CAQH Data Summary Date 6/6/2024
Gilbert, Coretta Clinical Social Worker
CAQH Provider ID : 14599685

Last Reattestation Date: 3/23/2024 3:04:37 PM

## PREPARE

| | | | |
|---|---|---|---|
| NUCC Grouping: | **Behavioral Health & Social Service Providers** | | |
| Provider Type: | **Clinical Social Worker** | Practice Setting: | **Inpatient/Outpatient or Outpatient Only** |
| Primary Practice State: | **CT** | | |
| Other Practice State(s): | | | |

## PERSONAL INFORMATION

**Name**

| | | | |
|---|---|---|---|
| First Name : | **Coretta** | Middle Name : | |
| Last Name : | **Gilbert** | Suffix : | |
| Have you used other names? | **No** | | |

**Home Address**

| | | | |
|---|---|---|---|
| Street 1 : | **51 Park Avenue** | Street 2 : | |
| City : | **Bloomfield** | State : | **CT** |
| Country : | **United States** | Province : | |
| County : | **Hartford County** | Zip Code : | **06002** |

**Mailing Address**

| | | | |
|---|---|---|---|
| Is Mailing address and Home Address Same? | Yes | | |
| Street 1 : | **51 Park Ave** | Street 2 : | |
| City : | **Bloomfield** | State : | **CT** |
| Country : | **United States** | Province : | |
| County : | **Hartford County** | Zip Code : | **06002-3232** |

**Primary Method of Contact**

| | | | |
|---|---|---|---|
| Primary E-mail Address : | **piecetopeace.services@gmail.com** | Personal E-Mail Address : | **Coretta.gilbert@uconn.edu** |
| PMOC CC Email1 : | | PMOC CC Email2 : | |

**Phone Numbers**

| | | | |
|---|---|---|---|
| Home Phone : | | Personal Cell Phone : | **860-881-6436** |
| Personal Fax : | | | |

**Personal Identification Numbers**

| | | | |
|---|---|---|---|
| Social Security Number : | **045-92-1635** | | |
| Foreign National Identification Number : | | FNIN Country of Issue : | |
| Do you have a Unique Physicians Identification Number (UPIN)? | **No** | | |
| Do you have an Individual (Type 1) National Provider Identifier (NPI)? | **Yes** | Individual NPI : | **1962924498** |

**Demographics**

| | | | |
|---|---|---|---|
| Gender Identity: | **Female** | | |
| Race/Ethnicity : | **Black or African American** | | |
| Birth Date : | **1/17/1994** | Birth City : | **Hartford** |
| Birth State : | **CT** | Birth Country : | **United States** |

**Languages**

Non-English languages spoken by provider :

## PROFESSIONAL IDENTIFICATION NUMBERS

**Professional License**

| | | | |
|---|---|---|---|
| License State : | **CT** | Do you currently practice in this state? | **Yes** |
| License Number : | **10906** | License Type : | **Licensed Clinical Social Worker Associate** |
| License Status : | **Active** | | |
| Issue Date : | **01/02/2020** | Expiration Date : | **01/31/2025** |

**DEA Registration**

Do you have a DEA Registration Certificate? **No**

**Controlled Dangerous Substance (CDS) Registration**

Do you have a CDS Registration Certificate? **No**

**Medicare**

Are you a participating Medicare provider? **No**

**Medicaid**

Are you a participating Medicaid provider? **No**

**ECFMG**

Do you have a Educational Commission for Foreign Medical Graduates (ECFMG) Number? **No**

**USMLE**

| | | | |
|---|---|---|---|
| USMLE No. : | | Exam Date : | |

**Workers Compensation Number**

Workers Compensation Number :

## EDUCATION

Graduate Type : **US/Canada Graduate**

**Professional School Information**

| | | | |
|---|---|---|---|
| Country : | **United States** | State : | **CT** |
| County : | **Hartford County** | | |
| Professional School : | **University of Connecticut** | Street 1 : | **358 Mansfield Rd** |
| Street 2 : | | City : | **Storrs Mansfield** |
| Province : | | | |
| Zip Code : | **06269** | | |
| Phone Number : | | Fax Number : | |
| Degree : | **Master of Social Work (MSW)** | | |
| Professional School Start Date : | **07/2016** | Professional School End Date : | **05/2017** |
| Area of Training / Course of Study / Major : | **Social Work** | | |
| Did you complete your professional education at this school? | **Yes** | Graduation Date : | **05/14/2017** |

**Undergraduate Education**

| | | | |
|---|---|---|---|
| Country : | **United States** | State : | **CT** |
| School : | **Central Connecticut State University** | Street 1 : | **1615 Stanley St** |
| Street 2 : | | City : | **New Britain** |
| Province : | | | |
| Zip Code : | **06053** | | |
| Phone Number : | **860-832-3200** | Fax Number : | |
| Degree : | **Bachelor of Social Work (BSW)** | | |
| Start Date : | **08/2012** | End Date : | **05/2016** |
| Area of Training / Course of Study / Major : | **Social Work** | | |
| Did you complete your Undergraduate education at this school? | **Yes** | Graduation Date : | **05/06/2016** |
| Certificate Received/Awarded : | **Bachelor of Arts - Social Work** | | |

## TRAINING INFORMATION

**Internship :**

Did you do any internships? Yes

If your Residency information was migrated to the CAQH Provider Data profile but appears on the Internship section, use the "Type" field to move data from the Internship to the Residency section.

| | | | |
|---|---|---|---|
| Type : | **Internship** | | |
| Country : | **United States** | State : | **CT** |
| County : | **Hartford County** | | |
| Institution/Hospital Name : | **Global Communications Academy** | Affiliated University : | **University of Connecticut** |
| Street1 : | **85 Edwards Street** | Street2 : | |
| City : | **Hartford** | Province : | |
| Zip Code : | **06120** | Phone : | **860-695-6020** |
| Phone Extension : | | Fax Number : | |
| Email Address : | | Start Date : | **09/2016** |
| End Date : | **05/2017** | Type of Program : | |
| Department : | **Social Work** | | |
| Specialty : | | Name of Director : | **Merline Clark** |
| Did you complete the training program at this institution? | **Yes** | Completion Date : | **5/05/2017** |

**Cultural Competency Training :**

Have you completed cultural competency training? Yes

## SPECIALTY INFORMATION

**Primary Specialty**

| | |
|---|---|
| Primary Specialty : | **Social Worker, Clinical (1041C0700X)** |
| Board Certified? | **No** |
| Do you wish to be listed in the directory under this primary specialty? By HMO | **Yes** |
| Do you wish to be listed in the directory under this primary specialty? By PPO | **Yes** |
| Do you wish to be listed in the directory under this primary specialty? By POS | **Yes** |
| Not Certified Status : | **Exam Taken Results Pending** |
| Results pending for: | |

**Secondary Specialty**

Do you have a Secondary Specialty? **No**

**Special Experience, Skills and Training**

Please select one or more special experience, skills and training that apply from the list below:

