10721240 (CAQH PROVIDER ID) 01/22/2013 (LAST ATTESTATION DATE)

Provider Application

CORRECT NUMBERS AND LETTERS: A B C 1 2 3 CORRECT MARK: X INCORRECT MARKS: ✗ ✓ •

Instructions

Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays:
1. Complete only this application and its supplemental forms. Do not use another provider's application.
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 41.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1 Personal Information and Professional IDs

Provider Type

MD

[ ] YES [X] NO DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (EX. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name

Do not use nicknames or initials, unless they are part of your legal name.

Singh
LAST NAME* | SUFFIX (JR, III)

Pariksith
FIRST NAME* | MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?* [ ] YES [X] NO IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE:

OTHER LAST NAME | SUFFIX (JR, III)

OTHER FIRST NAME | OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME | DATE STOPPED USING OTHER NAME

General Information

Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

GENDER*: [X] MALE [ ] FEMALE DATE OF BIRTH* 05/07/1968

Rajasthan
CITY OF BIRTH | STATE OF BIRTH | India COUNTRY OF BIRTH

SSN*: 052-82-9007 FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN) FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK:

Urdu	Spanish	Hindi		
LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE

Home Address

7443 Oak Tree Lane
STREET

Spring Hill | FL | 34607
CITY | STATE | ZIP CODE

TELEPHONE 3525853690

NOTE: CAQH will use this method for application follow-up.

E-MAIL:

FAX: (352) 688-7940

3076

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1 | **Personal Information and Professional IDs** (Continued)

Professional IDs

Include all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/ certifications.

Non-licensed professionals should enter certification/ registration number in the space provided for license number.

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

BS4971354
FEDERAL DEA NUMBER

02/01/2011
DEA ISSUE DATE:

FL
DEA STATE OF REGISTRATION

02/28/2014
DEA EXPIRATION DATE:

CDS CERTIFICATE NUMBER

CDS ISSUE DATE:

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE:

ME71088
STATE LICENSE NUMBER

FL
LICENSE ISSUING STATE

01/15/2011
LICENSE ISSUE DATE:

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? [X] YES [ ] NO

01/31/2013
LICENSE EXPIRATION DATE:

Active
LICENSE STATUS

MD
LICENSE TYPE

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE:

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? [ ] YES [ ] NO

LICENSE EXPIRATION DATE:

LICENSE STATUS

LICENSE TYPE

Other ID Numbers

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

ARE YOU A PARTICIPATING MEDICARE PROVIDER?* [X] YES [ ] NO

31545S
MEDICARE NUMBER

G65154
UPIN

ARE YOU A PARTICIPATING MEDICAID PROVIDER?* [X] YES [ ] NO

253729000
MEDICAID NUMBER

FL
MEDICAID STATE

1417989625
NPI NUMBER

USMLE NUMBER (WITHOUT HYPHENS)

WORKERS COMPENSATION NUMBER

04815080
ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)

11/07/1992
ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY)

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 2 — Education and Training

Undergraduate School(s)

Provide the appropriate information for the school that issued your undergraduate degree and all schools attempted.

Professional School(s)

Provide the appropriate information for the school that issued your professional degree and all schools attempted.

Fifth Pathway Graduates please complete the following sections: U.S. School that issued your certificate, the Non-U.S. School where your attended, and the Fifth Pathway institution where you completed your training on Supplemental Page 20.

Code lists are found on pages 38-43. Enter the associated 3-digit code in the space provided.

If you have additional Undergraduate or Professional Schools to report, use the Education Supplemental Form on page 20.

UNDERGRADUATE SCHOOL

Saint Xavier School
OFFICIAL NAME OF UNDERGRADUATE SCHOOL

Bhagwan Das Road
ADDRESS

Jaipur — CITY
RI — STATE
99999 — POSTAL CODE

India — COUNTRY
TELEPHONE
FAX

01/1976 — START DATE
01/1985 — END DATE (GRADUATION DATE)
(Other) — DEGREE AWARDED

DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL? [X] YES [ ] NO

GRADUATE TYPE:

[ ] U.S. OR CANADIAN GRADUATE [X] NON-U.S./CANADIAN GRADUATE [ ] FIFTH PATHWAY GRADUATE

PROFESSIONAL/MEDICAL SCHOOL

NAME OF U.S./ CANADIAN SCHOOL:

ADDRESS

CITY — STATE — COUNTRY — POSTAL CODE

DID YOU COMPLETE YOUR PROFESSIONAL EDUCATION AT THIS SCHOOL?* [ ] YES [ ] NO

START DATE* — END DATE (GRADUATION DATE)* — DEGREE AWARDED

NON - U.S. OR CANADIAN SCHOOL

Sawai Man Singh Medical College
OFFICIAL NAME OF PROFESSIONAL/MEDICAL SCHOOL

Rajasthan University
ADDRESS

Jaipur — CITY
STATE
302003 — POSTAL CODE

India — COUNTRY
TELEPHONE
FAX

DID YOU COMPLETE YOUR PROFESSIONAL EDUCATION AT THIS SCHOOL?* [X] YES [ ] NO

01/1985 — START DATE*
01/1992 — END DATE (GRADUATION DATE)*
MD — DEGREE AWARDED

3078

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2 Education and Training (Continued)

Training

List all training programs you attended. Use one section per institution.

If you have additional post-graduate training programs, use the Supplemental Training Form on page 21.

Please explain on the Supplemental Professional / Work History Gap Form on page 33 any training gap(s) of three (3) months or greater, or any gap(s) of a shorter duration if required by the organization for which you are being credentialed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

New York Medical College
AFFILIATED MEDICAL SCHOOL

Mount Sinai-NYU Hospitals
INSTITUTION/HOSPITAL NAME

One Gustave Levy Place
STREET | SUITE/BLDG.

New York | *NY* | *10019*
CITY | STATE | POSTAL CODE

United States
COUNTRY | TELEPHONE | FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? (IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.) [X] YES [ ] NO

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

[X] INTERNSHIP/ RESIDENCY [ ] FELLOWSHIP [ ] OTHER
02/1993 START DATE | *02/1996* END DATE

Internal Medicine
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

[ ] INTERNSHIP/ RESIDENCY [ ] FELLOWSHIP [ ] OTHER
START DATE | END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

[ ] INTERNSHIP/ RESIDENCY [ ] FELLOWSHIP [ ] OTHER
START DATE | END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 3 — Professional / Medical Specialty Information

Primary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SPECIALTY: *Internal Medicine*

BOARD CERTIFIED? [X] YES [ ] NO

CERTIFYING BOARD: *American Board of Internal Medicine*

INITIAL CERTIFICATION DATE: *11/01/1996*

RECERTIFICATION DATE (IF APPLICABLE): *12/31/2006*

EXPIRATION DATE (IF APPLICABLE): *12/31/2016*

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO: [X] YES [ ] NO

PPO: [X] YES [ ] NO

POS: [X] YES [ ] NO

IF NOT BOARD CERTIFIED (SELECT ONE):

[ ] I HAVE TAKEN EXAM, RESULTS PENDING FOR: _____ CERTIFYING BOARD

[ ] I INTEND TO SIT FOR AN EXAM ON: _____

[ ] I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF CHECKED, PLEASE EXPLAIN WHY YOU DO NOT INTEND TO TAKE THE EXAM IN THE SPACE BELOW.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE SPACE ABOVE TO EXPLAIN. OTHERWISE, LEAVE THE SPACE ABOVE BLANK.

