GOVERNMENT OF PUERTO RICO
OFFICE OF THE COMMISIONER OF INSURANCE

Individual and Incorporated Provider Credentialing Application

To facilitate the collection of data from health service providers during the credentialing process, and to create an updated Provider Directory, the Puerto Rico Insurance Commissioner's Office requests that all providers complete the Individual and/or Provider Credentialing Application, and an authentic and legible copy of the documents detailed in the **Required Credentials and Documents** List. The information required to complete the Individual and/or Incorporated Provider Credentialing Application is listed in each of the sections provided. All the information stated in the Individual and/or Incorporated Provider Credentialing Application must be current. If your application cannot be completed due to inaccurate information, you will be contacted by the insurance companies working on your credentialing status. For your records, make sure to keep copies of any supporting documents.

I. Individual Primary Practice Profile: Mandatory Fields

Please complete the information requested in each of the provided fields. Official documents considered as part of the list of credentials specified in the **Required Credentials and Documents List**, must be attached in the same order as the application

Provider Name (Last, First, Middle): Ayala, Luis, Antonio
Date of Birth (month/day/year): 01/25/1980
Gender (Male / Female / Unspecified): Male
Rendering NPI Number/ Individual NPI Number: 12345678901234
Social Security Number: ***-**-5555
Individual Tax ID Number (If apply): ***-**-5555
Medical License Number: 987654321
Subspecialty (if apply): Alergista
Individual Practice Physical Address: Calle Luna, Esquina Sol #40, San Juan PR 00936
Individual Practice Mailing Address: Calle Luna, Esquina Sol #40, San Juan PR 00936
Office Phone Number: 787-555-5555
Email: 787-555-5555

II. Incorporated Practice Profile: Mandatory Fields, if apply.

Please complete the information requested in each of the provided fields. Official documents considered as part of the list of credentials specified in the **Required Credentials and Documents List**, must be attached in the same order as the application. For your records, make sure to keep copies of any supporting documents.

Corporate Practice Name: CORPORATION 1
Incorporation Effective Date: 01/25/1980
Rendering NPI Number: 43215678901234
Corporate Tax ID Number: ***-**-5555
Provider Specialty (Please specify the specialty: Primary Care / or Specialty Care): Primary Care
Subspecialty (if apply): Allergist
Corporate Practice Physical Address: Calle Luna, Esquina Sol #40, San Juan PR 00936
Medicaid ID for this Location: 987654321
Corporate Practice Mailing Address: Calle Luna, Esquina Sol #40, San Juan PR 00936
Corporate Entity Contact Phone Number: 787-555-5555
Employer ID Physical Address: Calle Luna, Esquina Sol #40, San Juan PR 00936
Entity Type: Limited Liability Corporation
W-9: 123456789

a. Additional Incorporated Practices Profile: Mandatory Fields, if apply.

Please complete the information requested in each of the provided fields. Official documents considered as part of the list of credentials specified in the **Required Credentials and Documents List**, must be attached in the same order as the application. For your records, make sure to keep copies of any supporting documents.

Incorporated Practice Name: SEE ABOVE CORPORATION 2A
Rendering NPI Number: 43215678901234
Tax ID Number: ***-**-5555
Specialty and Subspecialty: Primary Care, Alergista
Tax ID Name, if apply: CORPORATION 2A
Incorporated Practice Physical Address: Calle Luna, Esquina Sol #40, San Juan PR 00936
Incorporated Practice Mailing Address: Calle Luna, Esquina Sol #40, San Juan PR 00936

Incorporated Entity Contact Phone Number: 787-555-5555
Calle Luna, Esquina Sol #40, San Juan PR 00936 Employer ID Physical Address:
Entity Type: Limited Liability Corporation
W-9: 123456789

b. Additional Incorporated Practices Profile: Mandatory Fields, if apply.

Please complete the information requested in each of the provided fields. Official documents considered as part of the list of credentials specified in the **Required Credentials and Documents List**, must be attached in the same order as the application. For your records, make sure to keep copies of any supporting documents.

