Global TPA

☐ FREEDOM HEALTH ☐ OPTIMUM HealthCare, Inc.

MEDICAL STAFF CREDENTIALING APPLICATION FORM

For MD; DO; DDS; DMD; DC; DPM; PharmD; PhD; PsyD; OD

APPLICANT NAME:_____**SPECIALTY:**_____

In order to expedite the credentialing process, please complete every item on this application. Please DO NOT write "see CV" or "refer to CV" or "refer to CV" in place of completing the information requested. Please enclose copies of the documentation listed below, and sign and date the attestation of accuracy and the consent and release form. Thank you for your assistance!

"**X**" if enclosed

- ☐ Current Professional Liability Insurance Certificate;
- ☐ Curriculum Vitae/Work History; (must include month & year)
- ☐ Patient load attestation form (PCP's Florida requirement); enclosed (if applicable)
- ☐ Additional Locations information sheet; (enclosed)
- ☐ CLIA Certificate or Waiver (as applicable)
- ☐ W9 Form must be enclosed;
- ☐ Signed and dated Consent and Release Form

FOR PLAN USE ONLY – *To be completed by Provider Representative*:

- ☐ Contract Processing Form (CPF)
- ☐ Site Inspection Evaluation (SIE) (PCP and OBGYN) attached ; (if applicable)
- ☐ Application information and supporting documentation has been reviewed;
- ☐ All information meets Plan criteria and documentation is current and complete.

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Practitioner Last Name:_____ **First Name:**_____ **Middle Initial**_____ **Degree**_____

Primary Physical Office Address City State Zip for Additional Locations *(Please complete next page)*

County Office Phone# Office Fax # Handicap Access(Y/N) Handicap Assistance (Y/N) Bus Rte. (Y/N)

Office Manager or Contact Name Telephone and Extension *(if applicable)* Email Address *(for receiving email from plan)*

Office Hours: Mon Tues Wed Thu Fri Sat Sun

Practice or Group Name

Name to whom checks should be made payable *(if different than Practice/Group name)*

Billing Address *(Location where payments will be sent)* City State Zip

Billing Office Telephone Number Billing Office Fax Number

Correspondence Address *(for credentialing purposes only)* City State Zip

Office Phone # Office Fax# Contact Name

Patient Age Ranges

- ☐ 00 yrs - 21 yrs Pediatrics
- ☐ 00 yrs - 99+ yrs Family Practice
- ☐ 12 yrs - 99+ yrs Internal Medicine
- ☐ 12 yrs - 99+ yrs Geriatric Medicine
- ☐ 21 yrs - 99+ yrs General Practice
- ☐ 00 yrs - 99+ yrs General Practice for Health Dept Only

Other_____

General Information:

Gender: Male_____ Female_____ Date of Birth_____

Language(s) spoken in addition to English_____

For EEOC Compliance Requirements Only: *Please indicate the following:*

- ☐ African American
- ☐ Arabic
- ☐ Hispanic American
- ☐ Asian American
- ☐ Caucasian
- ☐ Native American

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Practitioner's Name:_____

Information Sheet Required for Additional Locations

(PLEASE PRINT)

Name of Provider/Group/Practice Name:

_____

List any additional Office Locations: Please include all necessary information listed below.

Second Physical Address: _____

_____

Practice/Group Name: _____
Telephone Number: _____
Fax Number: _____
E-mail Address: _____
Tax Identification Number: _____
Contact Name: _____
Handicapped Access Yes_____ No_____ Handicapped Assistance Yes_____ No_____ Bus Rte. Yes_____ No _____
Office Hours _____

Second Billing Address: _____

_____

Checks payable to: _____
Telephone number: _____
Fax Number: _____
Email Address: _____
Tax Identification Number: _____
Contac Name: _____

Third Physical Address: _____

_____

Practice/Group Name: _____
Telephone Number: _____
Fax Number: _____
E-mail Address: _____
Tax Identification Number: _____
Contact Name: _____
Handicapped Access Yes_____ No_____ Handicapped Assistance Yes_____ No_____ Bus Rte. Yes_____ No _____
Office Hours _____

Third Billing Address: _____

_____

Checks payable to: _____
Telephone number: _____
Fax Number: _____
Email Address: _____
Tax Identification Number: _____
Contac Name: _____

Please attach additional location information as necessary.