Secondary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Professional / Medical Specialties to report, use the Additional Specialties Supplemental Form on page 22.

SPECIALTY:

BOARD CERTIFIED? [ ] YES [ ] NO

CERTIFYING BOARD:

INITIAL CERTIFICATION DATE:

RECERTIFICATION DATE (IF APPLICABLE):

EXPIRATION DATE (IF APPLICABLE):

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO: [ ] YES [ ] NO

PPO: [ ] YES [ ] NO

POS: [ ] YES [ ] NO

IF NOT BOARD CERTIFIED (SELECT ONE):

[ ] I HAVE TAKEN EXAM, RESULTS PENDING FOR: _____ CERTIFYING BOARD CODE

[ ] I INTEND TO SIT FOR AN EXAM ON: _____

[ ] I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF CHECKED, PLEASE EXPLAIN WHY YOU DO NOT INTEND TO TAKE THE EXAM IN THE SPACE BELOW.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE SPACE ABOVE TO EXPLAIN. OTHERWISE, LEAVE THE SPACE ABOVE BLANK.

Section 3 — Professional / Medical Specialty Information (Continued)

Certifications

Do you hold the following certifications? If yes, provide expiration dates.

			EXPIRATION DATE:				EXPIRATION DATE:
BASIC LIFE SUPPORT?*	X YES	NO	01/31/2007	ADV LIFE SUPPORT IN OB?*	YES	X NO	
CPR?*	X YES	NO	01/31/2007	ADV TRAUMA LIFE SUPPORT?*	YES	X NO	
ADV CARDIAC LIFE SPT?*	X YES	NO	01/31/2007	PEDIATRIC ADVANCED LIFE SPT?*	YES	X NO	
NEONATAL ADVANCED LIFE SPT?*	YES	X NO					

Practice Interests:

Provide additional areas of professional practice interest, activities, procedures, diagnoses or populations.

Primary Credentialing Contact

CHECK HERE TO USE THE OFFICE MANAGER AND ADDRESS OF THE PRIMARY PRACTICE LOCATION AS THE CREDENTIALING INFORMATION. ☐

Note:

Even if you checked the boxes above, please provide the e-mail address, if available.

Emerick
LAST NAME

Annmarie
FIRST NAME

M.I.

12225 28th Street North Suite A
ADDRESS

St Petersburg
CITY

FL
STATE

33716-1860
ZIP CODE

(727) 823-2188
TELEPHONE

(727) 828-0723
FAX

americk9a6@medenet.net
E-MAIL ADDRESS

3082

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information

Primary Practice Location

If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 25-29.

NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.

TIP: Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 4, YOU ARE ONLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT QUESTION ABOVE. SECTION 4 MAY BE LEFT BLANK. YOU MAY PROCEED TO SECTION 5 ON PAGE 11.

CURRENTLY PRACTICING AT THIS ADDRESS?* [X] YES [ ] NO — PREVIOUS OR FUTURE START DATE? 07/01/2011

ACCESS HEALTH CARE PHYSICIANS LLC
PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

ACCESS HEALTH CARE PHYSICIANS LLC
GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

5350 SPRING HILL DR
ADDRESS*

SPRING HILL — CITY* | FL — STATE* | 34606 4562 — ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* [X] YES [ ] NO

(352) 688-8116
TELEPHONE*

(352) 688-7940
FAX

OFFICE E-MAIL ADDRESS

59-3682760
INDIVIDUAL TAX ID

45-1444883
GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)*: [ ] USE INDIVIDUAL TAX ID [X] USE GROUP TAX ID

Office Manager or Business Office Staff Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

Burrkhardt
LAST NAME*

Diane
FIRST NAME & M.I.*

(352) 688-8116
TELEPHONE*

(352) 686-9477
FAX

dburkhardt@accesshealthcarellc.net
E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

Note:

Even if you checked the box above, please provide the E-mail Address of the Billing Contact.

Patel
LAST NAME*

val
FIRST NAME* — M.I.

P.O. Box 636233
STREET* — SUITE/BLDG

Cincinnati — CITY* | OH — STATE* | 45263 — ZIP CODE*

(352) 593-4101
TELEPHONE*

(352) 593-4994
FAX

valp@medenet.net
E-MAIL ADDRESS

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 4 — Practice Location Information (Continued)

Payment and Remittance

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS PAYEE INFORMATION [ ]

ELECTRONIC BILLING CAPABILITIES?* [X] YES [ ] NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

ACCESS HEALTH CARE PHYSICIANS LLC
CHECK PAYABLE TO*

Patel
LAST NAME*

val
FIRST NAME* M.I.

P.O. Box 636233
STREET* SUITE/BLDG

Cincinnati — CITY* | OH — STATE* | 45263 — ZIP CODE*

Note:

Even if you checked the box above, please provide the E-mail Address of the Payee Contact.

(352) 593-4101
TELEPHONE*

(352) 593-4994
FAX

valp@medenet.net
E-MAIL ADDRESS

Office Hours

(USE HH:MM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY:	8:30 am		4:00 pm		FRIDAY:	8:30 am		4:00 pm	
TUESDAY:	8:30 am		4:00 pm		SATURDAY:				
WEDNESDAY:	8:30 am		4:00 pm		SUNDAY:				
THURSDAY:	8:30 am		4:00 pm						

Note:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE?* [X] YES [ ] NO

IF YES: [X] ANSWERING SERVICE [ ] VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE [ ] VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE
(352) 666-9912

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?*	[X] YES [ ] NO	ACCEPT ALL NEW PATIENTS?*	[X] YES [ ] NO
ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?*	[X] YES [ ] NO	ACCEPT NEW MEDICARE PATIENTS?*	[X] YES [ ] NO
ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?*	[X] YES [ ] NO	ACCEPT NEW MEDICAID PATIENTS?*	[ ] YES [X] NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN: (USE BOTH LINES IF REQUIRED)

no longer accepting patients with Medicaid and Quality
Health Plans.