**Anxiety, Child Welfare, Co-occurring Disorders, Depression, Group Therapy, Substance Abuse, Trauma**

## CERTIFICATION INFORMATION

*** THERE IS NO DATA ON RECORD FOR THIS SECTION ***

## PRACTICE LOCATIONS

Active Locations

**General Information :**

Confirmed Date : **3/23/2024**

| | | | |
|---|---|---|---|
| Office Type : | **Primary Practice** | Providers's Start Date : | **10/1/2020** |
| Do you practice at this location?: | **Yes, I practice at this location** | | |
| Please Explain: | **I see patients by appointment at least one day per week on a regular basis** | | |
| Provider Directory Classification : | | | |
| Specialty : | **Social Worker, Clinical** | Subspecialty : | **Social Worker, Clinical** |
| Will you continue to practice at this location | **Yes** | | |
| Type of Service provided : | | | |
| Provide a narrative description of your clinical practice including special interests : | | | |
| Practice Name : | **Piece to Peace, LLC** | | |
| Street 1 : | **151 New Park Ave Unit 2D** | | |
| Street 2 : | | Country : | **United States** |
| City : | **Hartford** | State : | **CT** |
| County : | **Hartford County** | Province : | |
| Zip Code : | **06106-2191** | Email Address : | **piecetopeace.services@gmail.com** |
| Can general correspondence be sent to this location? | **Yes** | Practice Location Website | |
| Appointment Scheduling Website | | | |

**Mailing Address :**

| | | | |
|---|---|---|---|
| Street1 : | **151 NEW PARK AVE** | Street2 : | **UNIT 2D** |
| City : | **HARTFORD** | State : | **CT** |
| County : | **Hartford County** | Province : | |
| Country : | **United States** | Zip Code : | **06106-2191** |
| Type of Practice : | **Individual** | | |
| Do you have an organization (Type 2) NPI? : | **Yes** | Organization (Type 2) NPI : | **1013549252** |
| Group Medicaid Number : | | Group Medicare Number : | |

**Phone Numbers :**

| | | | |
|---|---|---|---|
| Appointment Phone Number : | **860-785-5897** | Phone Extention : | |
| Fax Number : | | | |
| Back Office Phone Number : | | | |

**Phone Coverage :**

| | | | |
|---|---|---|---|
| Does this location provide 24hour/7day a week phone coverage?: | **No** | | |
| Phone Coverage Type : | **Voice Mail Other** | | |

**Tax Information :**

| | | | |
|---|---|---|---|
| Practice Name as it appears on the W-9 : | | | |
| Tax ID : | **844407685** | Type of Tax ID : | **Group** |
| Is this the primary Tax ID for this practice location? | **Yes** | | |
| Group Name : | | | |

**Network Denial :**

| | |
|---|---|
| Have you closed your practice to any plans or programs ? | **No** |

**Office Hours :**

| | | | |
|---|---|---|---|
| Monday | | | |
| Start Time : | **9:00 AM** | End Time : | **5:00 PM** |
| Tuesday | | | |
| Start Time : | **9:00 AM** | End Time : | **5:00 PM** |
| Wednesday | | | |
| Start Time : | **9:00 AM** | End Time : | **5:00 PM** |
| Thursday | | | |
| Start Time : | **9:00 AM** | End Time : | **5:00 PM** |
| Friday | | | |
| Start Time : | **9:00 AM** | End Time : | **5:00 PM** |
| Saturday | | | |
| Start Time : | **9:00 AM** | End Time : | **5:00 PM** |
| Sunday | | | |
| Start Time : | **9:00 AM** | End Time : | **5:00 PM** |

**Patients :**

| | |
|---|---|
| Do you accept new patients at this practice location? | **Yes** |
| Do you accept existing patients with change of payor at this location? | **Yes** |
| Do you accept all new patients at this location? | **Yes** |
| Do you accept new Medicare patients at this location? | **No** |
| Do you accept new Medicaid patients at this location? | **Yes** |
| Do you accept new patients from physician referrals (i.e., referring letter) at this location? | **Yes** |
| Under what circumstances do you accept referrals? (i.e., letter from another | |

physician, etc.

What questions should we ask a patient, to help determine the appropriateness of the referral?

**Will you require medication management services from the provider?**

Does this information vary by health plan ? **No**

**Colleagues :**

Do you have any Partners/Associate at this location ? **No**

**Covering Colleagues :**

**Mid-Level Practitioners :**

Do you have any mid-level practitioners at this location? **No**

**Office Manager or Business Staff Contact :**

| | | | |
|---|---|---|---|
| First Name : | **Coretta** | Last Name : | **Gilbert** |
| Middle Name : | | Suffix : | |
| Phone Number : | **860-785-5897** | Fax Number : | |
| E-mail Address : | **piecetopeace.services@gmail.com** | | |
| Is Office Manager Credentialing Contact : | **Yes** | | |

**Billing Contact :**

Office Manager & Billing Contact are same ? **Yes**

| | | | |
|---|---|---|---|
| First Name : | | Middle Name : | |
| Last Name : | | Street 1 : | |
| Billing Company Name : | | | |
| Street 2 : | | City : | |
| State: | | Province : | |
| Country : | | Zip Code : | |
| Phone Number : | | Fax Number : | |
| E-mail Address : | | | |

**Payment and Remittance :**

| | | | |
|---|---|---|---|
| Billing department name : | | Check Payable to : | **Piece to Peace, LLC** |
| Electronic billing capabilities ? | **Yes** | | |
| Office Manager & Payee Contact are same ? | **Yes** | | |

| | | | |
|---|---|---|---|
| First Name : | | Middle Name : | |
| Last Name : | | Street 1 : | |
| Street 2 : | | City : | |
| State: | | Province : | |
| Country : | | Zip Code : | |
| Phone Number : | | | |
| Fax Number : | | E-mail Address : | |

**Practice Limitations and Patient Populations :**

| | |
|---|---|
| Are there any Practice Limitations ? | **No** |
| Gender Limitations : | **No** |
| Are there any Age Limitations? : | **No** |
| Other Limitations : | |

**Accessibility :**

| | |
|---|---|
| Does this office meet ADA accessibility requirements ? | **Yes** |
| Does this office provide handicapped accessibility ? | **Yes** |

**Please specify how this location meets handicapped accessibility requirements:**

| | |
|---|---|
| Exterior Building | Yes |
| Interior Building | Yes |
| Wheelchair access to exam room | Yes |
| Exam table/scale/chair | No |
| Gurneys & Stretchers | No |
| Portable Lifts | No |
| Radiologic Equipment | No |
| Signage & documents | No |
| Parking | Yes |
| Restroom | Yes |
| Other Handicapped Access : | |
| Does this office have other services for the disabled ? | **No** |

**Please specify other services for the disabled:**

| | |
|---|---|
| Text Telephony (TTL) : | No |
| American Sign Language : | No |
| Mental/Physical Impairment Services : | No |
| Other Disability Services : | |
| Is this office accessible by public transportation ? | **Yes** |