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Practitioner's Name:_____

REGULATORY **Please provide copy of document

Tax ID# ** (copy of W-9)	SS#
State License #	DEA #
CDS # *(if applicable)*	CSR # *(if applicable)*
Medicare Provider #	Medicaid Provider #
National Provider Identification #-Type 1 must be completed	CLIA Registration or Waiver # **
Type 1- Individual Practitioner / Type 2 – Group	

SPECIALTY/TAXONOMY

Name of Specialty	*Taxonomy Code*

BOARD CERTIFICATIONS STATUS

Name of Specialty Board	*Certification Status*	*Certification Date*	*Expiration Date*

If not Board Certified in specialty requested, please indicate if you plan on taking Board Certification ☐ yes ☐ no
If yes, please indicate the date of the next Board Certification Examination_____

HOSPITAL AFFILIATIONS – Please list your primary admitting facility first. ***If you are a PCP without hospital admitting privileges, please provide a completed hospital admitting arrangement form.***

Hospital Name	*Hospital Location*	*Specialty of Privileges*	*Staff Status*	*Current & Unrestricted*
				Y ☐ N ☐
				Y ☐ N ☐
				Y ☐ N ☐

COVERING PHYSICIAN INFORMATION – If you are a PCP in solo practice, please provide name, address, phone and fax number of a Plan practitioner who will provide coverage for our members in your absence, including ability to hospitalize if necessary, and act as a peer reference. If you are a member of a group, please provide a list of group members and their specialty(ies):

_____

Last Name First Middle Degree Specialty

_____

Office Address, City, State, Zip Code Office Phone # Office Fax#

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Practitioner's Name:_____

ALLIED HEALTH PROFESSIONALS – Please list all Nurses Practitioners and Physician Assistants who may see members on your behalf.

Name	*Degree/License Type*	*License #*	*Specialty*

PEER REFERENCE INFORMATION – Please provide the name, address, phone and fax number of two practicing peers who are able to provide a reference as to your recent clinical practice.

Last Name First Middle Degree Specialty

Office Address, City, State, Zip Code Office Phone # Office Fax#

Last Name First Middle Degree Specialty

Office Address, City, State, Zip Code Office Phone # Office Fax#

EDUCATION – Please provide full address

Professional School	**Degree Type**	**Year of Graduation**

TRAINING – Please complete separate sheet if necessary

Internship/Residency/Fellowship Training	**Specialty of Training**	**Dates of Training**
Internship -Name and campus location of facility		
Residency - Name and campus location of facility		
Fellowship - Name and campus location of facility		

Liability Insurance Attestation

Name of Insurer: _____
Address: _____
City, State: _____
Telephone number: _____
Facsimile: _____

Policy Number: _____
Effective date: _____
End date: _____
Retroactive Date: _____
Policy Limits: Occurrence _____
Aggregate _____

The above information is true and correct as of the signature date listed below.

_____ _____
Provider Name (print) Provider Name (signature)

_____
Date

Practitioner's Name:_____

QUESTIONNAIRE – If the answer to any question is **yes,** please provide details on a separate sheet.

Please answer the following questions by checking the appropriate box:	**YES**	**NO**
1. Do you have any physical or mental health problems or limitations in ability that may affect your ability to practice medicine and provide health care with reasonable skill and safety?		
2. Do you have any history of chemical dependency / substance abuse?		
3. Have you been the subject of an investigation, or have proceedings ***ever*** been initiated to have your license to practice limited, suspended, revoke, denied, sanctioned or subject to probationary conditions, or have you voluntarily or involuntarily relinquished your license in this or any other state?		
4. Has your narcotics registration certificate ***ever*** been voluntarily or involuntarily relinquished, limited, suspended, sanctioned or revoked, or are any such actions pending?		
5. Have you been the subject of an investigation, or have ***ever*** been suspended, sanctioned or otherwise restricted from participating in any private, state, or federal health insurance program, for example Medicare or Medicaid?		
6. Have you ***ever*** been named as a defendant in criminal proceeding?		
7. Has your medical staff membership, employment, or medical staff status at any health care institution, ***ever*** been rejected, limited, suspended, revoked, not renewed or subject to probationary conditions, or have you been the subject of an investigation, or, relinquished medical staff membership or clinical privileges while under investigation or disciplinary action, or are any such actions pending?		
8. In the past five years, have you been a defendant in a malpractice/professional liability suit, or are there currently any pending or potential suits against you, or have any judgments been made or settlements paid on your behalf?		
9. Have you ***ever*** been denied professional liability insurance coverage or had your professional liability insurance coverage cancelled by your carrier for reasons other than the carrier's termination of operation in your state?		
10. Have you ***failed*** to meet the State Licensure requirements for continuing medical education?		
11. Have you opted out of Medicare?		
12. Do you have the following documents posted in your office? (This question applies to FL applicants only) a. The Agency's statewide consumer call center telephone number including hours of operation; b. The Florida Patient's Bill of Rights and Responsibilities (also is a copy made available by PCP's to patients upon request); c. Consumer assistance notice prominently displayed in the reception area.		

AFFIRMATION OF ACCURACY AND COMPLETENESS

I understand I have the responsibility for producing adequate information for proper evaluation of my qualifications and for addressing any concerns about such qualifications. I understand that a condition of this application is this any misrepresentation or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and it shall not be processed any further. In the event credentialing information received from other sources substantially varies from that provided by me, I will be notified by the Company, and I understand I will be given the opportunity to correct such information. In the event that my application is rejected for this reason, I many not be entitled to any hearing, appeal or other due process rights as may otherwise be provided in the Policies and Procedures of the Company. I affirm that information provided in or attached to this application is correct and complete. I affirm that I adhere to the principles of ethics of the American Medical Association, the American Osteopathic Association or other appropriate professional organization. I affirm the ability to perform or directly supervise the ambulatory primary care services or members (as applicable). I affirm that nurse practitioners or physician assistants (if any) under my supervision are performing within the scope of their licensure.

