ULTIMATE
HEALTH PLANS
Good health is where you live.

Provider Recredentialing Application

Note: Please send completed applications <u>directly</u> to the address or fax listed below:

Ultimate Health Plans, Inc.
Attention: Credentialing Department
1244 Mariner Blvd.
Spring Hill, FL 34609

Phone: (352) 835-7151
Fax: (352) 515-5978

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

Provider Name: _____ **Specialty:** _____

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

For continued participation without interruption in participation as a provider for Ultimate Health Plans, Inc., the following information must be submitted to the *Credentialing Department* prior to your initial credentialing approval date.

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.*

RECREDENTIALING APPLICATION CHECKLIST

Please include <u>all items below</u> in order for your recredentialing package to be accepted. Please call the *Credentialing Department* if you have any questions about the required information or your last attestation/initial credentialing date.

If you are a provider participating in CAQH:

x **GROUP NPI #** 1245529742

x **CAQH #**_____ **SKIP TO PAGES 6 – 10**
***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*.**

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

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

x Attestation, Consent and Release form

If you are a provider NOT participating in CAQH:

_____ Recredentialing Application – Please complete ALL sections legibly.

_____ 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**

_____ Current copy of 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 #: _____ 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

PROFESSIONAL LIABILITY INSURANCE

Name of Carrier	Policy Number	Policy Limits	Effective Date	Expiration Date

ADDITIONAL EDUCATION

If you have completed additional residencies or fellowships within the past Three (3) years, please provide the following information: ***Does Not Apply*** ☐

	Institution	State	Specialty	Years	
Residency:				From	To
Fellowship:				From	To
Other *(specify)*:				From	To

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 in network 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

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:_____

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 level of surgical procedures authorized to perform.

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 #		

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

Location 1 **Location 2**

_____ _____

_____ _____

BILLING / REMIT LOCATION

Remit Name: _____

Billing Street Address: _____

City: _____State: _____ Zip: _____

Billing Contact: _____ Billing Email Address: _____

Billing Phone: _____ Billing Fax: _____

PROFESSIONAL HISTORICAL DATA QUESTIONNAIRE

The following must be answered by Provider. Complete based upon activity SINCE YOUR INITIAL/LAST ATTESTATION DATE. 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.	Since your initial/last attestation, have you ever been convicted of a felony or do you have any pending misdemeanor and/or felony charges?		
2.	Since your initial/last attestation, has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned, or otherwise limited?		
3.	Since your initial/last attestation, have you ever been publicly reprimanded or disciplined by a professional licensing agency or Board?		
4.	Since your initial/last attestation, has your DEA certification and/or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?		
5.	Since your initial/last attestation, have any of your privileges or memberships at any hospital or institution ever been denied, suspended, reduced, revoked, not renewed or otherwise limited?		
6.	Since your initial/last attestation, 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.	Since your initial/last attestation, have you ever been convicted or pled "nolo contendere" to a criminal offense related to Medicare, Medicaid or any other Federal program?		
8.	Since your initial/last attestation, has your participation in an HMO and/or an Insurance Company network ever been limited, restricted, suspended or terminated?		
9.	Since your initial/last attestation, 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, since your initial/last attestation, 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.	Since your initial/last attestation, 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.	Since your initial/last attestation, has any malpractice carrier made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf or are any medical malpractice suits pending against you?		
14.	Are you currently uninsured for professional liability (malpractice insurance) coverage?		
15.	Since your initial/last attestation, has your malpractice/professional liability insurer placed conditions or restrictions on your coverage or ability to obtain coverage?		

I certify that I have answered the questions listed on this questionnaire truthfully, accurately, correctly 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 continued 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 accurate, 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, 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 continued 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.

I understand that I have the right to review and correct erroneous information obtained by Ultimate Health Plans to evaluate my recredentialing 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 recredentialing 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

ADDENDUM FOR ALLIED HEALTH PROFESSIONALS ONLY

Please check applicable selection; if your title does not appear, please indicate your specialty beside the "other" category.

Nurse professionals: Please include a signed collaborative practice agreement with supervising Physician if form not completed.

☐ Physician Assistant

☐ Advanced Registered Nurse Practitioner

☐ Certified Nurse Midwife

☐ Other: _____
(Please Specify)

Print Name: _____

Signature: _____ Date: _____

COLLABORATING OR SUPERVISING PHYSICIAN

To be completed and signed by collaborating or supervising physician:

Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

License #:_____