7100 Commerce Way
Suite 285
Brentwood, TN 37027
(615) 782-7851
(800) 316-2273
TTY (800) 848-0298
FAX (615) 782-7827

WHP PRACTITIONER CHECKLIST
Credentialing Application-Medicare*Extra*

[ ] Signed and completed Application/Attestation Statement

[ ] Signed and completed Provider Release of Information

[ ] Signed and completed State Volunteer Authorization Release

[ ] Copy of current Medical License(s)

[ ] Copy of current Board Certification (or two letters of recommendation from non-co-worker peers if not board certified)

[ ] Copy of current DEA License or Certificate of Fitness

[ ] Copy of Malpractice Insurance Certificate(s) **within past 5 years unless in a residency program**

[ ] Explanation of Malpractice History (**for any case within past 5 years**)

[ ] Signed and completed W-9 form

[ ] Copy of current Curriculum Vitae or Work History

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.

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Windsor Health Plan
Practitioner Credentialing Application-Medicare*Extra*

DO NOT refer to Curriculum Vitae. All information must be filled in on application. All Blanks must be filled in. Curriculum Vitae should be attached.

General Information

Last Name:_____________________ First Name:__________________ MI:___

Professional Degree: _____

List any other names under which you have been known? ___________________________

Social Security #: _______________ Sex: M ___ F ___ Date of Birth: _____________

Place of Birth: ____ Ethnicity: ____________________

Practice Name: ____________________________________

Billing Address: ____(___)___________________
(Billing Agent Location) (Facility) (City) (State) (ZIP Code) (Phone)

Submit Electronic Claims? Y ____ N ____ Claims Payable to: ______________________________

Pay-to Address: ____(___)___________________
(Pay-to Agent Location) (Facility) (City) (State) (ZIP Code) (Phone)

Office Contact: _______________________ Phone: (___)_______________ Fax: (___)___________

Physical Address: ____
(Primary Office Location) (Site) (City) (State) (ZIP Code)

County: _______________ Telephone: _________________ Fax: _________________

Handicap Accessible? Y __ N ___

E-Mail Address to send Health Plan Correspondence: ____________________________

Office Manager: ___________________________________ Accept assignment? Y ____ N ____

Office Hours:
Sun: ____ Mon: ____ Tues: ____ Wed: ____ Thurs: ____ Fri: ____ Sat: ___

Your Schedule:
Sun: ____ Mon: ____ Tues: ____ Wed: ____ Thurs: ____ Fri: ____ Sat: ____

Accepting new WHP patients? Y ____ N ____ Patient age/type restrictions? ________________

Laboratory tests performed onsite: ____
____

Federal Tax ID#: ______________________ Medicaid Group Provider #: _______________

Medicaid Individual Provider #: ___________ Medicare Group Provider #: _______________

Medicare Individual Provider #: ____________ National Provider ID #: _____________________
(Required as of May 2007; contact CMS for more info)

UPIN#: __________

Practice is organized as a:

☐ sole proprietorship ☐ partnership ☐ professional corporation

☐ for-profit business corporation under the laws of the State of ____________

☐ not-for-profit business corporation under the laws of the State of ___________

☐ (if applicable) and exempt from Federal income taxation under § 501 (c) (3) of the Internal Revenue Code of 1986, as amended

☐ governmental entity (*please describe*): ____
____

Name of group and business entity, if different from above: _______________________________
____

Your relationship with the group:

☐ sole proprietor ☐ partner ☐ employee ☐ shareholder ☐ other (describe) __________
____

Name all physicians in group: ____
____

Secondary Office Address: ___________________________ City ___________ State _____ ZIP ______

Handicap Accessible? Y ____ N ____ Office Manager: ___________________________________

Phone: (___)______________ Fax: (___)_____________ County: _________________________

Office Hours:
Sun: ____ Mon: ____ Tues: ____ Wed: ____ Thurs: ____ Fri: ____ Sat: ____

Your Schedule:
Sun: ____ Mon: ____ Tues: ____ Wed: ____ Thurs: ____ Fri: ____ Sat:____

Accepting new WHP patients? Y ____ N ____ Patient age/type restrictions? ___________________

Lab tests performed onsite: ____

Attach a list of all locations where you will see WHP members. Include information requested above.