Practitioner's Name:_____

APPLICANT'S RELEASE AND HOLD HARMLESS

By applying for provider participation, I accept the following conditions. These conditions shall remain in effect for the duration of any term of participation I may be granted.

I acknowledge that the Company may at its sole discretion share or disclose the information provided in the credentialing and re-credentialing process to affiliates and subsidiaries or other related entities of Global TPA, Inc.

1) I release and hold harmless the Company, its authorized representatives and third parties, as defined below, for any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken or received by the Company or its authorized representative in good faith, relating to matters or inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; or any other matter that might directly or indirectly have an effect on my competence, on patient care, or on the orderly operation of this health care organization.
2) I authorize the Company and its authorized representatives to consult with any third party who may have information bearing on my professional qualifications (credentials). This authorization includes the right to inspect or obtain clinical privileges, documents, recommendations, reports, statements or disclosures relating to such questions. I also authorize said third parties to release this information to the Company and its authorized representatives upon request.
3) The term "Company and its authorized representatives" means any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application:
    a. member of the Board and its appointed representative;
    b. the Chief Executive Officer or his/her designee;
    c. all appointees to committees;
    d. Company employees;
    e. Consultants to the Company;
    f. the Company's attorney and members of his/her firm, associates or designee;
    g. delegated or sub-delegated agency with which the Company contracts for credentialing purposes.
4) The term "third parties" means the following:
    a. Government agencies;
    b. Professional liability insurance carriers;
    c. Peer references;
    d. Hospital affiliations;
    e. delegated or sub-delegated agency with which the Company contracts for credentialing purposes.

_____ _____

SIGNATURE OF APPLICANT DATE

_____

PRINTED NAME

FREEDOM HEALTH

OPTIMUM HealthCare, Inc.

Disclosure of Ownership and Control Interest

Providers who are entering into or renewing a provider agreement are required to disclose to the U.S. Department of Health and Human Services, State Medicaid Agency, and managed care organizations that contract with federal and state agencies the following information: 1) the identity of all owners with a control interest 5% or greater (42 CFR 455.104); 2) certain business transactions (42 CFR 455.105); and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity (42 CFR 455.106). If necessary, attach a separate sheet to provide the required information, noting the applicable section number. **Please attach a W-9 displaying your practice information.**

I. Ownership & Control Interest Information (42 CFR 455.104).
List the name, title, date of birth, SSN, and address for each officer and/or individual who has direct or indirect ownership or control interest, separately or in combination, amounting to an ownership interest of 5% or more of the provider entity. List the name, TIN, and address of any organization, corporation, or entity having direct or indirect ownership or control interest, separately or in combination, amounting to an ownership interest of 5% or more in the provider entity.

II. Direct/Indirect Ownership or Control Interest of Subcontractors (42 CFR 455.104)
If there are any subcontractors that the provider entity has direct or indirect ownership of 5% or greater, list the name, title, date of birth, SSN, and address of each person with an ownership or control interest of 5% or more.

III. Relationships of Individuals with Ownership or Control Interest (42 CFR 455.104)
If any of the individuals listed above in Sections I and/or II are related to one another, list the individuals and their relationship to one another – spouse, parent, child, or sibling.

Complete the table below as relevant to items I, II and III above. Please include additional sheet if needed.

Item #	Name of Individual or Entity/Title	DOB	SSN/TIN	Address	Perc e-ntage	Subcontract or	Relationship

IV. Business Transactions (42 CFR 455.105)
42 CFR 455.105 mandates States Medicaid Agencies to ensure its provider agreements contain notice that a response is required within 35 days of receipt of a written request from the State Medicaid agency or the Secretary of the U.S. Department of Health and Human Services (HHS) for: ownership information about any subcontractor with which the provider has had more than $25,000 in business transactions during the 12-month period ending on the date of the request; and information about any significant business transactions between the provider and a wholly owned supplier or between the provider and any subcontractor during the 5-year period ending on the date of the request.

V. Criminal Offenses (42 CFR 455.106)
List the name, title, date of birth, SSN, and address of each officer and/or individual who has ownership or control interest in the provider entity, or is an agent or managing employee of the provider entity and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XXI services program since the inception of those programs.

Complete the table below as relevant to V above. Please include additional sheet if needed.

Name of Individual/Title	DOB	SSN	Address

The provider entity shall have a continuing obligation to notify the health plan of any changes to the information listed above. Additions or revisions to the information reported above shall be submitted immediately upon revision.

I understand that misleading, inaccurate, or incomplete information may result in denial of a request to participate or termination of an existing agreement or contract. By signature I certify that the information provided within, is true and correct and I fully understand the consequences as explained above.

_____ _____
Signature (Written, Not Signature Stamp) Title of Authorized Representative

_____ _____
Name (Please Print) Date