ARE THERE ANY PRACTICE LIMITATIONS?* [ ] YES [X] NO

IF YES:

GENDER LIMITATIONS: [ ] MALE ONLY [X] NONE [ ] FEMALE ONLY

AGE LIMITATIONS: 12 MINIMUM AGE; 112 MAXIMUM AGE

LIST OTHER LIMITATIONS:

Section 4 **Practice Location Information** (Continued)

Mid-Level Practitioners

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* X YES NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

Lowenstein
PRACTITIONER LAST NAME

Sharona — PA
PRACTITIONER FIRST NAME — M.I. — PRACTITIONER TYPE (E.G., PA, CNM, NP)

PA9103282 — FL
PRACTITIONER LICENSE / CERTIFICATE NUMBER — PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME — M.I. — PRACTITIONER TYPE (E.G., PA, CNM, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER — PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME — M.I. — PRACTITIONER TYPE (E.G., PA, CNM, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER — PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME — M.I. — PRACTITIONER TYPE (E.G., PA, CNM, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER — PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME — M.I. — PRACTITIONER TYPE (E.G., PA, CNM, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER — PRACTITIONER STATE

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 4 Practice Location Information (Continued)

Languages

Code lists are found on pages 37. Enter the associated 3-digit code in the space provided.

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL:

LANGUAGE 1	LANGUAGE 2	LANGUAGE 3	LANGUAGE 4	LANGUAGE 5
Greek	Gujarati	Hindi	Italian	

INTERPRETERS AVAILABLE?* [ ] YES [X] NO

LANGUAGES INTERPRETED:

LANGUAGE 1	LANGUAGE 2	LANGUAGE 3	LANGUAGE 4

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* [X] YES [ ] NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING:

BUILDING?*	[X]	YES	[ ]	NO	TEXT TELEPHONY (TTY)*	[ ]	YES	[X]	NO
PARKING?*	[X]	YES	[ ]	NO	AMERICAN SIGN LANGUAGE*	[ ]	YES	[X]	NO
RESTROOM?*	[X]	YES	[ ]	NO	MENTAL/PHYSICAL IMPAIRMENT SERVICES*	[ ]	YES	[X]	NO

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* [ ] YES [X] NO

ACCESSIBLE BY PUBLIC TRANSPORTATION?* [X] YES [ ] NO

BUS*	[X]	YES	[ ]	NO	SUBWAY*	[ ]	YES	[X]	NO
REGIONAL TRAIN*	[ ]	YES	[X]	NO					

OTHER HANDICAPPED ACCESS

OTHER DISABILITY SERVICES

Taxi

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

LABORATORY SERVICES?	[X]	YES	[ ]	NO	IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE):										
RADIOLOGY SERVICES?	[ ]	YES	[X]	NO	IF YES, PROVIDE X-RAY CERTIFICATION TYPE:										
EKGS?	[X]	YES	[ ]	NO	ALLERGY INJECTIONS?	[X]	YES	[ ]	NO	ALLERGY SKIN TESTING?	[ ]	YES	[X]	NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)?	[X]	YES	[ ]	NO
DRAWING BLOOD?	[X]	YES	[ ]	NO	AGE APPROPRIATE IMMUNIZATIONS?	[ ]	YES	[X]	NO	FLEXIBLE SIGMOIDOSCOPY?	[ ]	YES	[X]	NO	TYMPANOMETRY/ AUDIOMETRY SCREENING?	[ ]	YES	[X]	NO
ASTHMA TREATMENT?	[X]	YES	[ ]	NO	OSTEOPATHIC MANIPULATION?	[ ]	YES	[X]	NO	IV HYDRATION/ TREATMENT?	[X]	YES	[ ]	NO	CARDIAC STRESS TEST?	[X]	YES	[ ]	NO
PULMONARY FUNCTION TESTING?	[X]	YES	[ ]	NO	PHYSICAL THERAPY?	[ ]	YES	[X]	NO	CARE OF MINOR LACERATIONS?	[X]	YES	[ ]	NO					

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? [ ] YES [X] NO

IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT?

NAME

TYPE OF PRACTICE: (SELECT ONE ONLY)* [ ] SOLO PRACTICE [ ] SINGLE SPECIALTY GROUP [X] MULTI-SPECIALTY GROUP

SERVICES (Continued)

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES):

3086

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Practice Location Information (Continued)

Partners/ Associates

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME	SPECIALTY	COVERING COLLEAGUE?
SCUNZIANO MD	Internal Medicine	X

FIRST NAME	PROVIDER TYPE (MD, ETC.)
MARIA	MD

LAST NAME	SPECIALTY	COVERING COLLEAGUE?

FIRST NAME	PROVIDER TYPE (MD, ETC.)

LAST NAME	SPECIALTY	COVERING COLLEAGUE?

FIRST NAME	PROVIDER TYPE (MD, ETC.)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at this location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME	SPECIALTY

FIRST NAME	PROVIDER TYPE (MD, ETC.)

LAST NAME	SPECIALTY

FIRST NAME	PROVIDER TYPE (MD, ETC.)

LAST NAME	SPECIALTY

FIRST NAME	PROVIDER TYPE (MD, ETC.)

Section 5 Hospital Affiliations

Admitting Arrangements

DO YOU HAVE HOSPITAL PRIVILEGES?* [X] YES [ ] NO

IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?

3087

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 5 Hospital Affiliations (Continued)

Hospital Privileges

If applicable, list all hospital affiliations. List primary hospital, then other current affiliations, followed by previous affiliations in chronological order.

If you have additional hospital privileges, use the Supplemental Hospital Privileges Form on page 30.

PRIMARY HOSPITAL

Brooksville and Spring Hill Regional Hospital
HOSPITAL NAME

10461 Quality Dr
ADDRESS

Brooksville | FL | 34609
CITY | STATE | ZIP CODE

TELEPHONE | FAX

MEDICINE
DEPARTMENT NAME

DEPARTMENT DIRECTOR LAST NAME

DEPARTMENT DIRECTOR FIRST NAME & M.I.

01/2012 | 12/2013
AFFILIATION START DATE | AFFILIATION END DATE

FULL, UNRESTRICTED PRIVILEGES? [X] YES [ ] NO

ARE PRIVILEGES TEMPORARY? [ ] YES [X] NO

TIP: Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

Active
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? 30 %

OTHER HOSPITAL

Medical Center Trinity
HOSPITAL NAME

9330 St Rd 54
ADDRESS

Trinity | FL | 34655
CITY | STATE | ZIP CODE

(727) 834-4000
TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR LAST NAME

DEPARTMENT DIRECTOR FIRST NAME & M.I.

01/2010 | 12/2012
AFFILIATION START DATE | AFFILIATION END DATE

FULL, UNRESTRICTED PRIVILEGES? [X] YES [ ] NO

ARE PRIVILEGES TEMPORARY? [ ] YES [X] NO

Active
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION:

3088

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6 Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

IMPORTANT: IF YOU DO NOT CARRY MALPRACTICE INSURANCE, CHECK THIS BOX AND SKIP THIS SECTION ☐

MAG Mutual
CARRIER OR SELF-INSURED NAME*

SELF-INSURED?* YES ☒ NO

8345 Gunn Hwy
ADDRESS*

Tampa
CITY*

FL United States
STATE/COUNTRY*

33626
POSTAL CODE*

02/2012
ORIGINAL EFFECTIVE DATE*

04/2012
EFFECTIVE DATE*

04/2013
EXPIRATION DATE

TYPE OF COVERAGE?* ☒ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?* YES ☒ NO

$1,000,000.00
AMOUNT OF COVERAGE PER OCCURRENCE

$3,000,000.00
AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE?* YES ☒ NO

PSL160036713
POLICY NUMBER*

Professional Liability Insurance Carrier

List other current, future, or previous carrier(s) if current carrier is less that ten (10) years.

