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Brentwood, TN 37027
(615) 782-7851
(800) 316-2273
TTY (800) 848-0298
FAX (615) 782-7827

Windsor Health Plan – Behavioral Health Practitioner Application *MedicareExtra*

The following application is for Licensed Personnel not required to complete a State Mandated Application.

Initial Application

Recredentialing Application

- [] Completed Criteria for Network Participation Checksheet
- [] Signed and completed Application/Attestation Statement
- [] Signed and completed Provider Release of Information
- [] Signed and completed State Volunteer Authorization Release *if applicable*
- [] Copy of **current** Professional Licenses
- [] Copy of **current** Board Certification (or two **current** letters of recommendation from non-coworker peers **if not board certified**)
- [] Copy of **current** DEA License or CDS Registration or Certificate of Fitness
- [] Chemical Substances or Alcohol Abuse Information Form
- [] Copy of Malpractice Insurance Certificate(s) **within past 5 years unless in a residency program**
- [] Explanation of Malpractice History ([see page 7](#))
- [] Signed and completed W-9 form for each Tax Identification Number
- [] Copy of current Curriculum Vitae or Work History – **must include month & year**
Any lapse in continuous employment/work history since graduation from your highest level of education must be fully explained on a separate sheet
- [] Copy of current APN Collaboration agreement with Psychiatrists (if applicable)

Please make sure your packet contains all forms and are signed and dated before returning to WHP. Failure to do so will delay the credentialing of your information.

Criteria for Network Participation

1. Please review the application section for your discipline **ONLY**.
2. Check the criteria met in each box

PSYCHIATRISTS

- Must possess a Doctor of Medicine (MD) degree or Doctor of Osteopathy (DO) degree from an accredited medical school
- Board Certified in psychiatry as defined by the American Board of Psychiatry and Neurology **OR** Certified by the American Society of Addiction Medicine (ASAM) or the American Board of Psychiatry and Neurology in Addiction Medicine **OR** graduated from an accredited residency program
- Unrestricted, current license to practice medicine in the state where practice is to occur
- Must possess a current Drug Enforcement Administration (DEA) certificate
- Must possess a current State Controlled Dangerous Substances (CDS) registration Certificate (where applicable)
- Completed a training program approved by the American Council of Graduate Medical Education (ACGME) or Osteopathic approved residency training program in psychiatry
- Graduates of foreign medical schools must submit an Educational Commission for Foreign Medical Graduates (ECFMG) Certificate
- All eligible providers must have a minimum of three (3) years residency experience in a mental health/substance abuse setting providing direct patient care
- Provide a certificate of Professional Liability Coverage at a minimum level of \$1,000,000 per episode and \$3,000,000 aggregate
- Primary admitting privileges or designate an in-network physician or facility

ADDICTIONOLOGISTS (NON-PSYCHIATRIST)

- Must possess a Doctor of Medicine (MD) degree or Doctor of Osteopathy (DO) degree from an accredited medical school
- Certified by the American Society of Addiction Medicine (ASAM) as an addictions specialist
- Unrestricted, current license to practice medicine in the state where practice is to occur
- Must possess a current Drug Enforcement Administration (DEA) certificate
- Must possess a current State Controlled Dangerous Substances (CDS) registration Certificate (where applicable)
- Graduates of foreign medical schools must submit an Educational Commission for Foreign Medical Graduates (ECFMG) Certificate
- All eligible providers must have a minimum of three (3) years residency experience in a mental health/substance abuse setting providing direct patient care
- Provide a certificate of Professional Liability Coverage at a minimum level of \$1,000,000 per episode and \$3,000,000 aggregate
- Primary admitting privileges or designate an in-network physician or facility

PSYCHOLOGISTS OR PSYCHOLOGICAL EXAMINER

- Must possess Doctoral degree (PhD, EdD, PsyD) in clinical psychology or counseling psychology from an accredited college or university **AND** meet one of the following:
 - a. Doctorate was received from a college program on the American Psychological Association (APA) approved list of counseling psychology or clinical psychology programs **at the time of graduation OR**
 - b. Completion of a pre-doctoral APA approved clinical internship **at the time of graduation OR**
 - c. Listed in the National Register of Health Service Providers **OR**
 - d. Be a diplomate with the American Board of Professional Psychology (ABPP) under the clinical psychology or counseling psychology categories