Incorporated Practice Name: SEE ABOVE CORPORATION 2B
Rendering NPI Number: 43215678901234
Tax ID Number: ***-**-5555
Specialty and Subspecialty: Primary Care, Alergista
Tax ID Name, if apply: CORPORATION 2B
Calle Luna, Esquina Sol #40, San Juan PR 00936 Incorporated Practice Physical Address:
Calle Luna, Esquina Sol #40, San Juan PR 00936 Incorporated Practice Mailing Address:
Incorporated Entity Contact Phone Number: 787-555-5555
Calle Luna, Esquina Sol #40, San Juan PR 00936 Employer ID Physical Address:
Entity Type: LLC or nonprofit, LLP, Corporation, Professional Corporation Limited Liability Corporation
W-9: ATTACHMENT 123456789

III. Primary Care Physician (PCP) contract. Mandatory Fields, if apply.

Please complete the information requested in each of the provided fields. Official documents considered as part of the list of credentials specified in the **Required Credentials and Documents List**, must be attached in the same order as the application. For your records, make sure to keep copies of any supporting documents.

Group Name or PMG Name: PRIMARY CARE PHYSICIAN PCP
Billing NPI Number: 43215678901234
Tax ID Group Number: ***-**-5555
Medicaid ID for this Location: 987654321
NPI Group Number: 43215678901234

Group Physical Address:	Calle Luna, Esquina Sol #40, San Juan PR 00936
Group Mailing Address:	Calle Luna, Esquina Sol #40, San Juan PR 00936
PMG Endorsement Letter Date: + Attachment 12/20/2010	
Group Contact Phone Number: 787-555-5555	
Group Employer ID Number: ***-**-5555	
Group Email Address: pcpgroup@gmail.com	
PCP or Specialist: If PCP please specify: *General Practice / Family Practice / Internal Medicine / Pediatrician/ OB*	Family Practice
Provider Specialty: Please specify the specialty: *Primary Care / or Specialty Care*	Specialty Care
VITAL Service Hours: Monday to Sunday / AM Hours / PM Hours	Monday, Tuesday, 8:00-10:00AM, 2:00-4:00PM

IV. Federally Qualified Health Centers (330) Please complete mandatory Fields for FQHC, if apply

Please complete the information requested in each of the provided fields. Official documents considered as part of the list of credentials specified in the **Required Credentials and Documents List**, must be attached in the same order as the application. For your records, make sure to keep copies of any supporting documents.

Group Name or PMG Name: FEDERAL QUALIFIED HEALTH CENTER 330	
Billing NPI Number: 43215678901234	
Tax ID Group Number: ***-**-5555	
Medicaid ID for this Location: 987654321	
NPI Group Number: 43215678901234	
Group Physical Address:	Calle Luna, Esquina Sol #40, San Juan PR 00936
Group Mailing Address:	Calle Luna, Esquina Sol #40, San Juan PR 00936
PMG Endorsement Letter Date, *if apply*: 12/20/2010	
Group Contact Phone Number: 787-555-5555	
Group Employer ID Number: ***-**-5555	
Group Email Address: pcpgroup@gmail.com	
PCP or Specialist: If PCP please specify: *General Practice / Family Practice / Internal Medicine / Pediatrician/ OB*	Family Practice
Provider Specialty: Please specify the specialty: *Primary Care / or Specialty Care*	Specialty Care

VITAL Service Hours: Monday to Sunday / AM Hours / PM Hours	Monday, Tuesday, 8:00-10:00AM, 2:00-4:00PM

V. Hospital Affiliations: Mandatory Fields, if apply.

Please complete the information requested in each of the provided fields. Official documents considered as part of the list of credentials specified in the **Required Credentials and Documents List**, must be attached in the same order as the application. For your records, make sure to keep copies of any supporting documents.

Primary Hospital Name (1): HOSPITAL NAME A
Hospital Privileges Type: *Active / Consulting Affiliate / Clinical / Courtesy / Temporary / Other* Consulting Affilliate
Hospital Privileges Effective Date: Date (month/year) From: 12/20/2021 To: 12/20/2022
Secondary Hospital Name (2): HOSPITAL NAME B
Hospital Privileges Type: *Active / Consulting Affiliate / Clinical / Courtesy / Temporary / Other* Clinical
Hospital Privileges Effective Date: Date (month/year) From: 12/20/2022 To:12/20/2023

VI. Education and Training: Mandatory Fields, if apply.

CV, Diplomas, Internships, Fellowships, Certificates, and Completed Continue Education Hours:
Please complete the information requested in each of the provided fields. Official documents considered as part of the list of credentials specified in the **Required Credentials and Documents List**, must be attached in the same order as the application. For your records, make sure to keep copies of any supporting documents.

