Florida Blue

In the pursuit of health®

Mail to: Florida Blue
Network Operations
P.O. Box 41109
Jacksonville, FL 32203
Fax to: (904) 301-1884

Non-Participating Provider Registration Form

Registration Type: ☐ Group/Organization (skip section 2) ☐ Individual (skip section 1)

Section 1 - Group/Organization Information (Complete in full)

Group / Organization Name _____

Tax ID (IRS notification letter) _____ Group NPI # _____ NPI Effective Date _____

Section 2 - Individual Information

Note: Individual practitioners must complete all applicable fields on this page and submit a completed Billing Authorization for Professional Associations Form when adding a practitioner to a group or creating a new group.

Name Jude A Pierre Title MD

Legal Name (if different from above) _____ E-mail jpierre@accesshealthcarellc.net

Date of Birth 8/12/1971 12:00:00 A Gender ☐ Male ☐ Female Social Security 085728327

Individual NPI # 1669474219 NPI Effective Date _____

CAQH # 11045698 Tax ID (IRS notification letter) _____

Primary Role (check one) ☐ Primary Care ☐ Specialist ☐ Hospitalist

License Type Medical Doctor License # ME77112 State(s) Florida Expiration 01-31-2017

Section 3 - Practice Details

Medical/DOH License # ME77112

Medicaid # 005638500

Medicare # 49170R

Speciality Internal Medicine

Board Certification: Primary _____ Other _____

Are you a member of a group practice? ☑ Yes ☐ No

If yes, please complete Section 3 Supplement on pg. 6 of this form.

Practicing Specialty Internal Medicine

Office Contact Name Michelle Maves

Street Address _____

City _____

State _____ Zip Code _____

Phone# +1-3526763101 Fax# +1-3526888713

Email mmaves@phyaurs.com

List types of services to be rendered:

(Please attach additional sheet, if applicable.)

MEDICAL

Do you have privileges at any hospital? ☐ Yes ☐ No

If yes, where? _____

If no, where have you had privileges within the last five years? _____

Have you ever had to relinquish privileges? ☐ Yes ☐ No

If yes, please explain why: _____

Section 4 - Payment Mailing Address

☐ (If same as above check here)

Street Address PO Box 919469

City Orlando

State Florida Zip Code 32891-9469

Phone# (727) 823-2188 Fax# (727) 828-0723

Receive Payment via EFT? ☐ Yes ☐ No

If yes, attach copy of voided check (including Routing #)

Section 5 - Billing Company Information (if applicable)

Name MEDENET INC.

Street Address PO Box 919469

City ST. PETERSBURG

State Florida Zip Code 32891-9469

Phone# +1-7278232188 Fax# +1-7278280723

Contact Person Val Patel

Non-Participating Provider Registration Form

Section 6(a) – Provider Locations and Administration

For each location of entity or Provider identified in Section 1 or 2 above, please complete the information found in this Section 6. If you have additional locations report these on the supplemental form pages 7-10.

Do you have multiple office or provider locations? ☐ Yes ☐ No

If you indicated yes above, list each location on duplicate copy

Name _____

Street Address 5290 Applegate Drive

City Spring Hill

State Florida Zip Code 34606

Phone# _____ Fax# 6888713

☐ Office Location

☐ Hospital-based Location

☐ Other _____

_____

Section 6 (b) - Owners and Medical Directors: Additional Information Required

List and provide copies of photo ID (clear copy of driver's license preferred).
Please attach sheet for additional names if necessary. **Note:** If the applicable information is not received with the submitted request, the forms will be returned to the requestor, unprocessed.

Name	Position	Drivers License Number	Social Security Number	Other Service Locations (Only for Medical Directors)
	Owner			
	Owner			
	Medical Director			
	Medical Director			
	Other Physician/ Provider			
	Other Physician/ Provider			

If you are an entity and there is no medical director, please explain why: _____

_____

Does your Medical Director work at more than one location? ☐ Yes ☐ No

Or for other providers and entities? ☐ Yes ☐ No

If so, list each entity he/she works for including unaffiliated entities. _____

Section 6(c) – Key Office Staff

List and provide copies of photo ID (clear copy of driver's license preferred) for each key office employee. Please attach sheet for additional names, if necessary. **Note:** If the applicable information is not received with the submitted request, the forms will be returned to the requestor, unprocessed.

Name	Position	Driver's License Number
	Office Manager	
	Billing Manager	

Non-Participating Provider Registration Form

Section 6(d) – Key Documents

Complete all applicable fields and submit the appropriate supporting documentation.

