NEW PHYSICIAN INFORMATION SHEET

1. MSO Name: _____
2. Physician: Last _____ First _____ Middle_____
3. Physician Suffix: MD/DO_____ Sex: Male □ Female □
4. Physician group name: _____
5. Address: _____
6. County: _____ Phone # _____ Fax # _____
7. NPI ID: _____SSN_____Email address_____Date of Birth _____
8. Point of contact in physician's office: _____
9. How do you want this physician to be listed in the directory and on member id card (under individual, group name or both): _____ Credentialed Specialty:

   _____
10. New Center or Existing, New □ Existing □
11. If existing, please provide center #: _____
12. Is physician credentialed? Yes □ No □ If not, physician needs credentialing application or CAQH No.
13. Is physician employed? Yes □ No □ If yes, physician needs a Humana Letter of Agreement (employment status needs to be documented). If not, the affiliate physician needs an approved downstream agreement and a Humana Letter of Agreement.
14. What are the office hours:_____ How does physician/office handle after hours? Answering Service : _____
15. List all Health Plans the physician is currently participating with :

    _____
16. What exclusivity level will the primary care physician be requesting: A B C
17. Is physician currently contracted with Humana for commercial products? Yes □ No □ If no why not:

    _____
18. Is physician participating with CarePlus Health Plans? Yes □ No □
19. Will anyone else be practicing at location (even if not participating with Humana)? Yes □ No □ If yes, please list physicians: _____
20. Name of electronic Medical Records System: (or status of implementation)_____
21. Languages spoken by Physician_____
22. Languages spoken by Office Staff _____
23. Panel Status: _____

Checklist

- **Credentialing Application or if on CAQH, please provide the following:**
  - **CAQH Number** _____
  - **DEA License**
  - **Malpractice Certificate**
- **Exclusivity form if new center**
- **Downstream Agreement (for affiliate physician only)**
- **Humana Letter of Agreement**
- v drive: Senior Segment/How to Folder/New Physician Sheet

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LETTER OF AGREEMENT
ATTACHMENT

WHEREAS, Humana Insurance Company, Humana Health Insurance Company of Florida, Inc., Humana Medical Plan, Inc. and their affiliates that underwrite or administer health plans (hereinafter referred to as "**Humana**") and _____ (hereinafter referred to as "**Physician**") entered into a Physician Participation Agreement (hereinafter "**Agreement**") on _____, **AND**

WHEREAS, Physician and **Humana** agreed to be bound by the terms and conditions of the Agreement, **AND**

WHEREAS, the undersigned physician (hereinafter referred to as "**Participating Provider**") is a member of **Physician**, and a Participating Provider pursuant to the Agreement between **Physician** and **Humana** , **AND**

WHEREAS, **Participating Provider** acknowledges and agrees that the joinder of the **Humana** companies above shall not be construed as imposing joint responsibility or cross guarantee between or among **Humana** companies.

NOW, THEREFORE, the parties hereby agree as follows:

Participating Provider agrees to abide by all of the terms and conditions set forth in the Agreement, and to abide by all **Humana** policies and procedures established and revised from time to time by **Humana** including, but not limited to, quality assurance, quality improvement, risk management, utilization management, credentialing and recredentialing, and grievances/appeals.

Participating Provider unconditionally authorizes **Humana** and **Physician** to share information, including but not limited to credentialing, recredentialing, quality management and utilization management information as related to treatment of individuals covered under those **Humana** health benefits plans covered under the Agreement (hereinafter "**Members**"). However, it is understood expressly that the information shall not be shared with anyone not a party to the Agreement, unless required by law or pursuant to prior written consent of **Participating Provider.**

Participating Provider acknowledges that **Participating Provider** has been provided an opportunity to read the Agreement, all of the terms of which are hereby incorporated by reference.

Participating Provider further agrees that payment to **Physician** or **Participating Provider**, as applicable, from **Humana**, less any Copayments owed by the Member, is payment in full for health care services provided or arranged for Members in accordance with the applicable Member health benefits contract and the terms and conditions of this Agreement. **Participating Provider** shall look solely to **Physician** for payment and agrees that payments made by **Humana** to **Physician** for Covered Services rendered to Members by **Participating Provider** constitutes payment in full to **Participating Provider**.

Participating Provider further agrees that in the event of termination or expiration of the Agreement, or in the event **Physician** is dissolved for whatever reason, **Participating Provider** shall continue to provide health care services under the terms and conditions of the Agreement and **Humana** agrees to continue to pay **Participating Provider** in accordance with the fee-for-service payment arrangements stated in the payment attachment of the Agreement, for a period of one hundred and eighty (180) days after notice of dissolution of **Physician** or the effective date of termination or expiration of the Agreement, during which time a new physician agreement may be negotiated between **Humana** and the individual **Participating Provider**. **Humana** may terminate such **Participating Provider** participation at any time after dissolution of **Physician** or termination or expiration of the Agreement upon written notice to **Participating Provider**.

PARTICIPATING PROVIDER	**HUMANA**
Signature: _____	Signature: _____
Print Name: _____	Print Name: _____
Date: _____	Date: _____

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