NOTE: A longer period may be required by your healthcare entity.

If you have additional insurance, use the Supplemental Insurance Form on page 31.

CARRIER OR SELF-INSURED NAME

SELF-INSURED? YES NO

ADDRESS*

CITY*

STATE/COUNTRY*

POSTAL CODE*

ORIGINAL EFFECTIVE DATE*

EFFECTIVE DATE*

EXPIRATION DATE

TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?* YES NO

AMOUNT OF COVERAGE PER OCCURRENCE

AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE?* YES NO

POLICY NUMBER*

Section 7 Work History and References

Military Duty

Are you currently on active military duty or military reserve?* YES ☒ NO

Work History

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity.

If you have additional work history, use the Supplemental Work History Form on page 32.

WORK HISTORY

ACCESS HEALTH CARE PHYSICIANS LLC
PRACTICE / EMPLOYER NAME

5350 Spring Hill Dr.
ADDRESS

Spring Hill
CITY*

FL
STATE*

34606
POSTAL CODE*

3089

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7 Work History and References (Continued)

Work History

Do not list current positions. Those should be listed in Section 4.

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity

If you have additional work history, use the Supplemental Work History Form on page 32.

(352) 688-8116
TELEPHONE

(352) 686-9477
FAX

United States
COUNTRY

07/2011
START DATE

PRESENT
END DATE

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

Access Healthcare, LLC
PRACTICE / EMPLOYER NAME

5350 Spring Hill Dr.
ADDRESS

Spring Hill
CITY

FL
STATE

34606
POSTAL CODE

(352) 688-8116
TELEPHONE

(352) 686-9477
FAX

United States
COUNTRY

06/2001
START DATE

06/2011
END DATE

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

ADDRESS

CITY

STATE

POSTAL CODE

TELEPHONE

FAX

COUNTRY

START DATE

END DATE

REASON FOR DEPARTURE (IF APPLICABLE)

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 7 Work History and References (Continued)

Gaps in Professional / Work History

If you have additional professional / work history gaps, use the Supplemental Professional Work History Gaps Form on page 33.

PLEASE EXPLAIN ANY TIME PERIODS OR GAPS IN TRAINING OR WORK HISTORY THAT HAVE OCCURRED SINCE GRADUATION FROM PROFESSIONAL SCHOOL AND ARE LONGER THAN THREE MONTHS IN DURATION OR OF A SHORTER DURATION IF REQUIRED BY THE ORGANIZATION FOR WHICH YOU ARE BEING CREDENTIALED.

GAP START DATE: GAP END DATE:

Professional References

Provide three professional references to whom you are not related or are not partners in your practice.

Code lists are found on pages 36-43. Enter the associated 3-digit code for provider type.

Note:

You are required to provide exactly 3 references. Your application will not be complete without this information.

Please check with credentialing entity for any special requirements.

Pierre
LAST NAME*

Jude Antoine — *MD*
FIRST NAME* — PROVIDER TYPE (MD, ETC.)

5290 Applegate Drive
ADDRESS*

Spring Hill — *FL* *United States* — *34606*
CITY* — STATE/COUNTRY* — POSTAL CODE*

(352) 686-3101 — *(352) 688-8713*
TELEPHONE — FAX

Alingu
LAST NAME*

Alfred — *MD*
FIRST NAME* — PROVIDER TYPE (MD, ETC.)

10045 Cortez Blvd. Suite 122
ADDRESS*

Brooksville — *FL* *United States* — *34613*
CITY* — STATE/COUNTRY* — POSTAL CODE*

(352) 596-0405
TELEPHONE — FAX

Benson
LAST NAME*

Dalton — *MD*
FIRST NAME* — PROVIDER TYPE (MD, ETC.)

13911 Lakeshore Blvd Suite 111
ADDRESS*

Hudson — *FL* *United States* — *34667*
CITY* — STATE/COUNTRY* — POSTAL CODE*

(727) 869-8800 — *(727) 869-8814*
TELEPHONE — FAX

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8 — Disclosure Questions

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

Allied Health Providers:

If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".

LICENSURE

1. YES [ ] NO [X] Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?*

2. YES [ ] NO [X] Has there been any challenge to your licensure, registration or certification?*

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. YES [ ] NO [X] Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*

4. YES [ ] NO [X] Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*

5. YES [ ] NO [X] Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*

EDUCATION, TRAINING AND BOARD CERTIFICATION

6. YES [ ] NO [X] Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*

7. YES [ ] NO [X] Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*

8. YES [ ] NO [X] Have any of your board certifications or eligibility ever been revoked?*

9. YES [ ] NO [X] Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

10. YES [ ] NO [X] Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

11. YES [ ] NO [X] Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*

OTHER SANCTIONS OR INVESTIGATIONS

12. YES [ ] NO [X] Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offence or sexual misconduct?*

13. YES [ ] NO [X] To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*

14. YES [ ] NO [X] Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*

15. YES [ ] NO [X] Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*

16. YES [ ] NO [X] Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. YES [ ] NO [X] Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*

18. YES [ ] NO [X] Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

Section 8 — Disclosure Questions (Continued)

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

IMPORTANT: If you answered "Yes" to **question #19**, you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.

MALPRACTICE CLAIMS HISTORY

18. [X] YES [ ] NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?* If yes, provide information for each case.

CRIMINAL/CIVIL HISTORY

20. [ ] YES [X] NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*

21. [ ] YES [X] NO In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offence or sexual misconduct?*

22. [ ] YES [X] NO Have you ever been court-martialed for actions related to your duties as a medical professional?*

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.

ABILITY TO PERFORM JOB

23. [ ] YES [X] NO Are you currently engaged in the illegal use of drugs?* ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

24. [ ] YES [X] NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*

25. [ ] YES [X] NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*

26. [ ] YES [X] NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

Provider: Pariksith Singh, MD

Provider CAQH ID: 10721240

Date Generated: 01/22/2013

Last Attestation Date: 01/22/2013

List of Authorized Plans

Blue Cross and Blue Shield of Florida / Health Options, Inc., CIGNA / Great-West Healthcare, Comprehensive Health Management, Inc, Global TPA, LLC, Humana/ChoiceCare, United Healthcare, Universal Health Care, Inc.

AND to any healthcare organization that in the future represents to CAQH either that I am a participating provider or that I am in the process of being credentialed as a participating provider.

Note: Please refer to the online Universal Credentialing DataSoure for the most current version.

Professional IDs Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1 **Personal Information and Professional IDs**

Professional IDs

Include all additional state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/ certifications.

If you need to report additional Professional IDs, photocopy this page as needed and submit as instructed.