**Please specify how this office is accessible by public transportation:**

| | |
|---|---|
| Bus Transportation: | Yes |
| Subway : | No |
| Regional Train : | No |
| Other Transportation : | |
| Does this Location Provide Child Care Services? | No |
| Does this office meet all state and local fire, safety and sanitation requirements? | **Yes** |

| | |
|---|---|
| Do you have TDD(hearing impaired device) available : | No |
| Do you accept Workers' Compensation Patients? | No |
| Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy? | No |
| Modified or alternative duty is actively evaluated for each Workers' Compensation claimant? | No |
| Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible | No |
| Staff are available and willing to provide compensation representatives information regarding a claimant's care. | No |

**Telehealth :**

| | |
|---|---|
| I provide telehealth services at this location: | **Yes** |
| Do you use a telehealth application or platform that is compliant with the Health Insurance Portability and Accountability Act (HIPAA)? | **Yes** |

Telehealth Service Type:

| | | | |
|---|---|---|---|
| Audio : | | Audio/Video : | **Yes** |
| Secure Text Messaging : | | Remote Monitoring : | |
| Store-and-Forward : | | | |
| Are you willing and able to support family caregivers? | Yes | | |

**Services :**

Does this location provide any of the following services:

| | | | |
|---|---|---|---|
| Laboratory Services? : | **No** | Accrediting/Certifying Program : | |
| Radiology Services : | **No** | X-ray? | **No** |
| X-Ray Certification Type : | | EKG Services? | **No** |
| Care of Minor Lacerations? | **No** | Pulmonary Function testing? | **No** |
| Allergy Injections : | **No** | Allergy Skin Testing : | **No** |
| Office Gynecology? | **No** | | |
| Drawing Blood? | **No** | | |
| Asthma Treatment? | **No** | Age Appropriate Immunizations? | **No** |
| Flexible Sigmoidoscopy? | **No** | Tympanometry/Audiometry Screening ? | **No** |
| Osteopathic Manipulation? | **No** | IV Hydration treatment? | **No** |
| Cardiac Stress Test? | **No** | Physical Therapy? | **No** |
| Treadmill? | | | |
| Is anesthesia administered in your office ? | **No** | What class/category of anesthesia is used ? | |
| Anesthesia Administered by First Name : | | Anesthesia Administered by Last Name : | |
| Other Services : | | | |
| Special Skills By The Practitioner : | | Special Skills By The Staff : | |
| Non-English language spoken by office personnel : | | | |
| Employee Type : | | | |
| Do you have any interpreters at this location? | **No** | | |

**General Information :**

| | | | |
|---|---|---|---|
| Confirmed Date : | **3/23/2024** | | |
| Office Type : | **Other Practice** | Providers's Start Date : | **3/1/2024** |
| Do you practice at this location?: | **Yes, I practice at this location** | | |
| Please Explain: | **I see patients by appointment at least one day per week on a regular basis** | | |
| Provider Directory Classification : | | | |
| Specialty : | **Social Worker, Clinical** | Subspecialty : | |
| Will you continue to practice at this location | | | |
| Type of Service provided : | | | |
| Provide a narrative description of your clinical practice including special interests : | | | |
| Practice Name : | **Confidant Providers, LLC** | | |
| Street 1 : | **1266 E Main St Ste 700R** | | |
| Street 2 : | | Country : | **United States** |
| City : | **Stamford** | State : | **CT** |
| County : | | Province : | |
| Zip Code : | **06902-3507** | Email Address : | |
| Can general correspondence be sent to this location? | | Practice Location Website | |
| Appointment Scheduling Website | | | |

**Mailing Address :**

| | | | |
|---|---|---|---|
| Street1 : | | Street2 : | |
| City : | | State : | |
| County : | | Province : | |
| Country : | | Zip Code : | |
| Type of Practice : | | | |
| Do you have an organization (Type 2) NPI? : | **Yes** | Organization (Type 2) NPI : | **1336761691** |
| Group Medicaid Number : | | Group Medicare Number : | |

**Phone Numbers :**

| | | | |
|---|---|---|---|
| Appointment Phone Number : | **203-747-8696** | Phone Extention : | |
| Fax Number : | | | |
| Back Office Phone Number : | | | |

**Phone Coverage :**

| | | | |
|---|---|---|---|
| Does this location provide 24hour/7day a week phone coverage?: | | | |
| Phone Coverage Type : | | | |

**Tax Information :**

| | | | |
|---|---|---|---|
| Practice Name as it appears on the W-9 : | | | |
| Tax ID : | **850921402** | Type of Tax ID : | **Group** |
| Is this the primary Tax ID for this practice location? | **Yes** | | |
| Group Name : | | | |

**Network Denial :**

| | |
|---|---|
| Have you closed your practice to any plans or programs ? | **No** |

**Office Hours :**

| | | | |
|---|---|---|---|
| Monday | | | |
| Start Time : | **None** | End Time : | **None** |
| Tuesday | | | |
| Start Time : | **None** | End Time : | **None** |
| Wednesday | | | |
| Start Time : | **None** | End Time : | **None** |
| Thursday | | | |
| Start Time : | **None** | End Time : | **None** |
| Friday | | | |
| Start Time : | **None** | End Time : | **None** |
| Saturday | | | |
| Start Time : | **None** | End Time : | **None** |
| Sunday | | | |
| Start Time : | **None** | End Time : | **None** |

**Patients :**

| | |
|---|---|
| Do you accept new patients at this practice location? | **Yes** |
| Do you accept existing patients with change of payor at this location? | **Yes** |
| Do you accept all new patients at this location? | **No** |
| Do you accept new Medicare patients at this location? | **No** |
| Do you accept new Medicaid patients at this location? | **No** |
| Do you accept new patients from physician referrals (i.e., referring letter) at this location? | **Yes** |
| Under what circumstances do you accept referrals? (i.e., letter from another physician, etc. | |
| What questions should we ask a patient, to help determine the appropriateness of the referral? | |

| | | | |
|---|---|---|---|
| Does this information vary by health plan ? | **Yes** | If Yes, please provide explanation below : | **I am in the process of credentialing with multiple payors.** |

**Colleagues :**

| | |
|---|---|
| Do you have any Partners/Associate at this location ? | |

**Covering Colleagues :**

**Mid-Level Practitioners :**

| | |
|---|---|
| Do you have any mid-level practitioners at this location? | |

**Office Manager or Business Staff Contact :**

| | | | |
|---|---|---|---|
| First Name : | **John** | Last Name : | **Dolores** |
| Middle Name : | | Suffix : | |
| Phone Number : | | Fax Number : | |
| E-mail Address : | **contracting@confidanthealth.com** | | |
| Is Office Manager Credentialing Contact : | **Yes** | | |

**Billing Contact :**

| | |
|---|---|
| Office Manager & Billing Contact are same ? | |

**Payment and Remittance :**

| | | | |
|---|---|---|---|
| Billing department name : | | Check Payable to : | |
| Electronic billing capabilities ? | | | |
| Office Manager & Payee Contact are same ? | | | |