Is the clinic a ☐ physician or ☐ non-physician owned clinic?

List and provide copies of all current operating documentations, registrations and accreditations; if applicable (e.g., state licenses/DCF certifications/accreditations/registrations or any other certifications/exemptions, to include CMS). Please attach sheet for additional names, if necessary. **Note:** If the applicable information is not received with the submitted request, the forms will be returned to the requestor, unprocessed.

Type of Document	License Number	Date of Last Certification

Have you opted out of Medicare? ☑ Yes ☐ No

If you answered yes above, what is the last date you were enrolled? _____

Section 7 – Psychiatric Facilities, IDTCs and Rehabilitation Therapy Groups

For Psychiatric Facilities Only: Please indicate facility type (check all that apply):

☐ Community Mental Health ☐ Crisis Stabilization Unit ☐ Psychiatric Hospital

☐ Residential Treatment Facility ☐ Substance Abuse Facility ☐ Other _____ (describe)

For Independent Diagnostic Testing Centers (IDTCs) only: Complete below.

Physician's Supervisory Certification Statement

I hereby acknowledge the fact that I have agreed to provide the (insert IDTC name) _____ psychological lab with general physician supervisory responsibilities in the areas of non-invasive and diagnostic services. The supervisory responsibilities include, but may not be limited to, verifying periodically that the equipment is functioning properly and producing the quality of results expected from similar equipment. I have also assumed responsibility for following on an ongoing basis those technicians who are providing non-invasive and diagnostic testing and assisting them with any problems they may encounter in providing such services. It also includes providing direction and recommendations to management on an ongoing basis regarding proper training or follow-up for those technicians who are doing the testing.

_____ _____ _____

Physician's Name (Please print or type) **Florida License Number** **National Provider Identifier**

_____ _____

Physician's Signature **Date**

Non-Participating Provider Registration Form

For Rehabilitation Therapy Groups Only - Groups must have at least any two licensed therapists of the following types: Occupational (OT), physical (PT) and/or speech (ST). Clinic must have a Health Care Clinic License or Health Care Clinic Certificate of Exemption. (If 100% owned by a physician or therapist or hospital, a letter is required indicating such.) Please attach copy.

Type of Staff	Number of Staff for Each Type	License(s)	State(s)	Type	Expiration Date
Physical Therapy					
Occupational Therapy					
Speech Therapy					

Section 8: Final Adverse Legal Actions/Penalties for Falsification of Information

By signing this document, you are attesting to the commitment not to commit the adverse acts and crimes (collectively 'Offenses') listed below. If there is a conviction, plea of nolo contendere or adverse event related to the Offenses listed below, please provide that information in the subsection below labeled 'Final Adverse History'. Please report all final adverse legal actions, regardless of whether any records were expunged or appeals are pending.

Offenses Include:

- Violation(s) of Florida Statute §456.054, the Florida prohibition of kickbacks, punishable as a felony of the third degree under Florida law, per F.S. §817.505(4).
- Violation(s) of the Federal anti-kickback statute, found at Section 1128B-7(b) of the Act, punishable by penalties of $25,000 per violation or up to five (5) years imprisonment, or both.
- Violation(s) of Florida Statute §817.234, submission of False and Fraudulent Insurance Claims, punishable as a felony of the third, second or first degree under Florida law. Violation(s) of §817.234 can also be prosecuted and punished under Federal law 18 U.S.C. §1001, which subjects the offender to fines of up to $250,000 and imprisonment for up to five (5) years.
- Violation(s) of Florida Statute §458.331, the Florida Patient Brokering provisions, which could result in denial of a license or disciplinary action by the Florida Board of Medicine.
- Violation(s) of the Federal Civil False Claims Act, 31 U.S.C. §3729, which imposes civil penalties of $5,000 to $10,000 per violation, plus three (3) times the amount of damages sustained by the Government. Additionally, section 1128A(a)(1) of the Act imposes civil liabilities for false claims of $10,000 per claim and up to three times the amount of damages sustained by the Government, as well as possible exclusion from Federal health care programs.
- Felony crimes under Federal or State law against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct), such felonies carrying with them federal criminal penalties under 18 U.S.C. §1347, including significant financial penalties and prison terms ranging from ten (10) years to life imprisonment; and any felonies other than those identified herein that would result in a mandatory exclusion from Medicare or Medicaid.
- Any felony or misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service, or (c) the theft, fraud, embezzlement, breach of fiduciary duty, or (d) the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201, or (e) the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
- Any revocation or suspension of payment, or suspension or revocation of participation by Medicare or Medicaid, or any revocation or suspension of a license to provide health care any State licensing authority, any debarment from participation by any owner, officer, employee or contractor/subcontractor of the entity in any Federal Executive Branch procurement or non-procurement program, or any revocation of accreditation by an accrediting authority.
- Violation(s) of Federal or State government common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment." Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