MEDICAL/ PROFFESIONAL SCHOOL NAME:
School Name: EDUCATION AND TRAINING
Address / Street: Calle Luna, Esquina Sol #40
City / State / Zip Code: San Juan PR 00936
Graduation Date (Month/Year) From: 12/20/2000 To: 12/20/2010
Specialty, Completion Date: Degree Received: Allergist, 12/20/2010, Family Care
Internship Institution Name: INTERNSHIP
Address / Street: Calle Luna, Esquina Sol #40, San Juan PR 00936
Dates Attended (Month/Year) From: 12/20/2008 To: 12/20/2010
Program Type: Internship Program Type
Residency: RESIDENCY
Residency Institution Name: RESIDENCY NAME

Address / Street:	Calle Luna, Esquina Sol #40, San Juan PR 00936
City / State / Zip Code: San Juan PR 00936	
Dates Attended (Month/Year) From: 12/20/2008 To: 12/20/2010	
Residence Type: Residency Type	
Residency Completion Date: SEE ABOVE 12/20/2008	
Hospital Post- Graduate and Internship Completion Date: SEE ABOVE HOSPITAL A, 12/20/2008	
Fellowship: FELLOWSHIP	
Institution Name/ Graduate and Internship Completion Date: FELLOWSHIP NAME, 12/20/2008	
Address / Street:	Calle Luna, Esquina Sol #40
City / State / Zip Code: San Juan PR 00936	
Dates Attended (Month/Year) From: 12/20/2008 To: 12/20/2010	
Fellowship Type: Residency Type	
Fellowship/Training Completion Date: SEE ABOVE 12/20/2008	
Board Certification: BOARD CETIFICATION	
Specialty Board: Allergist	
Specialty Board Certificate Issued Date: 12/20/2020	
Specialty Board Certificate Expiration Date: 12/20/2021	
PROFESSIONAL LICENCES/CERTIFICATES:	
DEA Certificate: YES / N/A / License Number / Expiration Date (month/day/year)	DEA CERTIFICATE, Lic# 12345678, 12/20/2025
State Narcotics License (ASSMCA): YES / N/A / License Number / Expiration Date (month/day/year)	ASSMCA CERTIFICATE, Lic# 12345678, 12/20/2025
License Registration: YES / N/A / License Number / Expiration Date (month/day/year)	PR MEDICAL LICENSE, Lic# 12345678, 12/20/2025
Collegiate Membership Name 1: Collegiate YES / N/A / License Number / Expiration Date (month/day/year)	COLLEGIATE MEMBER, Lic# 12345678, 12/20/2025
PTAN Number (Medicare Program): YES / N/A / License Number / Expiration Date (month/day/year)	PTAN, Lic# 12345678, 12/20/2025

Telemedicine Certificate YES / N/A / License Number / Expiration Date (month/day/year) TELEMEDICINE, Lic# 12345678, 12/20/2025

VII. Criminal Record:

Please complete the information requested in each of the provided fields. Official documents considered as part of the list of credentials specified in the **Required Credentials and Documents List**, must be attached in the same order as the application. For your records, make sure to keep copies of any supporting documents.

Negative Certificate of Penal Records Date: 12/10/2020

VIII. Malpractice and Professional Liability Insurance: Mandatory Fields and Documentation, if apply. (Professional Liability Insurance can include office personnel)

Please complete the information requested in each of the provided fields. Official documents considered as part of the list of credentials specified in the **Required Credentials and Documents List**, must be attached in the same order as the application. For your records, make sure to keep copies of any supporting documents.