**Practice Limitations and Patient Populations :**

| | |
|---|---|
| Are there any Practice Limitations ? | **No** |

| | |
|---|---|
| Gender Limitations : | |
| Are there any Age Limitations? : | |
| Other Limitations : | |
| **Accessibility :** | |
| Does this office meet ADA accessibility requirements ? | **No** |
| Does this office provide handicapped accessibility ? | No |
| **Please specify how this location meets handicapped accessibility requirements:** | |
| Exterior Building | No |
| Interior Building | No |
| Wheelchair access to exam room | No |
| Exam table/scale/chair | No |
| Gurneys & Stretchers | No |
| Portable Lifts | No |
| Radiologic Equipment | No |
| Signage & documents | No |
| Parking | No |
| Restroom | No |
| Other Handicapped Access : | |
| Does this office have other services for the disabled ? | **No** |
| **Please specify other services for the disabled:** | |
| Text Telephony (TTL) : | No |
| American Sign Language : | No |
| Mental/Physical Impairment Services : | No |
| Other Disability Services : | |
| Is this office accessible by public transportation ? | **No** |
| **Please specify how this office is accessible by public transportation:** | |
| Bus Transportation: | No |
| Subway : | No |
| Regional Train : | No |
| Other Transportation : | |
| Does this Location Provide Child Care Services? | No |
| Does this office meet all state and local fire, safety and sanitation requirements? | No |
| Do you have TDD(hearing impaired device) available : | No |
| Do you accept Workers' Compensation Patients? | No |
| Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy? | No |
| Modified or alternative duty is actively evaluated for each Workers' Compensation claimant? | No |
| Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible | No |
| Staff are available and willing to provide compensation representatives information regarding a claimant's care. | No |
| **Telehealth :** | |
| I provide telehealth services at this location: | **Yes** |
| Do you use a telehealth application or platform that is compliant with the Health Insurance Portability and Accountability Act (HIPAA)? | **Yes** |
| Telehealth Service Type: | |

| | | | |
|---|---|---|---|
| Audio : | **No** | Audio/Video : | **Yes** |
| Secure Text Messaging : | **No** | Remote Monitoring : | **No** |
| Store-and-Forward : | **No** | | |
| Are you willing and able to support family caregivers? | No | | |

**Services :**

Does this location provide any of the following services:

| | | | |
|---|---|---|---|
| Laboratory Services? : | **No** | Accrediting/Certifying Program : | |
| Radiology Services : | **No** | X-ray? | **No** |
| X-Ray Certification Type : | | EKG Services? | **No** |
| Care of Minor Lacerations? | **No** | Pulmonary Function testing? | **No** |
| Allergy Injections : | **No** | Allergy Skin Testing : | **No** |
| Office Gynecology? | **No** | | |
| Drawing Blood? | **No** | | |
| Asthma Treatment? | **No** | Age Appropriate Immunizations? | **No** |
| Flexible Sigmoidoscopy? | **No** | Tympanometry/Audiometry Screening ? | **No** |
| Osteopathic Manipulation? | **No** | IV Hydration treatment? | **No** |
| Cardiac Stress Test? | **No** | Physical Therapy? | **No** |
| Treadmill? | | | |
| Is anesthesia administered in your office ? | **No** | What class/category of anesthesia is used ? | |
| Anesthesia Administered by First Name : | | Anesthesia Administered by Last Name : | |
| Other Services : | | | |
| Special Skills By The Practitioner : | | Special Skills By The Staff : | |
| Non-English language spoken by office personnel : | | | |
| Employee Type : | | | |
| Do you have any interpreters at this | **No** | | |

location?

## Archived Locations

**General Information :**

| | | | |
|---|---|---|---|
| Confirmed Date : | **9/28/2023** | | |
| Office Type : | **Other Practice** | Providers's Start Date : | **2/13/2023** |
| Do you practice at this location?: | **No, I do not practice here** | | |
| Please Explain: | **I no longer practice at this location** | | |
| End Date : | **8/4/2023** | | |
| Provider Directory Classification : | | | |
| Specialty : | **Social Worker, Clinical** | Subspecialty : | |
| Will you continue to practice at this location | | | |
| Type of Service provided : | | | |
| Provide a narrative description of your clinical practice including special interests : | | | |
| Practice Name : | **Hartford HealthCare Medical Group Specialists, LLC** | | |
| Street 1 : | **1060 Day Hill Rd Ste 203** | | |
| Street 2 : | | Country : | **United States** |
| City : | **Windsor** | State : | **CT** |
| County : | | Province : | |
| Zip Code : | **06095-5720** | Email Address : | |
| Can general correspondence be sent to this location? | | Practice Location Website | |
| Appointment Scheduling Website | | | |

**Mailing Address :**

| | | | |
|---|---|---|---|
| Street1 : | **1290 Silas Deane Hwy** | Street2 : | **Hartford Healthcare-CVO** |
| City : | **Wethersfield** | State : | **CT** |
| County : | | Province : | |
| Country : | | Zip Code : | **06109-4337** |
| Type of Practice : | | | |
| Do you have an organization (Type 2) NPI? : | **Yes** | Organization (Type 2) NPI : | **1023584216** |
| Group Medicaid Number : | | Group Medicare Number : | |

**Phone Numbers :**

| | | | |
|---|---|---|---|
| Appointment Phone Number : | **860-696-2450** | Phone Extention : | |
| Fax Number : | **860-696-2460** | | |
| Back Office Phone Number : | | | |

**Phone Coverage :**

| | |
|---|---|
| Does this location provide 24hour/7day a week phone coverage?: | |
| Phone Coverage Type : | |

**Tax Information :**

| | | | |
|---|---|---|---|
| Practice Name as it appears on the W-9 : | | | |
| Tax ID : | **371911194** | Type of Tax ID : | **Group** |
| Is this the primary Tax ID for this practice location? | **Yes** | | |
| Group Name : | | | |

**Network Denial :**

| | |
|---|---|
| Have you closed your practice to any plans or programs ? | **No** |

**Office Hours :**

| | | | |
|---|---|---|---|
| Monday | | | |
| Start Time : | **None** | End Time : | **None** |
| Tuesday | | | |
| Start Time : | **None** | End Time : | **None** |
| Wednesday | | | |
| Start Time : | **None** | End Time : | **None** |
| Thursday | | | |
| Start Time : | **None** | End Time : | **None** |
| Friday | | | |
| Start Time : | **None** | End Time : | **None** |
| Saturday | | | |
| Start Time : | **None** | End Time : | **None** |
| Sunday | | | |
| Start Time : | **None** | End Time : | **None** |

