accepted for participation, I consent to the inspection of my patient records for Plan Members as necessary for peer and utilization review purposes and agree to be bound by the participation agreement, credentialing plan and provider manual. * Potential Provider is defined as any and all parties who wish to be considered for participation with Ultimate Health Plans and its affiliates, as a Primary Care physician or as a Specialty Care physician.

I understand that I have the right to review and correct erroneous information obtained by Ultimate Health Plans to evaluate my credentialing application. This includes information obtained from primary sources. The review must take place within 6 months of this application. Any corrections must be made in writing within 30 days of the review. This does not require Ultimate Health Plans to allow a provider to review references or recommendations or other information that is peer-review protected. I understand that I have the right to be informed of credentialing/re-credentialing status, upon request, either in writing or verbally, as well as the right to inquire the date for future Credentialing Committee meeting(s), during the application process.

I understand and agree that the information submitted by me on this form, and the information provided to Ultimate Health Plans, its affiliates, its officers, directors, employees and representatives may be used to evaluate my credentials for provider status; and to re-evaluate my credentials for provider status; and to re-evaluate my credentials at any time during my provider's relationship with Ultimate Health Plans and its affiliates.

I certify that all information in this application and all its attachments are accurate, complete and true and am eligible to participate as a Medicare provider. I hereby acknowledge that this Attestation, Consent and Release Form will be valid for a period of thirty six (36) months from the date it is signed by me, and that a photocopy or fax will serve as an original, and further understand that this attestation statement must be signed no more than 180 days prior to the credentialing decision.

_____ _____

Printed Name Degree

_____ _____

Signature Date

MALPRACTICE CLAIMS INFORMATION

Please complete this form if you reported any malpractice actions on your application. All questions must be answered completely. A separate sheet must be used for each malpractice action. If additional sheets are required, please photocopy this page as many times as needed prior to completing.

Case #: _____

Allegation: _____

Relationship to Patient (attending physician, covering physician, surgeon, etc.):

_____

Date of Incident: _____ Date Reported: _____

Location of Incident: _____

Insurance Carrier: _____

Additional Defendants: _____

Claim Status (check one): Open / Closed

Attach a copy of Complaint Notice with Affidavit

If Closed: Date Closed: _____ Indicate Method of Closing: Dismissed / Settled / Judgment

Amount of Settlement or Judgment: $ _____

Describe your care and treatment of the patient. Explain the condition and diagnosis at time of incident, dates and description of treatment rendered, and condition of patient subsequent to treatment. If additional space is necessary, attach additional sheets. Your narrative must provide adequate clinical details to allow proper evaluation by a committee of physicians.

Narrative:

Printed Name: _____ Signature: _____ Date: _____

PRIMARY CARE PHYSICIAN
ATTESTATION OF PATIENT LOAD

Dear Physician:

Regulations of the Agency for Health Care Administration require that each HMO participating Primary Care Physician (PCP) shall not exceed a patient load of 3,000. This figure encompasses all lines of business and services, including commercial insurance.

Active patients are defined as, "Patients who have been seen by the Primary Care Physician at least three times per year."

In order for Ultimate Health Plans to achieve our regulatory obligations, we ask that you complete the information below.

_____

✘ I **do <u>not</u>** have more than 3,000 active patients.

_____ I **do have** 3,000 or more active patients.

_____
Signature of Primary Care Physician

_____
Please PRINT Name

_____
Date Signed

Patient load calculation:

A PCP with 3,000 active patients would see in excess of 4 patients every hour for 8 hours a day, 5 days a week 52 weeks of the year.

3,000 patients x 3 visits/year = 9,000 visits/year
9,000/52 weeks = 173 visits/week
173 visits/5 = 35 visits/day
35/8 = 4+ visits/hour

ULTIMATE HEALTH PLANS, INC. JOINDER

This agreement **("Joinder")** serves as an Attachment to the Independent Physician Association Primary Care Provider Participation Agreement **("Agreement")** between **Ultimate Health Plans, Inc. ("PLAN")** and **Unity Healthcare, LLC ("IPA")** and the undersigned IPA Physician, who may be an individual or entity, who joins in the Agreement for the purposes of setting forth the terms and conditions under which IPA Physician, who is a subcontractor of IPA, shall render Covered Services to Members.

1. **Definitions:** Any capitalized terms not specifically defined in this Joinder shall have the same meaning as defined in the Agreement.

2. **Credentialing**: IPA and/or IPA Physician shall supply all information requested by PLAN to credential IPA Physician. Prior to rendering Covered Services to Members, IPA Physician must receive written approval for participation by PLAN. IPA and/or IPA Physician agrees to notify PLAN immediately of any change of status in IPA Physician's license or any credentialing information provided to PLAN.

3. **Rights and Obligations:** IPA Physician agrees to assume IPA obligations under the Agreement that apply to IPA Physician's provision of Covered Services to Members. IPA Physician further agrees to be bound by certain provisions of the Agreement, including but not limited to all regulatory requirements applicable to PLAN. PLAN and IPA may amend the Agreement without right of approval of IPA Physician, and PLAN's notice to IPA shall be sufficient to notify IPA Physician of such amendment.

4. **Reimbursement:** IPA shall be solely responsible to IPA Physician if reimbursement for Covered Services rendered to Members is on a capitated basis. IPA shall be solely responsible to Physician/Provider if reimbursement for Covered Services rendered to Members is on a fee-for-service basis. The reimbursement rate provided for Physician/Provider named on this Attachment H shall supersede the reimbursement rates contained in the Agreement or any other Attachments to the Agreement.

5. **Priority of Agreements:** IPA and IPA Physician have a written agreement regarding the provision of Covered Services to Members. In the event of any conflict between IPA Physician's contract with the IPA and this Joinder, IPA Physician agrees that the terms and conditions of this Joinder shall prevail.

IN WITNESS WHEREOF, the parties have the authority necessary to bind the entities identified herein and agree to and acknowledge the foregoing through their signatures effective as of the Effective Date of the Agreement.

PLAN: Ultimate Health Plans, Inc.	**IPA: Unity Healthcare, LLC**
Signed By: _____	Signed By: _____
Print Name: Mike Turrell	Print Name: Pariksith Singh, MD
Title: CEO	Title: CEO
Date: _____	Date: _____

IPA Physician: Print Name	IPA Physician Signature	Effective Date	Reimbursement
			$50 PMPM