Malpractice Policy Current Insurance Carrier Name: SSS
Malpractice Insurance Policies Effective Date: Effective Date (month/day/year): From: 12/8/2020 To: 12/8/2020
Malpractice Policy Number: 12345678
Malpractice Coverage Amount: Per Occurrence/Aggregate Limit 5,000/10,000
Professional Liability Action Explanation Form (include)
Malpractice Information OIG Case Number, if apply: 987654321
Professional Liability Policy Current Insurance Carrier Name: SSS
Professional Liability Policy Number: 12345678
Professional Liability Coverage Amount: Per Occurrence/Aggregate Limit: 5,000/10,000
Professional Liability Insurance Policies Effective Date: Effective Date (month/day/year): From: 12/8/2020 To: 12/8/2020
Self-Reported Information: Disclosure of actions, license changes, or any action against the license under ASSMCA or DEA license during a governmental contract or program. Investigations or actions under the Professional Liability Policy. ***Please, refer to the Required Credentials and Documents List Section- Reference Section 9- Redirigir a los links-***
Professional Service Contract Disclosure: For services over $25,000 for the past 12 months. Please, attach documentation and project description in the field provided for that purpose, including Effective and Expiration dates of the contract.Please, refer to the Required Credentials and Documents List Section***

Management Employees Information: For Medicaid purposes, formularies are individually provided by the office. ***Please, refer to the Required Credentials and Documents List Section
Business Ownership Participation: Every member with no less than 5% of equity. Executive Officer, Director, and/or Managing Member of the entity defined by its category. ***Please, refer to the Required Credentials and Documents List Section **Add list of questions, in case of denied license- VITAL- hacer la nota para redirigir el médico**

IX. Additional Directory Required Information: Mandatory Fields and Documentation, if apply.

Please complete the information requested in each of the provided fields. Official documents considered as part of the list of credentials specified in the **Required Credentials and Documents List**, must be attached in the same order as the application. For your records, make sure to keep copies of any supporting documents.

Individual or Corporate Name Update: Ayala, Luis, Antonio
Physical Address Update: Calle Luna, Esquina Sol #40, San Juan PR 00936
Email Update: drlayala@gmail.com
Mailing Address Update: Calle Luna, Esquina Sol #40, San Juan PR 00936
Office Phone Number Update: 787-555-5555
Facilities adapted to Disabled Patients: yes
New Patients Acceptance: yes
NPI Changes: 987654321
Practice Transfer or Practice Closed: yes
Office Practice Hours: 8:00am 5:00pm
New Affiliations: Hostpital Hima
New Practice Associations: Practica 123
New Billing Information:
Practice moved more than five (5) miles: yes
Plan Acceptance List: SSS, MCS

Required Credentials and Documents List: All documents should be attached in the same order as the application.

All the required credentials listed below must be current. Future dated or expired credentials will cause your application to be returned by the covered entity authorized to collect your information. All attachments must be

recent, complete, and readable. For your records, make sure to keep copies of any supporting documents.

1. Individual and Incorporated Provider Credentialing Application
2. NPI Certificate/Letter
3. Tax ID Certificate- Individual or Corporate
4. Employer ID Certificate/IRS Letter
5. W9, if apply
6. Corporation Certificate, if apply
7. Medical License
8. School of Medicine Diploma/ Residency Certificate
9. Specialty and Subspecialty Diploma, if apply
10. Board Certificate
11. Curriculum Vitae- Five (5) years, Provide an explanation of any gaps of six (6) months or more
12. DEA Certificate
13. ASSMCA Certificate
14. Past and Completed Continue Education Certificate
15. Malpractice Insurance Certificated of Coverage and Endorsements
16. Professional Liability Insurance Certificated of Coverage
17. Professional Liability Action Explanation Form
18. Attestation
19. Disclosure of Authorization, Ownership & Control Interest (42 CFR 455.104)
20. Significant Business Transactions (42 CFR 455.105)
21. Excluded Individuals or Entities (42 CFR 455.106)
22. Negative Certificate of Penal Record
23. Non-Prescriber Narcotics Letter
24. Re-credentialing Junta de Licenciamiento Card
25. IPA or PMG Endorsement Letter, if apply
26. Medicaid Letter (Medicaid ID)
27. Medicare Letter (PTAN)
28. Self-Reported Information- Case Track number
29. Professional Service Contract Disclosure-Yes or No.
30. Management Employees Information- Attach updated list, company’s role, and effective date.
31. Business Ownership Participation- Corporation by Laws from the Department of State, if apply
32. Colegio de Cirujanos Médicos Affiliation (Colegiación)