**Patients :**

| | |
|---|---|
| Do you accept new patients at this practice location? | **No** |
| Do you accept existing patients with change of payor at this location? | **No** |
| Do you accept all new patients at this location? | **No** |
| Do you accept new Medicare patients at | **No** |

| | | | |
|---|---|---|---|
| this location? | | | |
| Do you accept new Medicaid patients at this location? | **No** | | |
| Do you accept new patients from physician referrals (i.e., referring letter) at this location? | **No** | | |
| Under what circumstances do you accept referrals? (i.e., letter from another physician, etc. | | | |
| What questions should we ask a patient, to help determine the appropriateness of the referral? | | | |
| Does this information vary by health plan ? | **No** | | |
| **Colleagues :** | | | |
| Do you have any Partners/Associate at this location ? | **No** | | |
| **Covering Colleagues :** | | | |
| **Mid-Level Practitioners :** | | | |
| Do you have any mid-level practitioners at this location? | **No** | | |
| **Office Manager or Business Staff Contact :** | | | |
| First Name : | **Jennifer** | Last Name : | **Weir** |
| Middle Name : | | Suffix : | |
| Phone Number : | | Fax Number : | |
| E-mail Address : | **jennifer.weir@hhchealth.org** | | |
| Is Office Manager Credentialing Contact : | | | |
| **Billing Contact :** | | | |
| Office Manager & Billing Contact are same ? | | | |
| First Name : | **Director of Billing** | Middle Name : | |
| Last Name : | **Director of Billing** | Street 1 : | |
| Billing Company Name : | | | |
| Street 2 : | | City : | |
| State: | | Province : | |
| Country : | | Zip Code : | |
| Phone Number : | **860-545-7500** | Fax Number : | **860-972-7040** |
| E-mail Address : | **RevCycleCorrespondence@hhchealth.org** | | |
| **Payment and Remittance :** | | | |
| Billing department name : | | Check Payable to : | **Hartford HealthCare Medical Group Specialists, LLC** |
| Electronic billing capabilities ? | | | |
| Office Manager & Payee Contact are same ? | | | |
| First Name : | **Hartford HealthCare Medical Group Specialists, LLC** | Middle Name : | |
| Last Name : | | Street 1 : | **P.O. Box 844327** |
| Street 2 : | | City : | **Boston** |
| State: | **MA** | Province : | |
| Country : | | Zip Code : | **02284** |
| Phone Number : | **860-545-7500** | | |
| Fax Number : | **860-972-7040** | E-mail Address : | **RevCycleCorrespondence@hhchealth.o** |
| **Practice Limitations and Patient Populations :** | | | |
| Are there any Practice Limitations ? | **No** | | |
| Gender Limitations : | | | |
| Are there any Age Limitations? : | | | |
| Other Limitations : | | | |
| **Accessibility :** | | | |
| Does this office meet ADA accessibility requirements ? | | **Yes** | |
| Does this office provide handicapped accessibility ? | | **Yes** | |
| **Please specify how this location meets handicapped accessibility requirements:** | | | |
| Exterior Building | | Yes | |
| Interior Building | | Yes | |
| Wheelchair access to exam room | | Yes | |
| Exam table/scale/chair | | No | |
| Gurneys & Stretchers | | No | |
| Portable Lifts | | No | |
| Radiologic Equipment | | No | |
| Signage & documents | | No | |
| Parking | | Yes | |
| Restroom | | Yes | |
| Other Handicapped Access : | | | |
| Does this office have other services for the disabled ? | | **No** | |
| **Please specify other services for the disabled:** | | | |
| Text Telephony (TTL) : | | No | |
| American Sign Language : | | No | |

| | |
|---|---|
| Mental/Physical Impairment Services : | No |
| Other Disability Services : | |
| Is this office accessible by public transportation ? | **No** |
| **Please specify how this office is accessible by public transportation:** | |
| Bus Transportation: | No |
| Subway : | No |
| Regional Train : | No |
| Other Transportation : | |
| Does this Location Provide Child Care Services? | No |
| Does this office meet all state and local fire, safety and sanitation requirements? | No |
| Do you have TDD(hearing impaired device) available : | No |
| Do you accept Workers' Compensation Patients? | No |
| Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy? | No |
| Modified or alternative duty is actively evaluated for each Workers' Compensation claimant? | No |
| Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible | No |
| Staff are available and willing to provide compensation representatives information regarding a claimant's care. | No |

**Telehealth :**

| | | | |
|---|---|---|---|
| I provide telehealth services at this location: | | | |
| Do you use a telehealth application or platform that is compliant with the Health Insurance Portability and Accountability Act (HIPAA)? | | | |
| Telehealth Service Type: | | | |
| Audio : | **No** | Audio/Video : | **No** |
| Secure Text Messaging : | **No** | Remote Monitoring : | **No** |
| Store-and-Forward : | **No** | | |
| Are you willing and able to support family caregivers? | No | | |

**Services :**

| | | | |
|---|---|---|---|
| Does this location provide any of the following services: | | | |
| Laboratory Services? : | **No** | Accrediting/Certifying Program : | |
| Radiology Services : | **No** | X-ray? | **No** |
| X-Ray Certification Type : | | EKG Services? | **No** |
| Care of Minor Lacerations? | **No** | Pulmonary Function testing? | **No** |
| Allergy Injections : | **No** | Allergy Skin Testing : | **No** |
| Office Gynecology? | **No** | | |
| Drawing Blood? | **No** | | |
| Asthma Treatment? | **No** | Age Appropriate Immunizations? | **No** |
| Flexible Sigmoidoscopy? | **No** | Tympanometry/Audiometry Screening ? | **No** |
| Osteopathic Manipulation? | **No** | IV Hydration treatment? | **No** |
| Cardiac Stress Test? | **No** | Physical Therapy? | **No** |
| Treadmill? | | | |
| Is anesthesia administered in your office ? | **No** | What class/category of anesthesia is used ? | |
| Anesthesia Administered by First Name : | | Anesthesia Administered by Last Name : | |
| Other Services : | | | |
| Special Skills By The Practitioner : | | Special Skills By The Staff : | |
| Non-English language spoken by office personnel : | | | |
| Employee Type : | | | |
| Do you have any interpreters at this location? | **No** | | |

**General Information :**

| | | | |
|---|---|---|---|
| Confirmed Date : | **9/28/2023** | | |
| Office Type : | **Other Practice** | Providers's Start Date : | **2/13/2023** |
| Do you practice at this location?: | **No, I do not practice here** | | |
| Please Explain: | **I no longer practice at this location** | | |
| End Date : | **8/4/2023** | | |
| Provider Directory Classification : | | | |
| Specialty : | **Social Worker, Clinical** | Subspecialty : | |
| Will you continue to practice at this location | | | |
| Type of Service provided : | | | |
| Provide a narrative description of your clinical practice including special interests : | | | |
| Practice Name : | **Hartford HealthCare Medical Group Specialists, LLC** | | |
| Street 1 : | **74 Mack St** | | |
| Street 2 : | | Country : | **United States** |
| City : | **Windsor** | State : | **CT** |
| County : | | Province : | |
| Zip Code : | **06095-2759** | Email Address : | |