Non-Participating Provider Registration Form

Section 9 – Certification Statement

An **authorized official** means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the Provider has granted the legal authority to conduct day-to-day business and to apply for a Provider number, to make changes or updates to the Provider's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Plan and the Medicaid and Medicare program.

A **delegated official** means an individual who is delegated by an authorized official as the authority to report changes and updates to the Provider's enrollment record. A delegated official must be an individual with an "ownership or control interest" in (as that term is defined in Section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of, the Provider.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates. Even when delegated officials are reported in this application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature.

Note: Authorized officials and delegated officials must be reported in Section 6, either on this application or on a previous application to this same Medicare free-for-service contractor. **If this is the first time an authorized and/or delegated official has been reported on the CMS-855GB, you must complete Section 6 for that individual.**

By his/her signature(s), an authorized official binds the Provider to all of the requirements listed in the Certification Statement and acknowledges that all the information in this Registration Form is true and accurate. By his/her signature, the authorized official also commits to updating certain key information listed in Sections 1, 2, and 6 when any such information materially changes within ten (10) days of the material change. All signatures must be original and in ink. Faxed, photocopied, or stamped signatures will not be accepted.

Only an authorized official has the authority to sign this Provider Registration Form on behalf of the Provider. A delegated official does not have this authority. The authorized official acknowledges Plan will also require this Registration Form to be updated every two (2) years in its entirety.

By signing this application, an authorized official agrees to immediately notify the Plan if any information furnished on the Registration Form is not true, correct, or complete. The Provider can have as many authorized officials as it wants. If the supplier has more than two authorized officials, it should copy and complete this section as needed. Each authorized and delegated official must have and disclose his/her Social Security Number.

1. I authorize the Plan to verify the information contained herein. I agree to notify the Plan of any future changes to the information contained in this Registration Form in accordance with the timeframes set forth herein. I understand that any change in the business structure may require the submission of a new Registration Form.
2. I have read and understand the certification section and understand the penalties for falsifying information, as printed in this Registration Form. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this Registration Form or contained in any communication supplying information to the state or federal agency or authority or any deliberate alteration of any text on this Registration Form may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of and loss of a Provider number to bill, and/or the imposition of fines, civil damages, and/or imprisonment.
3. Neither this Provider, nor any five percent or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.
4. I will not knowingly present or cause to be presented a false or fraudulent claim for payment to Plan by Medicare or Medicaid, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
5. I certify that none of the owners, practitioners, providers or employees listed in Section 6 or that are employed by a Provider is currently sanctioned, suspended, debarred, or excluded from participation in Medicare, Medicaid, or a federal health care program. In addition, I certify that on at least an annual basis, Provider queries the List of Excluded Entities and Excluded Provider List Serve lists to verify that its owners, practitioners, providers and employees statuses have not changed.

MD

Printed Name of Certifying Official

Date

P600421712920

Signature

Driver's License # (Please attach a copy of your current driver's license.)

(If on behalf of an entity identified in Section 1, name of entity)

Non-Participating Provider Registration Form

Section 3 Supplement - Group/Organization Information (Complete in full)

Group / Organization Name _____

Tax ID (IRS notification letter) _____ Group NPI #_____ NPI Effective Date _____

Section 3 – Practice Details

Medical/DOH License # _____

Medicaid #_____

Medicare # _____

Speciality _____

Board Certification: Primary _____ Other _____

Are you a member of a group practice? ☐ Yes ☐ No
If yes, please complete Section 3 Supplement on pg. 6 of this form.

Practicing Specialty _____

Office Contact Name _____

Street Address _____

City _____

State _____ Zip Code _____

Phone# _____ Fax# _____

Email _____

List types of services to be rendered:
(Please attach additional sheet, if applicable.)