NOTE: A respecialization in clinical psychology or counseling psychology is eligible with proof of completion of training

- Licensed independently as a clinical psychologist at the highest level in the state where practice is to occur
- All eligible providers must have a minimum of three (3) years post-licensure clinical experience in the direct provision of mental health/substance abuse setting providing direct patient care
- Provide a certificate of Professional Liability Coverage at a minimum level of \$1,000,000 per episode and \$3,000,000 aggregate

LICENSED SOCIAL WORKERS (LCSW)

- Must possess Master's degree or higher in Social Work from school accredited by the Council on Social Work Education
- State licensed or certified at the highest level of independent practice in the state where practice is to occur. Only acceptable in those states whose clinical experience and exam requirements equal or exceed 2 years or 2,000 hours of clinical experience or 1,000 hours of direct clinical contact (face-to-face) under an approved supervisor as defined by the appropriate state regulatory agency. Must have received 100 hours of face-to-face supervision by an approved supervisor (as defined by the state) during the first two years of post-graduate direct clinical experience
- All eligible providers must have a minimum of three (3) years post-licensure clinical experience in a mental health and/or substance abuse setting providing direct patient care
- Provide a certificate of Professional Liability Coverage at a minimum level of \$1,000,000 per episode and \$3,000,000 Aggregate in applicant's name (exceptions to be considered if allowed by the state in which services are provided)

ADVANCED PRACTICE NURSE (APN)

- State licensed to practice as a nurse at the highest level of independent practice in the state where practice is to occur
- Must possess Master's degree or higher in nursing from an accredited college or university in a program recognized by the National League for Nursing **OR** must met licensing requirements acceptable by the board to practice at the highest level of independent practice in the state where practice is to occur
- Must possess a current Drug Enforcement Agency (DEA) Certificate (if applicable for prescriptive authority)
- Must possess a current State Controlled Dangerous Substances (CDS) Registration (if applicable for prescriptive authority)
- Rx number or Certification issued to the APN in order to provide prescriptive authority ((if applicable for prescriptive authority)
- Certified by the American Nurses Association, American Nurses Credentialing Center (ANCC) as an APRN, Board Certified (BC). The certification held must be in **one** of the following areas:
 - Clinical Specialist in Adult Psychiatric and Mental Health Nursing
 - Clinical Specialist in Child and Adolescent Psychiatric & Mental Health Nursing
 - Family Psychiatric and Mental Health Nurse Practitioner
 - Adult Psychiatric and Mental Health Nurse Practitioner

(Please note: The APRN, BC certification is a new credential approved the ANCC)

- All eligible providers must have a minimum of three (3) years post-licensure clinical experience in the direct provision of mental health/substance abuse setting providing direct patient care
- The APN is required to maintain compliance with collaboration/supervision licensing requirements issued by the State(s) in which practice occurs. In states that require an APN to hold a collaborative agreement with a physician, Windsor Health Group requires the APN to be supervised by a psychiatrist (MD/DO). **The APN must submit a copy of the agreement.**
- Provide a certificate of Professional Liability Coverage at a minimum level of \$1,000,000 per episode and \$3,000,000 Aggregate

PROFESSIONAL COUNSELORS

- Must possess Master's degree or higher in mental health discipline from a regionally accredited college or university
- State licensed or certified at the highest level of independent practice in the state where practice is to occur. Only acceptable in those states where clinical experience and exam requirements equal or exceed 2 years of 2,000 hours of clinical experience or 1,000 hours of direct clinical contact (face-to-face) under an approved supervisor as defined by the appropriate state regulatory agency. Must have received 100 hours of face-to-face supervision by an approved supervisor (as defined by the state) during the first 2 years of post-graduate direct clinical experience
- All eligible providers must have a minimum of three (3) years post-licensure clinical experience in a mental health and/or substance abuse setting providing direct patient care
- Provide a certificate of Professional Liability Coverage at a minimum level of \$1,000,000 per episode and \$3,000,000 Aggregate in applicant's name (exceptions to be considered if allowed by the state in which services are provided)



BHO Practitioner Application- Medicare*Extra*

Curriculum Vitae should be attached.