| | | | |
|---|---|---|---|
| Can general correspondence be sent to this location? | | Practice Location Website | |
| Appointment Scheduling Website | | | |
| **Mailing Address :** | | | |
| Street1 : | **1290 Silas Deane Hwy** | Street2 : | **Hartford Healthcare-CVO** |
| City : | **Wethersfield** | State : | **CT** |
| County : | | Province : | |
| Country : | | Zip Code : | **06109-4337** |
| Type of Practice : | | | |
| Do you have an organization (Type 2) NPI? : | **Yes** | Organization (Type 2) NPI : | **1023584216** |
| Group Medicaid Number : | | Group Medicare Number : | |
| **Phone Numbers :** | | | |
| Appointment Phone Number : | **860-298-8830** | Phone Extention : | |
| Fax Number : | **860-648-4318** | | |
| Back Office Phone Number : | | | |
| **Phone Coverage :** | | | |
| Does this location provide 24hour/7day a week phone coverage?: | | | |
| Phone Coverage Type : | | | |
| **Tax Information :** | | | |
| Practice Name as it appears on the W-9 : | | | |
| Tax ID : | **371911194** | Type of Tax ID : | **Group** |
| Is this the primary Tax ID for this practice location? | **Yes** | | |
| Group Name : | | | |
| **Network Denial :** | | | |
| Have you closed your practice to any plans or programs ? | | **No** | |
| **Office Hours :** | | | |
| Monday | | | |
| Start Time : | **None** | End Time : | **None** |
| Tuesday | | | |
| Start Time : | **None** | End Time : | **None** |
| Wednesday | | | |
| Start Time : | **None** | End Time : | **None** |
| Thursday | | | |
| Start Time : | **None** | End Time : | **None** |
| Friday | | | |
| Start Time : | **None** | End Time : | **None** |
| Saturday | | | |
| Start Time : | **None** | End Time : | **None** |
| Sunday | | | |
| Start Time : | **None** | End Time : | **None** |
| **Patients :** | | | |
| Do you accept new patients at this practice location? | **No** | | |
| Do you accept existing patients with change of payor at this location? | **No** | | |
| Do you accept all new patients at this location? | **No** | | |
| Do you accept new Medicare patients at this location? | **No** | | |
| Do you accept new Medicaid patients at this location? | **No** | | |
| Do you accept new patients from physician referrals (i.e., referring letter) at this location? | **No** | | |
| Under what circumstances do you accept referrals? (i.e., letter from another physician, etc. | | | |
| What questions should we ask a patient, to help determine the appropriateness of the referral? | | | |
| Does this information vary by health plan ? | **No** | | |
| **Colleagues :** | | | |
| Do you have any Partners/Associate at this location ? | **No** | | |
| **Covering Colleagues :** | | | |
| **Mid-Level Practitioners :** | | | |
| Do you have any mid-level practitioners at this location? | **No** | | |
| **Office Manager or Business Staff Contact :** | | | |
| First Name : | **Jennifer** | Last Name : | **Weir** |
| Middle Name : | | Suffix : | |
| Phone Number : | | Fax Number : | |
| E-mail Address : | **jennifer.weir@hhchealth.org** | | |

| | | | |
|---|---|---|---|
| Is Office Manager Credentialing Contact : | | | |
| **Billing Contact :** | | | |
| Office Manager & Billing Contact are same ? | | | |
| First Name : | **Director of Billing** | Middle Name : | |
| Last Name : | **Director of Billing** | Street 1 : | |
| Billing Company Name : | | | |
| Street 2 : | | City : | |
| State: | | Province : | |
| Country : | | Zip Code : | |
| Phone Number : | **860-545-7500** | Fax Number : | **860-972-7040** |
| E-mail Address : | **RevCycleCorrespondence@hhchealth.org** | | |
| **Payment and Remittance :** | | | |
| Billing department name : | | Check Payable to : | **Hartford HealthCare Medical Group Specialists, LLC** |
| Electronic billing capabilities ? | | | |
| Office Manager & Payee Contact are same ? | | | |
| First Name : | **Hartford HealthCare Medical Group Specialists, LLC** | Middle Name : | |
| Last Name : | | Street 1 : | **P.O. Box 844327** |
| Street 2 : | | City : | **Boston** |
| State: | **MA** | Province : | |
| Country : | | Zip Code : | **02284-4327** |
| Phone Number : | **860-545-7500** | | |
| Fax Number : | **860-972-7040** | E-mail Address : | **RevCycleCorrespondence@hhchealth.o** |
| **Practice Limitations and Patient Populations :** | | | |
| Are there any Practice Limitations ? | **No** | | |
| Gender Limitations : | | | |
| Are there any Age Limitations? : | | | |
| Other Limitations : | | | |
| **Accessibility :** | | | |
| Does this office meet ADA accessibility requirements ? | | **Yes** | |
| Does this office provide handicapped accessibility ? | | **Yes** | |
| **Please specify how this location meets handicapped accessibility requirements:** | | | |
| Exterior Building | | Yes | |
| Interior Building | | Yes | |
| Wheelchair access to exam room | | Yes | |
| Exam table/scale/chair | | No | |
| Gurneys & Stretchers | | No | |
| Portable Lifts | | No | |
| Radiologic Equipment | | No | |
| Signage & documents | | Yes | |
| Parking | | Yes | |
| Restroom | | Yes | |
| Other Handicapped Access : | | | |
| Does this office have other services for the disabled ? | | **No** | |
| **Please specify other services for the disabled:** | | | |
| Text Telephony (TTL) : | | No | |
| American Sign Language : | | No | |
| Mental/Physical Impairment Services : | | No | |
| Other Disability Services : | | | |
| Is this office accessible by public transportation ? | | **No** | |
| **Please specify how this office is accessible by public transportation:** | | | |
| Bus Transportation: | | No | |
| Subway : | | No | |
| Regional Train : | | No | |
| Other Transportation : | | | |
| Does this Location Provide Child Care Services? | | No | |
| Does this office meet all state and local fire, safety and sanitation requirements? | | No | |
| Do you have TDD(hearing impaired device) available : | | No | |
| Do you accept Workers' Compensation Patients? | | No | |
| Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy? | | No | |
| Modified or alternative duty is actively evaluated for each Workers' Compensation claimant? | | No | |
| Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible | | No | |
| Staff are available and willing to provide compensation representatives information regarding a claimant's care. | | No | |
| **Telehealth :** | | | |
| I provide telehealth services at this location: | | | |
| Do you use a telehealth application or platform that is compliant with the Health Insurance Portability and Accountability Act (HIPAA)? | | | |
| Telehealth Service Type: | | | |

| | | | |
|---|---|---|---|
| Audio : | **No** | Audio/Video : | **No** |
| Secure Text Messaging : | **No** | Remote Monitoring : | **No** |
| Store-and-Forward : | **No** | | |
| Are you willing and able to support family caregivers? | No | | |