_____

_____

_____

_____

Do you have privileges at any hospital? ☐ Yes ☐ No

If yes, where? _____

If no, where have you had privileges within the last five years? _____

Have you ever had to relinquish privileges? ☐ Yes ☐ No

If yes, please explain why: _____

_____

Non-Participating Provider Registration Form

Supplemental Provider Locations and Administrative forms

Section 6(a) – Provider Locations and Administration

For each location of entity or Provider identified in Section 1 or 2 above, please complete the information found in this Section 6. Make duplicate copies of this Section 6 for each site location. For additional information regarding site locations, please use the attached blank pages, if necessary.

Do you have multiple office or provider locations? ☐ Yes ☐ No

If you indicated yes above, list each location on duplicate copy

Name _____

Street Address _____

City _____

State _____ Zip Code _____

Phone# _____ Fax# _____

☐ Office Location
☐ Hospital-based Location
☐ Other _____
_____

Office Hours

Office Hours	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
AM							
PM							

List non-English languages spoke by provider(s) and/or office staff in order of fluency.

Language #1 _____ ☐ Provider(s) ☐ Office staff

Language #2 _____ ☐ Provider(s) ☐ Office staff

Language #3 _____ ☐ Provider(s) ☐ Office staff

Section 6 (b) - Owners and Medical Directors: Additional Information Required

List and provide copies of photo ID (clear copy of driver's license preferred).
Please attach sheet for additional names if necessary.

Name	Position	Drivers License Number	Social Security Number	Other Service Locations (Only for Medical Directors)
	Owner			
	Owner			
	Medical Director			
	Medical Director			
	Other Physician/ Provider			
	Other Physician/ Provider			

If you are an entity and there is no medical director, please explain why: _____

_____

Does your Medical Director work at more than one location? ☐ Yes ☐ No

Or for other providers and entities? ☐ Yes ☐ No

If so, list each entity he/she works for including unaffiliated entities. _____

Non-Participating Provider Registration Form

Supplemental Provider Locations and Administrative forms

Section 6(c) – Key Office Staff

List and provide copies of photo ID (clear copy of driver's license preferred) for each key office employee. Please attach sheet for additional names, if necessary.

Name	Position	Driver's License Number
	Office Manager	
	Billing Manager	

Section 6(d) – Key Documents

Complete all applicable fields and submit the appropriate supporting documentation.

Is the clinic a ☐ physician or ☐ non-physician owned clinic?

List and provide copies of all current operating documentations, registrations and accreditations; if applicable (e.g., state licenses/DCF certifications/accreditations/registrations or any other certifications/exemptions, to include CMS). Please attach sheet for additional names, if necessary.

Type of Document	License Number	Date of Last Certification

Have you opted out of Medicare? ☐ Yes ☐ No

If you answered yes above, what is the last date you were enrolled? _____

Non-Participating Provider Registration Form

Supplemental Provider Locations and Administrative forms

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If you indicated yes above, list each location on duplicate copy

Name _____

Street Address _____

City _____

State _____ Zip Code _____

Phone# _____ Fax# _____

☐ Office Location
☐ Hospital-based Location
☐ Other _____
_____

Office Hours

Office Hours	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
AM							
PM							

List non-English languages spoke by provider(s) and/or office staff in order of fluency.

Language #1 _____ ☐ Provider(s) ☐ Office staff

Language #2 _____ ☐ Provider(s) ☐ Office staff

Language #3 _____ ☐ Provider(s) ☐ Office staff

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Please attach sheet for additional names if necessary.

Name	Position	Drivers License Number	Social Security Number	Other Service Locations (Only for Medical Directors)
	Owner			
	Owner			
	Medical Director			
	Medical Director			
	Other Physician/ Provider			
	Other Physician/ Provider			

If you are an entity and there is no medical director, please explain why: _____

_____

Does your Medical Director work at more than one location? ☐ Yes ☐ No

Or for other providers and entities? ☐ Yes ☐ No

If so, list each entity he/she works for including unaffiliated entities. _____

Non-Participating Provider Registration Form

Supplemental Provider Locations and Administrative forms

Section 6(c) – Key Office Staff

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	Office Manager	
	Billing Manager	

Section 6(d) – Key Documents

Complete all applicable fields and submit the appropriate supporting documentation.

Is the clinic a ☐ physician or ☐ non-physician owned clinic?

List and provide copies of all current operating documentations, registrations and accreditations; if applicable (e.g., state licenses/DCF certifications/accreditations/registrations or any other certifications/exemptions, to include CMS). Please attach sheet for additional names, if necessary.

Type of Document	License Number	Date of Last Certification

Have you opted out of Medicare? ☐ Yes ☐ No

If you answered yes above, what is the last date you were enrolled? _____