PROVIDER INFORMATION - DEMOGRAPHICS

Last Name	First Name	Middle	<input type="checkbox"/> M <input type="checkbox"/> F	Title	DOB
Indicate any other name you may have used in the past:					
PRIMARY PRACTICE INFORMATION					
Practice Name					
Address					
City	State	Zip	County		
Telephone Number	Fax Number		Email		
Office Contact Name	Office Contact Number		Office Contact Email		
Medicare #	Medicaid #	NPI #	Social Security #	UPIN #	

Handicapped Accessible? Y N Accessible to Public Transportation? Y N

Hours of Operation:

Monday _____ Tuesday _____ Wednesday _____

Thursday _____ Friday _____ Saturday _____ Sunday _____

On-Call Policy: _____

After Hours Numbers: _____

Billing Information Name	Tax ID (submit a W9 for each TID used)				
Address					
City	State	Zip	County		
Telephone Number	Fax Number		Email		
Billing Contact Name	Office Contact Number		Office Contact Email		

ADDITIONAL PRACTICE LOCATIONS: List all locations where you practice, use a separate sheet if necessary

Practice Name			
Address			
City	State	Zip	County
Telephone Number	Fax Number		Email
Office Contact Name	Office Contact Number		Office Contact Email

 Handicapped Accessible? Y N Accessible to Public Transportation? Y N

Hours of Operation:

 Monday _____ Tuesday _____ Wednesday _____

 Thursday _____ Friday _____ Saturday _____ Sunday _____

On-Call Policy: _____

After Hours Numbers: _____

Billing Information Name		Tax ID (submit a W9 for each TID used)	
Address			
City	State	Zip	County
Telephone Number	Fax Number		Email
Billing Contact Name	Office Contact Number		Office Contact Email

LICENSED DISCIPLINE: Indicate the discipline under which you are LICENSED and/or CERTIFIED at the highest level to practice independently.

- | | |
|---|--|
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> CAC, CADS, NCAC, etc |
| <input type="checkbox"/> Non-Psychiatric MD/DO | <input type="checkbox"/> Licensed Professional Counselor/Mental Health Counselor |
| <input type="checkbox"/> Child Psychiatrist | <input type="checkbox"/> Marriage & Family Therapist/Marriage Family & Child Counselor |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Pastoral Counselor |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Nurse Practitioner | |
| <input type="checkbox"/> Advanced Practice Nurse w/Prescriptive Authority | |

 Degree Levels: MD/DO Doctoral Level Masters Level Bachelors Level

PATIENT DEMOGRAPHIC INFORMATION: Identify the percentage of your practice dedicated to the following patient population categories (must equal 100%)

Population	Percentage	Accepting New Pts	Treatment Modality % of Practice
Young Child (0-5)		<input type="checkbox"/> Y <input type="checkbox"/> N	Inpatient
Child (6-12)		<input type="checkbox"/> Y <input type="checkbox"/> N	Day Treatment
Adolescent (13-17)		<input type="checkbox"/> Y <input type="checkbox"/> N	Outpatient
Adult (18-64)		<input type="checkbox"/> Y <input type="checkbox"/> N	Intensive Outpatient Programs
Geriatric (65+)		<input type="checkbox"/> Y <input type="checkbox"/> N	

Any populations you do not work with: Y N If yes, Please explain below:

Do you speak any foreign language or sign language that you use fluently in treating patients; If yes, please list

PROFESSIONAL MEMBERSHIPS:

- | | | |
|---|---|--|
| <input type="checkbox"/> American Psychiatric Association | <input type="checkbox"/> Assoc. of Marriage and Family Therapists | <input type="checkbox"/> Nat'l Association of Social Workers |
| <input type="checkbox"/> American Medical Association | <input type="checkbox"/> American Mental Health Counselors Assoc | <input type="checkbox"/> American Psychological Assoc. |
| <input type="checkbox"/> American Nurses Association | <input type="checkbox"/> American Counselors Association | <input type="checkbox"/> American Pastoral Counselor Assoc |
| <input type="checkbox"/> Other: | | |