**Services :**

Does this location provide any of the following services:

| | | | |
|---|---|---|---|
| Laboratory Services? : | **No** | Accrediting/Certifying Program : | |
| Radiology Services : | **No** | X-ray? | **No** |
| X-Ray Certification Type : | | EKG Services? | **No** |
| Care of Minor Lacerations? | **No** | Pulmonary Function testing? | **No** |
| Allergy Injections : | **No** | Allergy Skin Testing : | **No** |
| Office Gynecology? | **No** | | |
| Drawing Blood? | **No** | | |
| Asthma Treatment? | **No** | Age Appropriate Immunizations? | **No** |
| Flexible Sigmoidoscopy? | **No** | Tympanometry/Audiometry Screening ? | **No** |
| Osteopathic Manipulation? | **No** | IV Hydration treatment? | **No** |
| Cardiac Stress Test? | **No** | Physical Therapy? | **No** |
| Treadmill? | | | |
| Is anesthesia administered in your office ? | **No** | What class/category of anesthesia is used ? | |
| Anesthesia Administered by First Name : | | Anesthesia Administered by Last Name : | |
| Other Services : | | | |
| Special Skills By The Practitioner : | | Special Skills By The Staff : | |
| Non-English language spoken by office personnel : | | | |
| Employee Type : | | | |
| Do you have any interpreters at this location? | **No** | | |

## HOSPITAL AFFILIATIONS

**General :**

| | |
|---|---|
| Do you have admitting privileges at one or more hospitals? | **No** |
| Do you have an admitting arrangement where another provider admits for you? | **No** |
| Do you have any non-admitting hospital affiliations? | **No** |

## CREDENTIALING INFORMATION

| | | | |
|---|---|---|---|
| First Name : | **Coretta** | Middle Name : | |
| Last Name : | **Gilbert** | Street 1 : | **51 Park Avenue** |
| Street 2 : | | City : | **Bloomfield** |
| State : | **CT** | Zip Code : | **06002** |
| Country : | **United States** | Province : | |
| Phone Number : | **860-881-6436** | Fax Number : | |
| Email Address : | **piecetopeace.services@gmail.com** | | |
| Primary Credentialing Contact : | **No** | | |
| Location Type : | **PracticeLocation** | Location : | **Piece to Peace, LLC** |
| First Name : | **John** | Middle Name : | |
| Last Name : | **Dolores** | Street 1 : | **3030 K St NW** |
| Street 2 : | **PH 207** | City : | **Washington** |
| State : | **DC** | Zip Code : | **20007-5104** |
| Country : | **United States** | Province : | |
| Phone Number : | **916-385-4849** | Fax Number : | |
| Email Address : | **contracting@confidanthealth.com** | | |
| Primary Credentialing Contact : | **Yes** | | |
| Location Type : | **PracticeLocation** | Location : | **Confidant Providers, LLC** |

## INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| Policy Number : | **0684396532** | | |
| Covered Practice Locations : | **Piece to Peace, LLC** | | |
| Original Effective Date : | | | |
| Current Effective Date : | **02/01/2024** | | |
| Current Expiration Date : | **02/01/2025** | | |
| Carrier/Self Insured Name : | **Healthcare Providers Service Organization** | | |
| Street 1 : | **159 East County Line Road** | Street 2 : | |
| City : | **Hatboro** | Province : | |
| State : | **PA** | Country : | |
| Zip Code : | | Phone Number : | |
| Phone Extension : | | Fax Number : | |
| Do you have unlimited coverage with this insurance carrier? | **No** | | |
| Type of coverage : | **Individual** | | |
| Amount of coverage per occurrence : | **$1,000,000.00** | Amount of coverage aggregate : | **$3,000,000.00** |
| If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? | **No** | | |

| | | | |
|---|---|---|---|
| Individual Coverage : | **Yes** | | |
| Self-Insured? | **Yes** | | |
| Policy Number : | **0684396532** | | |
| Covered Practice Locations : | **Piece to Peace, LLC** | | |
| Original Effective Date : | | | |
| Current Effective Date : | **02/01/2023** | | |
| Current Expiration Date : | **02/01/2024** | | |
| Carrier/Self Insured Name : | **Healthcare Providers Service Organization** | | |
| Street 1 : | **159 East County Line Road** | Street 2 : | |
| City : | **Hatboro** | Province : | |
| State : | **PA** | Country : | |
| Zip Code : | | Phone Number : | |
| Phone Extension : | | Fax Number : | |
| Do you have unlimited coverage with this insurance carrier? | **No** | | |
| Type of coverage : | | | |
| Amount of coverage per occurrence : | **$1,000,000.00** | Amount of coverage aggregate : | **$3,000,000.00** |
| If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? | | | |
| Individual Coverage : | **Yes** | | |
| Self-Insured? | **Yes** | | |
| Policy Number : | **0684396532** | | |
| Covered Practice Locations : | **Piece to Peace, LLC** | | |
| Original Effective Date : | **02/01/2022** | | |
| Current Effective Date : | **02/01/2022** | | |
| Current Expiration Date : | **02/01/2023** | | |
| Carrier/Self Insured Name : | **Healthcare Providers Service Organization** | | |
| Street 1 : | **1100 Virginia Drive, Suite 250** | Street 2 : | |
| City : | **Fort Washington** | Province : | |
| State : | **PA** | Country : | **United States** |
| Zip Code : | **19034** | Phone Number : | |
| Phone Extension : | | Fax Number : | |
| Do you have unlimited coverage with this insurance carrier? | **No** | | |
| Type of coverage : | | | |
| Amount of coverage per occurrence : | **$1,000,000.00** | Amount of coverage aggregate : | **$3,000,000.00** |
| If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? | **No** | | |
| Individual Coverage : | **Yes** | | |
| Self-Insured? | **Yes** | | |
| Policy Number : | **0684396532** | | |
| Covered Practice Locations : | **Piece to Peace, LLC** | | |
| Original Effective Date : | **02/01/2020** | | |
| Current Effective Date : | **02/01/2021** | | |
| Current Expiration Date : | **02/01/2022** | | |
| Carrier/Self Insured Name : | **Healthcare Providers Service Organization** | | |
| Street 1 : | **159 East County Line Road** | Street 2 : | |
| City : | **Hatboro** | Province : | |
| State : | **PA** | Country : | |
| Zip Code : | | Phone Number : | |
| Phone Extension : | | Fax Number : | |
| Do you have unlimited coverage with this insurance carrier? | **No** | | |
| Type of coverage : | | | |
| Amount of coverage per occurrence : | **$1,000,000.00** | Amount of coverage aggregate : | **$3,000,000.00** |
| If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? | **No** | | |
| Individual Coverage : | **Yes** | | |
| Self-Insured? | **Yes** | | |
| Policy Number : | **684396532** | | |
| Covered Practice Locations : | | | |
| Original Effective Date : | **02/01/2020** | | |
| Current Effective Date : | **02/01/2020** | | |
| Current Expiration Date : | **02/01/2021** | | |
| Carrier/Self Insured Name : | **Piece to Peace, LLC** | | |
| Street 1 : | **51 Park Avenue** | Street 2 : | |
| City : | **Bloomfield** | Province : | |
| State : | **CT** | Country : | **United States** |
| Zip Code : | **06002** | Phone Number : | **860-881-6436** |
| Phone Extension : | | Fax Number : | |
| Do you have unlimited coverage with this insurance carrier? | **No** | | |
| Type of coverage : | | | |

| | | | |
|---|---|---|---|
| Amount of coverage per occurrence : | **$1,000,000.00** | Amount of coverage aggregate : | **$3,000,000.00** |
| If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? | **No** | | |
| Individual Coverage : | **Yes** | | |
| Self-Insured? | **Yes** | | |