FEDERAL DEA NUMBER

DEA ISSUE DATE:

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE:

FEDERAL DEA NUMBER

DEA ISSUE DATE:

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE:

CDS CERTIFICATE NUMBER

CDS ISSUE DATE:

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE:

CDS CERTIFICATE NUMBER

CDS ISSUE DATE:

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE:

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE:

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE:

LICENSE STATUS

LICENSE TYPE

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE:

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE:

LICENSE STATUS

LICENSE TYPE

Additional Medicare

31545U

Additional Medicaid

3095

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Other Training
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 2 **Education and Training**

Training

List all postgraduate training programs you attended. Use one section per institution.

If you need to report additional Training, photocopy this page as needed and submit as instructed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

All India Institute of Medical Services
AFFILIATED MEDICAL SCHOOL

All India Institute of Medical Services
INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

29 Aurobindo Marg Ansari Nagar
ADDRESS

New Delhi CITY | STATE | *11029* POSTAL CODE

India COUNTRY | TELEPHONE | FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? (IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.) [X] YES [ ] NO

List each department separately, if applicable. List Internship/ Residency, Fellowship and Other programs separately.

[X] INTERNSHIP/ RESIDENCY [ ] FELLOWSHIP [ ] OTHER

06/1972 START DATE | *06/1973* END DATE

Ophthalmology
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

AFFILIATED MEDICAL SCHOOL

INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

ADDRESS

CITY | STATE | POSTAL CODE

COUNTRY | TELEPHONE | FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? (IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.) [ ] YES [ ] NO

List each department separately, if applicable. List Internship/ Residency, Fellowship and Other programs separately.

[ ] INTERNSHIP/ RESIDENCY [ ] FELLOWSHIP [ ] OTHER

START DATE | END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

3096

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 1 of 5**

Additional Practice Location

IMPORTANT:

In the box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

TIP: Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

LOCATION* # 2

CURRENTLY PRACTICING AT THIS ADDRESS?* [X] YES [ ] NO

PREVIOUS OR FUTURE START DATE? 07/01/2011

ACCESS HEALTH CARE PHYSICIANS LLC
PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

ACCESS HEALTH CARE PHYSICIANS LLC
GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

15120 COUNTY LINE RD STE 101
ADDRESS*

SPRING HILL — CITY* | FL — STATE* | 34610 — ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* [ ] YES [X] NO

(727) 378-8588 — TELEPHONE* | (727) 857-5991 — FAX

OFFICE E-MAIL ADDRESS

59-3682760 — INDIVIDUAL TAX ID | 45-1444883 — GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)*: [ ] USE INDIVIDUAL TAX ID [X] USE GROUP TAX ID

Office Manager or Business Office Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

Burrkhardt
LAST NAME*

Diane
FIRST NAME & M.I.*

(352) 688-8116 — TELEPHONE* | (352) 686-9477 — FAX

dburkhardt@accesshealthcarellc.net
E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

Patel
LAST NAME*

val — FIRST NAME* | M.I.

P.O. Box 636233 — STREET* | SUITE/BLDG

Cincinnati — CITY* | OH — STATE* | 45263 — ZIP CODE*

Note:

Even if you checked the boxes above, please provide the e-mail address, if available.

(352) 593-4101 — TELEPHONE* | (352) 593-4994 — FAX

valp@medenet.net
E-MAIL ADDRESS

3100

* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 2 of 5**

Add'l Practice Location (Cont.)

LOCATION* # 2

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* [X] YES [ ] NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

ACCESS 2 HEALTH CARE PHYSICIANS LLC
CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION [ ]

Patel
LAST NAME*

val
FIRST NAME* M.I.

P.O. Box 636233
STREET* SUITE/BLDG

Cincinnati | OH | 45263
CITY* STATE* ZIP CODE*

NOTE:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

(352) 593-4101 | (352) 593-4994
TELEPHONE* FAX

valp@medenet.net
E-MAIL ADDRESS

Office Hours

(USE HH:MM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY:	8:00 am		5:00 pm		FRIDAY:	8:00 am		5:00 pm	
TUESDAY:	8:00 am		5:00 pm		SATURDAY:				
WEDNESDAY:	8:00 am		5:00 pm		SUNDAY:				
THURSDAY:	8:00 am		5:00 pm						

Note:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE?* [X] YES [ ] NO

IF YES: [X] ANSWERING SERVICE [ ] VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE [ ] VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE (352) 666-9912

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* [X] YES [ ] NO

ACCEPT ALL NEW PATIENTS?* [X] YES [ ] NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* [X] YES [ ] NO

ACCEPT NEW MEDICARE PATIENTS?* [X] YES [ ] NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* [X] YES [ ] NO

ACCEPT NEW MEDICAID PATIENTS?* [ ] YES [X] NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN: (USE BOTH LINES IF REQUIRED)

no longer accepting patients with Medicaid and Quality Health Plans.

ARE THERE ANY PRACTICE LIMITATIONS?* [ ] YES [X] NO

IF YES:

GENDER LIMITATIONS: [ ] MALE ONLY [X] NONE [ ] FEMALE ONLY

AGE LIMITATIONS: 12 MINIMUM AGE; 112 MAXIMUM AGE

LIST OTHER LIMITATIONS:

3101

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 4 | **Practice Location Information - Page 3 of 5**

Additional Practice Location (Continued)

IMPORTANT: In the box provided, indicate to which practice location this page belongs.

→ LOCATION* # 2

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* [X] YES [ ] NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

Mid-Level Practitioners

PRACTITIONER LAST NAME: Lowenstein

PRACTITIONER FIRST NAME: Sharona — M.I.: — PRACTITIONER TYPE (E.G., PA, CNM, NP): PA

PRACTITIONER LICENSE / CERTIFICATE NUMBER: PA9103282 — PRACTITIONER STATE: FL

PRACTITIONER LAST NAME:

PRACTITIONER FIRST NAME: — M.I.: — PRACTITIONER TYPE (E.G., PA, CNM, NP):

PRACTITIONER LICENSE / CERTIFICATE NUMBER: — PRACTITIONER STATE:

PRACTITIONER LAST NAME:

PRACTITIONER FIRST NAME: — M.I.: — PRACTITIONER TYPE (E.G., PA, CNM, NP):

PRACTITIONER LICENSE / CERTIFICATE NUMBER: — PRACTITIONER STATE:

PRACTITIONER LAST NAME:

PRACTITIONER FIRST NAME: — M.I.: — PRACTITIONER TYPE (E.G., PA, CNM, NP):

PRACTITIONER LICENSE / CERTIFICATE NUMBER: — PRACTITIONER STATE:

PRACTITIONER LAST NAME:

PRACTITIONER FIRST NAME: — M.I.: — PRACTITIONER TYPE (E.G., PA, CNM, NP):

PRACTITIONER LICENSE / CERTIFICATE NUMBER: — PRACTITIONER STATE:

3102

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 4 | **Practice Location Information - Page 4 of 5**

Additional Practice Location (Continued)

IMPORTANT:

In the box provided, indicate to which practice location this page belongs.