SPECIALTY AREAS

Please check any specialty areas that you have experience and/or clinical training

<input type="checkbox"/> ADHD	<input type="checkbox"/> Divorce Mediation	<input type="checkbox"/> Parenting Issues
<input type="checkbox"/> Adolescent Behavioral Disorders	<input type="checkbox"/> EAP Counseling	<input type="checkbox"/> Psychopharmacology
<input type="checkbox"/> Adoption	<input type="checkbox"/> Ethnic/Cultural Issues	<input type="checkbox"/> Physical Disabilities
<input type="checkbox"/> Adjustment Disorders	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> PTSD
<input type="checkbox"/> Alcohol/Drugs	<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Psychoanalytic Therapy
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Repressed Memory Syndrome
<input type="checkbox"/> Autism	<input type="checkbox"/> Grief/Bereavement	<input type="checkbox"/> Retirement Counseling
<input type="checkbox"/> Anxiety Disorders	<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Assertiveness Training	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> School-related issues
<input type="checkbox"/> Behavioral Disorder	<input type="checkbox"/> Hypnotherapy	<input type="checkbox"/> Severe/Persistent Mental Illness
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Head Trauma	<input type="checkbox"/> Sexual/Physical Abuse
<input type="checkbox"/> Biofeedback/Relaxation	<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> Sexual Deviations & Disorders
<input type="checkbox"/> Borderline Personality Disorder	<input type="checkbox"/> Legal Issues	<input type="checkbox"/> Sexual Identity/Orientation
<input type="checkbox"/> Chronic Pain/Terminal Illness	<input type="checkbox"/> Men's Issues	<input type="checkbox"/> Sleep Disorders
<input type="checkbox"/> Cognitive/Behavior Therapy	<input type="checkbox"/> Marital Therapy/Divorce/Separation	<input type="checkbox"/> Smoking Cessation
<input type="checkbox"/> Crisis/Trauma	<input type="checkbox"/> Mood Disorders/Depression	<input type="checkbox"/> Step/Blended Families
<input type="checkbox"/> Critical Incident Debriefing	<input type="checkbox"/> Multiple Personality Disorders	<input type="checkbox"/> Stress Management
<input type="checkbox"/> Compulsive Gambling	<input type="checkbox"/> Neuropsychological Testing	<input type="checkbox"/> Veteran's Issues
<input type="checkbox"/> Developmental Functioning	<input type="checkbox"/> Nutrition Counseling	<input type="checkbox"/> Women's Issues
<input type="checkbox"/> Dissociative Disorder	<input type="checkbox"/> OCD	<input type="checkbox"/> Weight Reduction
<input type="checkbox"/> Dual Diagnosis	<input type="checkbox"/> Panic/Phobia	<input type="checkbox"/> Workplace Issues
<input type="checkbox"/> Dementia Disorders	<input type="checkbox"/> Personality Disorders	<input type="checkbox"/> Other:



THERAPEUTIC MODALITIES: Please check the modality areas you use in treating patients.

- Brief Therapy Child Therapy Family Therapy Group Therapy
- ECT Outpatient ECT Inpatient Neuropsych Testing Psych Testing
- Psychopharmacology Other: _____

SERVICES OFFERED: Please indicate if you provide services in any of the following areas

- Case Management Services (please specify) _____
- Emergency assessment and counseling (Contact patient by telephone within 45 minutes)
- In Home Care
- Suicide Assessment/intervention (Contact patient by telephone immediately)
- Urgent/Crisis Intervention services
- Mandatory Prescreener

LICENSURE AND CERTIFICATIONS: List ALL Health care licenses held in the past 10 years. An explanation will be licensure actions

License number: _____ State: _____ Date issued: _____ Expiration date: _____
 License number: _____ State: _____ Date issued: _____ Expiration date: _____
 License number: _____ State: _____ Date issued: _____ Expiration date: _____

