



**ULTIMATE**  
**HEALTH PLANS**  
Good health is where you live.

# **Provider Recredentialing Application**

**Note: Please send completed applications directly 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: \_\_\_\_\_ Group NPI: \_\_\_\_\_

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 all items below 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:**

\_\_\_\_\_ GROUP NPI # \_\_\_\_\_

\_\_\_\_\_ 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.***

\_\_\_\_\_ 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

**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	
18-24	18-24
25-34	25-34
35-44	35-44
45-54	45-54
55-64	55-64
65-74	65-74
75-84	75-84
85-94	85-94
95-104	95-104
105-114	105-114
115-124	115-124
125-134	125-134
135-144	135-144
145-154	145-154
155-164	155-164
165-174	165-174
175-184	175-184
185-194	185-194
195-204	195-204
205-214	205-214
215-224	215-224
225-234	225-234
235-244	235-244
245-254	245-254
255-264	255-264
265-274	265-274
275-284	275-284
285-294	285-294
295-304	295-304
305-314	305-314
315-324	315-324
325-334	325-334
335-344	335-344
345-354	345-354
355-364	355-364
365-374	365-374
375-384	375-384
385-394	385-394
395-404	395-404
405-414	405-414
415-424	415-424
425-434	425-434
435-444	435-444
445-454	445-454
455-464	455-464
465-474	465-474
475-484	475-484
485-494	485-494
495-504	495-504
505-514	505-514
515-524	515-524
525-534	525-534
535-544	535-544
545-554	545-554
555-564	555-564
565-574	565-574
575-584	575-584
585-594	585-594
595-604	595-604
605-614	605-614
615-624	615-624
625-634	625-634
635-644	635-644
645-654	645-654
655-664	655-664
665-674	665-674
675-684	675-684
685-694	685-694
695-704	695-704
705-714	705-714
715-724	715-724
725-734	725-734
735-744	735-744
745-754	745-754
755-764	755-764
765-774	765-774
775-784	775-784
785-794	785-794
795-804	795-804
805-814	805-814
815-824	815-824
825-834	825-834
835-844	835-844
845-854	845-854
855-864	855-864
865-874	865-874
875-884	875-884
885-894	885-894
895-904	895-904
905-914	905-914
915-924	915-924
925-934	925-934
935-944	935-944
945-954	945-954
955-964	955-964
965-974	965-974
975-984	975-984
985-994	985-994
995-1004	995-1004
1005-1014	1005-1014
1015-1024	1015-1024
1025-1034	1025-1034
1035-1044	1035-1044
1045-1054	1045-1054
1055-1064	1055-1064
1065-1074	1065-1074
1075-1084	1075-1084
1085-1094	1085-1094
1095-1104	1095-1104
1105-1114	1105-1114
1115-1124	1115-1124
1125-1134	1125-1134
1135-1144	1135-1144
1145-1154	1145-1154
1155-1164	1155-1164
1165-1174	1165-1174
1175-1184	1175-1184
1185-1194	1185-1194
1195-1204	1195-1204
1205-1214	1205-1214
1215-1224	1215-1224
1225	

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

	<i>Location 1</i>	<i>Location 2</i>
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:

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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.

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\_\_\_\_\_ I **do not** have more than 3,000 active patients.

\_\_\_\_\_ I **do have** 3,000 or more active patients.

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Signature of Primary Care Physician

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Please PRINT Name

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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 #: \_\_\_\_\_