→ **LOCATION* # 2**

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL: *Greek* (LANGUAGE 1) *Gujarati* (LANGUAGE 2) *Hindi* (LANGUAGE 3) *Italian* (LANGUAGE 4) (LANGUAGE 5)

INTERPRETERS AVAILABLE?* YES [X] NO

LANGUAGES INTERPRETED: LANGUAGE 1 | LANGUAGE 2 | LANGUAGE 3 | LANGUAGE 4

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* [X] YES [ ] NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING:

BUILDING?*	[X] YES [ ] NO	TEXT TELEPHONY (TTY)*	[ ] YES [X] NO	BUS*	[X] YES [ ] NO
PARKING?*	[X] YES [ ] NO	AMERICAN SIGN LANGUAGE*	[ ] YES [X] NO	SUBWAY*	[ ] YES [X] NO
RESTROOM?*	[X] YES [ ] NO	MENTAL/PHYSICAL IMPAIRMENT SERVICES*	[ ] YES [X] NO	REGIONAL TRAIN*	[ ] YES [X] NO

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* [ ] YES [X] NO

ACCESSIBLE BY PUBLIC TRANSPORTATION?* [X] YES [ ] NO

OTHER HANDICAPPED ACCESS | OTHER DISABILITY SERVICES | OTHER TRANSPORTATION ACCESS: *Taxi*

Services

Does this location provide any of the following services?

LABORATORY SERVICES? [X] YES [ ] NO — IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE):

RADIOLOGY SERVICES? [ ] YES [X] NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE:

EKGS?	[X] YES	[ ] NO	ALLERGY INJECTIONS?	[X] YES	[ ] NO	ALLERGY SKIN TESTING?	[ ] YES	[X] NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)?	[X] YES	[ ] NO
DRAWING BLOOD?	[X] YES	[ ] NO	AGE APPROPRIATE IMMUNIZATIONS?	[ ] YES	[X] NO	FLEXIBLE SIGMOIDOSCOPY?	[ ] YES	[X] NO	TYMPANOMETRY/ AUDIOMETRY SCREENING?	[ ] YES	[X] NO
ASTHMA TREATMENT?	[X] YES	[ ] NO	OSTEOPATHIC MANIPULATION?	[ ] YES	[X] NO	IV HYDRATION/ TREATMENT?	[X] YES	[ ] NO	CARDIAC STRESS TEST?	[X] YES	[ ] NO
PULMONARY FUNCTION TESTING?	[X] YES	[ ] NO	PHYSICAL THERAPY?	[ ] YES	[X] NO	CARE OF MINOR LACERATIONS?	[X] YES	[ ] NO			

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? [ ] YES [X] NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT?

NAME

TYPE OF PRACTICE: (SELECT ONE ONLY)* [ ] SOLO PRACTICE [ ] SINGLE SPECIALTY GROUP [X] MULTI-SPECIALTY GROUP

SERVICES (Continued)

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES):

3103

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 4 **Practice Location Information - Page 5 of 5**

Additional Practice Location
(Continued)

IMPORTANT:

In the box provided, indicate to which practice location this page belongs.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

LOCATION* # 2

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME	SPECIALTY	COVERING COLLEAGUE (Y/N)?
SCUNZIANO MD	Internal Medicine	X

FIRST NAME	M.I.	PROVIDER TYPE (MD, ETC.)
MARIA		MD

LAST NAME	SPECIALTY	COVERING COLLEAGUE (Y/N)?

FIRST NAME	M.I.	PROVIDER TYPE (MD, ETC.)

LAST NAME	SPECIALTY	COVERING COLLEAGUE (Y/N)?

FIRST NAME	M.I.	PROVIDER TYPE (MD, ETC.)

LAST NAME	SPECIALTY	COVERING COLLEAGUE (Y/N)?

FIRST NAME	M.I.	PROVIDER TYPE (MD, ETC.)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at this location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME	SPECIALTY

FIRST NAME	PROVIDER TYPE (MD, ETC.)

LAST NAME	SPECIALTY

FIRST NAME	PROVIDER TYPE (MD, ETC.)

LAST NAME	SPECIALTY

FIRST NAME	PROVIDER TYPE (MD, ETC.)

LAST NAME	SPECIALTY

FIRST NAME	PROVIDER TYPE (MD, ETC.)

3104

* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 1 of 5**

Additional Practice Location

IMPORTANT:

In the box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

LOCATION* # 3

CURRENTLY PRACTICING AT THIS ADDRESS?* [X] YES [ ] NO

PREVIOUS OR FUTURE START DATE? 07/01/2011

ACCESS HEALTH CARE PHYSICIANS LLC
PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

ACCESS HEALTH CARE PHYSICIANS LLC
GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

3480 DELTONA BLVD
ADDRESS*

SPRING HILL — CITY* | FL — STATE* | 34606 — ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* [ ] YES [X] NO

(352) 600-7900 — TELEPHONE* | (352) 600-8994 — FAX

OFFICE E-MAIL ADDRESS

TIP: Your individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

59-3682760 — INDIVIDUAL TAX ID | 45-1444883 — GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)*: [ ] USE INDIVIDUAL TAX ID [X] USE GROUP TAX ID

Office Manager or Business Office Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

Burrkhardt
LAST NAME*

Diane
FIRST NAME & M.I.*

(352) 688-8116 — TELEPHONE* | (352) 686-9477 — FAX

dburkhardt@accesshealthcarellc.net
E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

Patel
LAST NAME*

val
FIRST NAME* | M.I.

P.O. Box 636233
STREET* | SUITE/BLDG

Cincinnati — CITY* | OH — STATE* | 45263 — ZIP CODE*

Note:

Even if you checked the boxes above, please provide the e-mail address, if available.

(352) 593-4101 — TELEPHONE* | (352) 593-4994 — FAX

valp@medenet.net
E-MAIL ADDRESS

3100

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 4 | **Practice Location Information - Page 2 of 5**

Add'l Practice Location (Cont.)

LOCATION* # 3

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* [X] YES [ ] NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

ACCESS 2 HEALTH CARE PHYSICIANS LLC

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION [ ]

Patel

LAST NAME*

val

FIRST NAME* M.I.

P.O. Box 636233

STREET* SUITE/BLDG

Cincinnati OH 45263

CITY* STATE* ZIP CODE*

NOTE:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

(352) 593-4101 (352) 593-4994

TELEPHONE* FAX

valp@medenet.net

E-MAIL ADDRESS

Office Hours

(USE HH:MM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY:	8:00 am		5:00 pm		FRIDAY:	8:00 am		5:00 pm	
TUESDAY:	8:00 am		5:00 pm		SATURDAY:				
WEDNESDAY:	8:00 am		5:00 pm		SUNDAY:				
THURSDAY:	8:00 am		5:00 pm						

Note:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24// PHONE COVERAGE?* [X] YES [ ] NO IF YES: [X] ANSWERING SERVICE [ ] VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE [ ] VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE (352) 666-9912

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* [X] YES [ ] NO

ACCEPT ALL NEW PATIENTS?* [X] YES [ ] NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* [X] YES [ ] NO

ACCEPT NEW MEDICARE PATIENTS?* [X] YES [ ] NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* [X] YES [ ] NO

ACCEPT NEW MEDICAID PATIENTS?* [ ] YES [X] NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN: (USE BOTH LINES IF REQUIRED)

no longer accepting patients with Medicaid and Quality Health Plans.