## WORK HISTORY INFORMATION

**Employment Information Record**

| | | | |
|---|---|---|---|
| Practice/Employer Name : | **Elevance Health** | Department : | |
| Street 1 : | **500 Enterprise Drive** | Street 2 : | |
| Country : | **United States** | | |
| City : | **Rocky Hill** | State : | **CT** |
| Province : | | Zip Code : | **06067** |
| Phone Number : | | Phone Extension : | |
| Fax Number : | | | |
| Start Date : | **08/2023** | | |
| Is this your current employer? | **Yes** | | |
| Practice/Employer Name : | **Hartford HealthCare Medical Group Specialists** | Department : | |
| Street 1 : | **1060 Day Hill Road** | Street 2 : | **Suite 203** |
| Country : | **United States** | | |
| City : | **Windsor** | State : | **CT** |
| Province : | | Zip Code : | **06095-1339** |
| Phone Number : | | Phone Extension : | |
| Fax Number : | | | |
| Start Date : | **02/2023** | | |
| Is this your current employer? | **No** | | |
| End Date : | **08/2023** | Reason for departure : | **New position through Elevance** |
| Practice/Employer Name : | **Centene Corporation** | Department : | **Remote Licensed Clinical Social Worker** |
| Street 1 : | **51 Park Avenue** | Street 2 : | |
| Country : | **United States** | | |
| City : | **Bloomfield** | State : | **CT** |
| Province : | | Zip Code : | **06002** |
| Phone Number : | | Phone Extension : | |
| Fax Number : | | | |
| Start Date : | **04/2022** | | |
| Is this your current employer? | **No** | | |
| End Date : | **02/2023** | Reason for departure : | **Offered new poition through HHC** |
| Practice/Employer Name : | **DaVita** | Department : | |
| Street 1 : | **675 Tower Avenue** | Street 2 : | |
| Country : | **United States** | | |
| City : | **Hartford** | State : | **CT** |
| Province : | | Zip Code : | **06112** |
| Phone Number : | | Phone Extension : | |
| Fax Number : | | | |
| Start Date : | **12/2021** | | |
| Is this your current employer? | **No** | | |
| End Date : | **03/2022** | Reason for departure : | **New Opportunity** |
| Practice/Employer Name : | **Bloomfield Leisure Services** | Department : | |
| Street 1 : | **330 Park Avenue** | Street 2 : | |
| Country : | **United States** | | |
| City : | **Bloomfield** | State : | **CT** |
| Province : | | Zip Code : | **06002** |
| Phone Number : | **860-242-2923** | Phone Extension : | |
| Fax Number : | | | |
| Start Date : | **11/2018** | | |
| Is this your current employer? | **No** | | |
| End Date : | **01/2022** | Reason for departure : | **New opportunity** |
| Practice/Employer Name : | **Community Health Resources** | Department : | |
| Street 1 : | **999 Asylum Avenue** | Street 2 : | |
| Country : | **United States** | | |
| City : | **Hartford** | State : | **CT** |
| Province : | | Zip Code : | **06105** |
| Phone Number : | | Phone Extension : | |
| Fax Number : | | | |
| Start Date : | **06/2017** | | |
| Is this your current employer? | **No** | | |
| End Date : | **11/2021** | Reason for departure : | **New opportunity** |
| Practice/Employer Name : | **Bloomfield Social and Youth Services** | Department : | |
| Street 1 : | **330 Park Avenue** | Street 2 : | |
| Country : | **United States** | | |
| City : | **Bloomfield** | State : | **CT** |
| Province : | | Zip Code : | **06002** |
| Phone Number : | **860-242-1835** | Phone Extension : | |

| | | | |
|---|---|---|---|
| Fax Number : | | | |
| Start Date : | **08/2014** | | |
| Is this your current employer? | **No** | | |
| End Date : | **06/2017** | Reason for departure : | **Received a full time clinical position at Community Health Resources.** |

**Employment Gap Record :**

| | | | |
|---|---|---|---|
| Start Date: | **07/2016** | End Date: | **05/2017** |
| Gap Explanation: | **Academic/Training leave** | | |
| Start Date: | **09/2016** | End Date: | **05/2017** |
| Gap Explanation: | **Academic/Training leave** | | |
| Start Date: | **08/2012** | End Date: | **05/2016** |
| Gap Explanation: | **Academic/Training leave** | | |

**Military :**

| | | | |
|---|---|---|---|
| Are you currently on active military duty? | **No** | Are you currently in the Reserves or National Guard? | **No** |

## REFERENCES INFORMATION

| | | | |
|---|---|---|---|
| Provider Type : | **Clinical Social Worker** | | |
| First Name : | **Abigail** | | |
| Last Name : | **Collins** | | |
| Street 1 : | **204 Deerfield Road** | Street 2 : | |
| City: | **Windsor** | State : | **CT** |
| Province : | | Zip Code : | **06095** |
| Country : | **United States** | Email Address : | **abigail.morales4@yahoo.com** |
| Phone Number : | **860-481-2226** | | |
| Fax Number : | | | |

## DISCLOSURE INFORMATION

**CAQH :**

**Licensure :**

| | |
|---|---|
| 1. Has your license, registration or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? | **No** |
| 2. Has there been any challenge to your licensure, registration or certification? | **No** |

**Hospital Privileges and Other Affiliations :**

| | |
|---|---|
| 3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? | **No** |
| 4. Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? | **No** |
| 5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? | **No** |

**Education, Training and Board Certification :**

| | |
|---|---|
| 6. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? | **No** |
| 7. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? | **No** |
| 8. Have any of your board certifications or eligibility ever been revoked? | **No** |
| 9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? | **No** |

**DEA or CDS :**

| | |
|---|---|
| 10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished? | **No** |

**Medicare, Medicaid or other Governmental Program Participation :**

| | |
|---|---|
| 11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs? | **No** |

**Other Sanctions or Investigations :**

| | |
|---|---|
| 12. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offence or sexual misconduct? | **No** |
| 13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? | **No** |
| 14. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? | **No** |
| 15. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct? | **No** |
| 16. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency? | **No** |

**Professional Liability Insurance Information and Claims History :**

| | |
|---|---|
| 17. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? | **No** |
| 18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history? | **No** |

**Malpractice Claims History :**

| | |
|---|---|
| 19. Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? If yes, provide | **No** |

information for each case.

**Criminal/Civil History :**

| | |
|---|---|
| 20. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony? | **No** |
| 21. In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offence or sexual misconduct? | **No** |
| 22. Have you ever been court-martialed for actions related to your duties as a medical professional? | **No** |

**Ability to Perform Job :**

| | |
|---|---|
| 23. Are you currently engaged in the illegal use of drugs? (Currently means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. Illegal use of drugs refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. 812.22. It does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the controlled Substances Act or other provision of Federal law. The term does include, however, the unlawful use of prescription controlled substances.) | **No** |
| 24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? | **No** |
| 25. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients? | **No** |
| 26. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation? | **No** |