INCLUDE A COPY OF YOUR DEA and/or CDS CERTIFICATE with your APPLICATION

DEA #: _____ Date issued: _____ Expiration date: _____

CDS #: _____ State: _____ Date issued: _____ Expiration date: _____

BOARD CERTIFICATIONS: Are you Board Certified Y N Board Eligible Y N

BOARD CERTIFIED SPECIALTY: _____

Education for MD/DO

College or University: _____ Starting Date: _____

Graduation Date: _____ City: _____ State: _____ Country: _____

Internship: _____ Specialty: _____ Starting Date: _____

Graduation Date: _____ City: _____ State: _____ Country: _____

Residency: _____ Specialty: _____ Starting Date: _____

Graduation Date: _____ City: _____ State: _____ Country: _____

Fellowship: _____ Specialty: _____ Starting Date: _____

Graduation Date: _____ City: _____ State: _____ Country: _____

NON MD/DO BHO PROFESSIONALS

College or University: _____ Starting Date: _____

Graduation Date: _____ City: _____ State: _____ Country: _____

Professional School: _____ Starting Date: _____

Graduation Date: _____ City: _____ State: _____ Country: _____

Or Certification Program: _____ Starting Date: _____

Graduation Date: _____ City: _____ State: _____ Country: _____

Post-Graduate Institution: _____ Starting Date: _____

Graduation Date: _____ City: _____ State: _____ Country: _____

Certificate of Fitness _____ Date Awarded: _____

This section to be completed by APN's who are required to collaborate or be supervised by a physician
 Include your Collaborative/Supervision agreement with your application

Advanced Practice Nurse - please list your supervising physician sign here: _____

Specialty of Collaborating/Supervising Physician: _____

- Are you currently recognized by your state licensing board to practice as an Advanced Practice Nurse? Y N
- Do you hold prescriptive authority in the state(s) in which you are licensed to practice? Y N
- Are you required by your licensing board to hold a collaboration agreement with a physician? Y N
- Does your licensing board require you to be supervised by a physician? Y N
- If you are required to collaborate or be supervised by a physician, is the physician a psychiatrist? Y N
- Do you have a Federal DEA certificate? Y N
- Do you hold a state issued Controlled Dangerous Substance (CDS) Registration or Rx#? Y N

Professional Work History (REQUIRED)

Chronologically list all professional activities since completion of post-graduate training. Explain any gaps in chronology. Additional information may be attached on a separate page, if noted in this section.

Activity	Location	Dates (mm/dd/yy)



Current Healthcare Facility Affiliations:

Do you admit patients or provide inpatient care? Y _____ N* _____

Please provide the following information:

- Primary facility: _____ City: _____
 State: _____ Phone: _____
 From (mm/dd/yy): _____ To (mm/dd/yy): _____
 Privileges: Active Courtesy Temporary In Process Other (attach full explanation)

***If no**, provide name and phone # of provider who will provide inpatient care for your assigned WHP members?

Name: _____

Phone #: _____

PROVIDERS WITHOUT ADMITTING PRIVILEGES ARE REQUIRED TO SUBMIT A COVERING PHYSICIAN ATTESTATION FORM

Professional Liability Insurance

Malpractice Carrier(s) for the last 5 years

Name: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____

Dates of Coverage: _____ Coverage Limits: _____

*Please list on separate form(s) the following information with regard to each professional liability claim or cause of action in which you have been involved:

- (a) plaintiff's/claimant's name;
- (b) agency, court, or jurisdiction;
- (c) date filed and docket number;
- (d) description of allegations, patient outcome; and
- (e) disposition (i.e., dismissed, settled {include amount}, judgment for defendant, judgment for plaintiff {include amount}, pending, or in discovery).

If none, indicate by initialing here: _____

NOTE: Documentation is required if you have malpractice claims pending or settled in the past 5 years (include any settlements/adjudications, original complaints and final disposition. The documentation must be from an attorney or the entity that issues the judgement



PROVIDER PROFILE: Please initial ALL provider profile questions.