ARE THERE ANY PRACTICE LIMITATIONS?* [ ] YES [X] NO

IF YES:

GENDER LIMITATIONS: [ ] MALE ONLY [X] NONE [ ] FEMALE ONLY

AGE LIMITATIONS: 12 MINIMUM AGE; 112 MAXIMUM AGE

LIST OTHER LIMITATIONS:

3101

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 3 of 5**

Additional Practice Location (Continued)

IMPORTANT: In the box provided, indicate to which practice location this page belongs.

LOCATION* # 3

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* [X] YES [ ] NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

Mid-Level Practitioners

PRACTITIONER LAST NAME	PRACTITIONER FIRST NAME	M.I.	PRACTITIONER TYPE (E.G., PA, CNM, NP)	PRACTITIONER LICENSE / CERTIFICATE NUMBER	PRACTITIONER STATE
Lowenstein	Sharona		PA	PA9103282	FL

3102

* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 4 | **Practice Location Information - Page 4 of 5**

Additional Practice Location (Continued)

IMPORTANT:

In the box provided, indicate to which practice location this page belongs.

→ **LOCATION* # 3**

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL: *Greek* (LANGUAGE 1) *Gujarati* (LANGUAGE 2) *Hindi* (LANGUAGE 3) *Italian* (LANGUAGE 4) (LANGUAGE 5)

INTERPRETERS AVAILABLE?* YES [X] NO

LANGUAGES INTERPRETED: (LANGUAGE 1) (LANGUAGE 2) (LANGUAGE 3) (LANGUAGE 4)

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* [X] YES [ ] NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING:

BUILDING?*	[X] YES	[ ] NO	TEXT TELEPHONY (TTY)*	[ ] YES	[X] NO	BUS*	[X] YES	[ ] NO
PARKING?*	[X] YES	[ ] NO	AMERICAN SIGN LANGUAGE*	[ ] YES	[X] NO	SUBWAY*	[ ] YES	[X] NO
RESTROOM?*	[X] YES	[ ] NO	MENTAL/PHYSICAL IMPAIRMENT SERVICES*	[ ] YES	[X] NO	REGIONAL TRAIN*	[ ] YES	[X] NO

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* [ ] YES [X] NO

ACCESSIBLE BY PUBLIC TRANSPORTATION?* [X] YES [ ] NO

OTHER HANDICAPPED ACCESS

OTHER DISABILITY SERVICES

Taxi (OTHER TRANSPORTATION ACCESS)

Services

Does this location provide any of the following services?

LABORATORY SERVICES? [X] YES [ ] NO — IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE):

RADIOLOGY SERVICES? [ ] YES [X] NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE:

EKGS?	[X] YES	[ ] NO	ALLERGY INJECTIONS?	[X] YES	[ ] NO	ALLERGY SKIN TESTING?	[ ] YES	[X] NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)?	[X] YES	[ ] NO
DRAWING BLOOD?	[X] YES	[ ] NO	AGE APPROPRIATE IMMUNIZATIONS?	[ ] YES	[X] NO	FLEXIBLE SIGMOIDOSCOPY?	[ ] YES	[X] NO	TYMPANOMETRY/ AUDIOMETRY SCREENING?	[ ] YES	[X] NO
ASTHMA TREATMENT?	[X] YES	[ ] NO	OSTEOPATHIC MANIPULATION?	[ ] YES	[X] NO	IV HYDRATION TREATMENT?	[X] YES	[ ] NO	CARDIAC STRESS TEST?	[X] YES	[ ] NO
PULMONARY FUNCTION TESTING?	[X] YES	[ ] NO	PHYSICAL THERAPY?	[ ] YES	[X] NO	CARE OF MINOR LACERATIONS?	[X] YES	[ ] NO			

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? [ ] YES [X] NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT?

NAME

TYPE OF PRACTICE: (SELECT ONE ONLY)* [ ] SOLO PRACTICE [ ] SINGLE SPECIALTY GROUP [X] MULTI-SPECIALTY GROUP

SERVICES (Continued)

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES):

3103

* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 **Practice Location Information - Page 5 of 5**

Additional Practice Location
(Continued)

IMPORTANT:

In the box provided, indicate to which practice location this page belongs.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

LOCATION* # 3

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME	SPECIALTY	COVERING COLLEAGUE (Y/N)?
SCUNZIANO MD	Internal Medicine	X

FIRST NAME	M.I.	PROVIDER TYPE (MD, ETC.)
MARIA		MD

LAST NAME	SPECIALTY	COVERING COLLEAGUE (Y/N)?

FIRST NAME	M.I.	PROVIDER TYPE (MD, ETC.)

LAST NAME	SPECIALTY	COVERING COLLEAGUE (Y/N)?

FIRST NAME	M.I.	PROVIDER TYPE (MD, ETC.)

LAST NAME	SPECIALTY	COVERING COLLEAGUE (Y/N)?

FIRST NAME	M.I.	PROVIDER TYPE (MD, ETC.)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at this location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME	SPECIALTY

FIRST NAME	PROVIDER TYPE (MD, ETC.)

LAST NAME	SPECIALTY

FIRST NAME	PROVIDER TYPE (MD, ETC.)

LAST NAME	SPECIALTY

FIRST NAME	PROVIDER TYPE (MD, ETC.)

LAST NAME	SPECIALTY

FIRST NAME	PROVIDER TYPE (MD, ETC.)

3104

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Hospital Privileges (Current)
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 5 **Hospital Affiliations**

Hospital Privileges

Use this form to continue listing hospitals where you currently have privileges.

If you need to report additional space for Hospital Privileges, photocopy this page as needed and submit as instructed.

TIP: Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

OTHER HOSPITAL

Oak Hill Hospital
HOSPITAL NAME

11375 Cortez Boulevard
ADDRESS

Spring Hill CITY | *FL* STATE | *34611* ZIP CODE

(352) 596-6632 TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR LAST NAME

DEPARTMENT DIRECTOR FIRST NAME & M.I.

09/2010 AFFILIATION START DATE | *09/2012* AFFILIATION END DATE

FULL, UNRESTRICTED PRIVILEGES? X YES NO

ARE PRIVILEGES TEMPORARY? YES X NO

Active
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION:

THIS SPACE HAS BEEN PURPOSELY LEFT BLANK

Hospital Privileges (Current)
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 5 | **Hospital Affiliations**

Hospital Privileges

Use this form to continue listing hospitals where you currently have privileges.

If you need to report additional space for Hospital Privileges, photocopy this page as needed and submit as instructed.

TIP: Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

OTHER HOSPITAL

Regional Medical Center (Hudson, FL)
HOSPITAL NAME

14000 Fivay Road
ADDRESS

Hudson | *FL* | *34667*
CITY | STATE | ZIP CODE

(727) 863-2411
TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR LAST NAME

DEPARTMENT DIRECTOR FIRST NAME & M.I.

06/2011 | *06/2013*
AFFILIATION START DATE | AFFILIATION END DATE

FULL, UNRESTRICTED PRIVILEGES? [X] YES [ ] NO

ARE PRIVILEGES TEMPORARY? [ ] YES [X] NO

Active
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION:

THIS SPACE HAS BEEN PURPOSELY LEFT BLANK

Hospital Privileges (Current)
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 5 | **Hospital Affiliations**

Hospital Privileges

Use this form to continue listing hospitals where you currently have privileges.

If you need to report additional space for Hospital Privileges, photocopy this page as needed and submit as instructed.

TIP: Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

OTHER HOSPITAL

Brookville Hospital (Brookville, PA)
HOSPITAL NAME

100 Hospital Road
ADDRESS

Brookville | *PA* | *15825*
CITY | STATE | ZIP CODE

(814) 849-2312
TELEPHONE

FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR LAST NAME

DEPARTMENT DIRECTOR FIRST NAME & M.I.

01/2010 AFFILIATION START DATE | *01/2012* AFFILIATION END DATE

FULL, UNRESTRICTED PRIVILEGES? [X] YES [ ] NO

ARE PRIVILEGES TEMPORARY? [ ] YES [X] NO

Active
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL, UNRESTRICTED, PROVISIONAL, TEMPORARY)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION:

THIS SPACE HAS BEEN PURPOSELY LEFT BLANK

Hospital Privileges (Current)
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 5 **Hospital Affiliations**

Hospital Privileges

Use this form to continue listing hospitals where you currently have privileges.

If you need to report additional space for Hospital Privileges, photocopy this page as needed and submit as instructed.

TIP: Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

OTHER HOSPITAL

Spring Hill Regional Hospital
HOSPITAL NAME

10461 Quality Drive
ADDRESS

Spring Hill CITY | *FL* STATE | *34609* ZIP CODE

(352) 688-8200 TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR LAST NAME

DEPARTMENT DIRECTOR FIRST NAME & M.I.

01/2012 AFFILIATION START DATE | *12/2013* AFFILIATION END DATE

FULL, UNRESTRICTED PRIVILEGES? X YES NO

ARE PRIVILEGES TEMPORARY? YES X NO

Active
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? *50* %

PLEASE EXPLAIN TERMINATED AFFILIATION:

THIS SPACE HAS BEEN PURPOSELY LEFT BLANK

Hospital Privileges (Current)
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 5 | **Hospital Affiliations**

Hospital Privileges

Use this form to continue listing hospitals where you currently have privileges.

If you need to report additional space for Hospital Privileges, photocopy this page as needed and submit as instructed.

TIP: Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

OTHER HOSPITAL

HealthSouth Rehabilitation Hospital of Spring Hill
HOSPITAL NAME

12440 Cortez Boulevard
ADDRESS

Brooksville CITY | *FL* STATE | *34613* ZIP CODE

(352) 592-4250 TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR LAST NAME

DEPARTMENT DIRECTOR FIRST NAME & M.I.

08/2010 AFFILIATION START DATE | *08/2012* AFFILIATION END DATE

FULL, UNRESTRICTED PRIVILEGES? X YES NO

ARE PRIVILEGES TEMPORARY? YES X NO

Active
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION:

THIS SPACE HAS BEEN PURPOSELY LEFT BLANK

Hospital Privileges (Current)
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Section 5 | **Hospital Affiliations**

Hospital Privileges

Use this form to continue listing hospitals where you currently have privileges.

If you need to report additional space for Hospital Privileges, photocopy this page as needed and submit as instructed.

TIP: Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

OTHER HOSPITAL

Columbia Regional Medical Ctr
HOSPITAL NAME

14000 Fivay Road
ADDRESS

Hudson | *FL* | *34667*
CITY | STATE | ZIP CODE

(813) 863-2411
TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR LAST NAME

DEPARTMENT DIRECTOR FIRST NAME & M.I.

08/2007
AFFILIATION START DATE

AFFILIATION END DATE

FULL, UNRESTRICTED PRIVILEGES? [X] YES [ ] NO

ARE PRIVILEGES TEMPORARY? [ ] YES [X] NO

Active
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION:

THIS SPACE HAS BEEN PURPOSELY LEFT BLANK

* REQUIRED RESPONSE (IF THIS PAGE IS USED) NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Malpractice Claims Explanation
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8 **Malpractice Claims Explanation**

Malpractice Claims Explanation

Use this form to report any "Yes" response to Disclosure Question #19.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

DATE OF OCCURRENCE*: 04/08/2003

DATE CLAIM WAS FILED*: 09/03/2003

STATUS OF CLAIM* (NOTE: IF CASE IS PENDING, SELECT OPEN):

OPEN [ ] CLOSED [X]

IF SETTLED, ENTER DATE CLAIM WAS SETTLED:

MAG Mutual

PROFESSIONAL LIABILITY CARRIER INVOLVED* (USE BOTH LINES IF NECESSARY)

3525 Piedmont Rd Ste 600

ADDRESS

Atlanta — CITY

GA — STATE

30305 — POSTAL CODE

(727) 823-2188 — TELEPHONE

PSL 1600367 04 — POLICY NUMBER*

$240,000.00 — AMOUNT OF AWARD OR SETTLEMENT*

METHOD OF RESOLUTION?* [ ] DISMISSED [X] SETTLED [ ] MEDIATION [ ] ARBITRATION [ ] JUDGMENT FOR DEFENDANT(S) [ ] JUDGMENT FOR PLAINTIFF(S)

DESCRIPTION OF ALLEGATIONS* (USE ALL FOUR LINES BELOW, IF NECESSARY):

misdiagnosis

WERE YOU THE PRIMARY DEFENDANT OR CO-DEFENDANT?* [X] PRIMARY DEFENDANT [ ] CO-DEFENDANT

NUMBER OF OTHER CO-DEFENDANTS (IF ANY): 1

YOUR INVOLVEMENT IN CASE* (ATTENDING, CONSULTING, ETC)

Primary Care Physican

DESCRIPTION OF ALLEGED INJURY TO THE PATIENT* (USE ALL FOUR LINES BELOW, IF NECESSARY):

misdiagnosis

DID THE ALLEGED INJURY RESULT IN DEATH? [ ] YES [ ] NO

TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?* [X] YES [ ] NO

3110

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and Agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by those bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Pariksith Singh, M.D.

Name (print)*

06/20/11

DATE SIGNED*