Are you currently, or have you ever been, subject to any of the following:

- 1. Suspension, limitation, denial, or revocation of hospital or facility practice? Yes ___ No ___
- 2. Investigation or Sanction as a Medicare or Medicaid practitioner? Yes ___ No ___
- 3. Sanction as a PPO, MCO, HMO, or other third-party practitioner? Yes ___ No ___
- 4. Sanction by state or county medical society? Yes ___ No ___
- 5. Professional liability insurance restriction, limitation, denial, or cancellation? Yes ___ No ___
- 6. State license investigation, restriction, suspension, revocation, or denial? Yes ___ No ___
- 7. Arrest or conviction of a felony, moral, or ethical crime? Yes ___ No ___
- 8. DEA investigation, restriction, suspension, revocation, or denial? Yes ___ No ___
- 9. Chronic illness or physical infirmity that impairs your ability to practice? Yes ___ No ___
- 10. Mental illness or substance abuse (chemical dependency)? Yes ___ No ___
- 11. If you answered "yes" to 9 or 10, do you have full advocacy of your states' Physicians Health Program? Yes ___ No ___
Complete Medical Condition Information Form (attachment 1) or Chemical Substances or Alcohol Abuse Information Form (attachment 2)
- 12. Ownership in any medical facility, or joint ownership of medical services or equipment with a facility to which you might refer patients? Yes ___ No ___

If you answered yes to any of the above questions, please provide a thorough written explanation.

Practitioner Attestation:

I certify that the information in this application is true and correct. I understand that factual misrepresentation may result in my nonselection, or, if discovered after selection, in my termination as a WHP practitioner. I understand that this application does not entitle me to participation in the WHP network. I authorize WHP to consult with and inspect all documents from individuals and organizations having information bearing on my qualifications, and authorize the copy of my signature on this application to be as binding as the original. I agree that WHP, their representatives, and any individuals or entities providing information to WHP in good faith shall not be liable for any act or occasion related to the evaluation or verification contained in this application. I agree to exhaust any and all administrative remedies available to me under any of the foregoing prior to initiating any judicial action relative to this application or my participation in a WHP practitioner panel. I further agree to notify WHP in a timely manner of any change to the information requested in this application. Information requested in this application that is not publicly available will be treated as confidential by WHP.

Signature

Date

Provider Release of Information

I, _____, (print name) authorize any organization or individual from whom information is requested by WHP to release to WHP all information in the possession of that individual or organization related to my professional credentials, qualifications, competence, or utilization or practice patterns and liabilities claims history. I release the Federation of State Medical Boards from any liability whatsoever for provision of information to WHP. I release any individual or organization providing information pursuant to this authorization from any and all liability resulting from the release of such information.

I understand that I have the right to correct erroneous information and the right to review information obtained to evaluate my credentialing application unless disclosure is prohibited by law or the information is protected by peer review.

Signature

Date



AUTHORIZATION AND RELEASE

To: State Volunteer Mutual Insurance Company
From: _____

Policy #: _____
Medical License #: _____

Re: Release of Information to WHP

State Volunteer Mutual Insurance Company (SVMIC) is the carrier of my medical professional liability insurance, and, as such, SVMIC maintains certain information regarding my medical practice, and specifically, the history of any malpractice claims against me. I understand that this information is extremely sensitive and confidential. I acknowledge that SVMIC is protective of this information, and will only release it upon my express and unambiguous consent and direction.

Therefore, I request that SVMIC deliver to WHP information relating to the following:

A report of any medical professional liability claims activity against me on record with SVMIC, but specifically limited to: 1) claims that have resulted in paid losses (settlements); and/or 2) lawsuits (openor closed).

I hereby authorize SVMIC to release the information requested to
WHP
Attention: Credentialing Department
7100 Commerce Way, Suite 285
Brentwood, TN 37027
(fx) 615-782-7823

I HEREBY RELEASE SVMIC, ITS OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS FROM ANY CLAIMS, LIABILITIES, ACTIONS, DAMAGES, OR OTHERWISE, FOR THE RELEASE OF SUCH INFORMATION IF SUCH RELEASED INFORMATION IS DELIVERED IN GOOD FAITH AND WITHOUT MALICE. I ALSO ACKNOWLEDGE THAT MISTAKES MAY OCCUR IN THE PROVISION OF SUCH INFORMATION, AND, WITHOUT LIMITING THE FOREGOING, I SPECIFICALLY RELEASE SVMIC, ITS OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS FROM ANY CLAIMS DUE TO INCORRECT, MISDELIVERED, OR OTHERWISE INAPPLICABLE INFORMATION IF SUCH ERRORS OCCURRED IN GOOD FAITH, AND UPON DISCOVERY, SVMIC TAKES REASONABLE CORRECTIVE ACTIONS.

Date

Signature of Insured

**MEDICAL CONDITION INFORMATION FORM
(Attachment 1)**

**DUPLICATE this form as necessary to complete a separate sheet for EACH condition.
Use reverse side of this form if additional space is needed.**

Applicant: _____
Last name First name Middle name

Describe this medical condition: _____

To what extent does or could this condition affect your ability to practice medicine in your specialty area or perform a full range of clinical activities? _____

What is the current status of your condition? _____

Provide the name and address of your personal physician/health care practitioner who can provide information about your health condition: _____

Name (____) _____
Area Code Telephone

Address City State Zip Code

If none, check here and sign & date below

Applicant Signature: _____ Date: _____



CHEMICAL SUBSTANCES OR ALCOHOL ABUSE INFORMATION FORM (Attachment 2)

DUPLICATE this form as necessary to complete a separate sheet for EACH condition. Use reverse side of this form if additional space is needed.

Applicant: _____
Last name First name Middle name

Describe the substance(s) abused: _____

To what extent does or could this condition affect your ability to practice medicine in your specialty area or perform a full range of clinical activities? _____

What is the current status of your condition? _____
_____ Or, Abstinent since (mm/yy): _____

Monitored by State Board Mandate:

Monitored Voluntarily

Name of Monitoring Entity/Agency/Individual

Name of Monitoring Entity/Agency/Individual

Address City State ZIP code

Address City State Zip code

(____) _____
Telephone

(____) _____
Telephone

Other information about the current status of your use of substances: _____

Provide the name and address of your personal physician/health care practitioner who can provide information about your health condition:

Name

(____) _____
Area Code Telephone

Address City State Zip Code

If none, check here and sign & date below

Applicant Signature: _____

Date: _____



COVERING PHYSICIAN ATTESTATION FORM

Windsor Health Plan, Inc. requires documentation that *Windsor MedicareExtra* patients under a network provider’s care will be able to be admitted by a Windsor provider to a participating Windsor facility should they require hospitalization.

The applicant must have a direct referral relationship with an appropriate provider. This provider must be a participating Psychiatrist/Psychologist credentialed for the *Windsor MedicareExtra* network to which the applicant is applying, or if the applicant practices in the area of substance abuse, the provider may be a participating Addiction Psychiatrist credentialed for the *Windsor MedicareExtra* network to which the applicant is applying.

The referral provider must be willing and able to admit applicant’s patients to a hospital in the *Windsor MedicareExtra* network to which the applicant is applying and to provide outpatient medical care to applicant’s patients.

Applicant must provide written evidence of the direct referral relationship document by a letter or signed statement from the WME provider willing to accept such referrals.

APPLICANTS ATTESTATION:

I understand the above noted credentialing/recredentialing criteria and agree that I will refer patient’s requiring hospitalization or other services beyond the scope of my license, to

_____ M.D., PhD (or Facility) should the situation deem necessary.

Printed Name

Signature

Date

COVERING PHYSICIAN’S ATTESTATION:

I am a *Windsor MedicareExtra* provider and agree to accept referrals from

_____, _____ for inpatient care. I agree to admit
Name of Applicant Title of Applicant

such referred patients to a Windsor MedicareExtra facility, provided, however, that referrals and admissions to non-WME Providers may be made for Emergency Services, when no WME Providers are reasonably available or when a Medically Necessary Health Service is not available through WME Providers.

Printed Name (In-Network Facility or Medical Director for Facility)

Signature

Date