Participation Status
Please indicate the level at which you are applying to participate:

_____ Primary Care Physician (PCP)

Eligible areas of specialty include Family Practice, General Practice, Internal Medicine, Pediatrics, Family Nurse Practitioners. Applicants should be willing and able to provide comprehensive primary care services, including preventive care services and case management. Physician applicants should be board-certified, or at least have fully completed a primary-care residency training program. Any applicant who does not have privileges at an in-network hospital should provide a signed copy of the Covering Physician Agreement for admissions purposes.

____ Specialty Care Specialty area: ____________ Appear in Directory? Y ____ N ____

Certification:
Please indicate your practice specialty area and board certification status:

______________________ Board certified? Y ____ N ____ Eligible? Y ____ N ____
(Primary Specialty)

Board Certification #: _________________ Date Certified: __________ Expiration date: _________

__________________________Board certified? Y ____ N ____ Eligible? Y ____ N ____
(Secondary Specialty)

Board Certification #: _________________ Date Certified: __________ Expiration date: _________

Licensure
License number: __________ State: _____ Date issued: ____________ Expiration date: ________

License number: ____________ State: _____ Date issued: ________ Expiration date: _________

DEA #: _______________________ Date issued: _____________ Expiration date: _______________

Education

Allied Health Professionals this section; Physicians complete next page:

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: ____________________

Physicians:

Professional School: ____ 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: ____________

Fellowship: ________________________ Specialty: ______________ Starting Date: ___________

Graduation Date: _______________ City: ____________ State: ________ Country: ____________

Professional Affiliations (County or State Medical/Nursing Association, etc.):

____

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)**

____

____

THE FOLLOWING QUESTION REQUIRES AN ANSWER:
Are you proficient in any languages other than English? : Yes*: _______ No: ______
*If YES, please list:____

Certificate of Fitness ___________________ **Date Awarded:** ____________

Continuing Education: *List all CME activities you have participated in during the past two years. Attach additional sheets if necessary.*

Activity/Title Location Dates (inclusive)

____

____

Is your office capable of handling hearing- or vision-impaired individuals? Y ____ N ____

Indicate the special needs patients for which you are available:

Sensory Impairment ____ HIV/AIDS_______

Mental Health/Substance Abuse _____ Physical Disability _____

Mental Retardation/Development Disabilities _____

Other (please specify): ____

Services offered:

Chest X-Ray _____ EKG _____ Endoscopy _____

General Surgery _____ Mammogram _____ Physical Therapy _____

PAP Smears _____ Bronchoscopy _____

Primary Care _____ Hernia Repair _____ Extremity X-Rays _____

Sigmoidoscopy _____ Colonoscopy _____

List Other Services Available, including any related to endoscopy: ____

____

If you have an in-office lab, is it Medicare or CLIA certified? (Attach certification copy) Y ____ N _____

Allied Health Practitioners please have supervising physician sign here: __________________________
Signature of Supervising Physician

<u>Current Healthcare Facility Affiliations:</u>

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)

- Secondary 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 #: ____

Professional Liability Insurance

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).

Note that individual managed care organizations will review a minimum of five years' professional liability history.

If none, indicate by initialing here: _______________

Support Information

Do you use physician assistants and/or nurse practitioners? Y __ N __ If yes, list names / license numbers:

____

____

List WHP Participating Practitioners who are able to cover for you on call, if needed:

Name Telephone Specialty

____

____

Your after-hours telephone number / answering service number: _______________________________

Approximate number of days to obtain an appointment for:

New patients ____ Elective visits ____ Urgent care ____ Physical exams ____ Follow-up visits ____

How many patient visits do you average per hour? _______ Average patient waiting time? ___________

Are you accepting new WHP patients? Y ____ N ____ Patient age range accepted? _____ to _____

Do you have any restrictions on accepting new patients? Y ____ N ____ If yes, describe: ____________

____

List diagnostic facilities or reference labs you use: ____

____

____

Please attach copies of your current medical license, DEA certificate, CV, and insurance certificate face sheet. Please also provide explanations of any professional liability incidents, sanctions, restrictions or investigations you have been subject to.

Practice Review

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

IMPORTANT: Applicant must initial answers. Do not use "check marks" as responses.

Failure to initial each response will result in rejected application.

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 MedicalCondition 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 Policy #: ______________________
From: ____ 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 (open or closed).
>
> I hereby authorize SVMIC to release the information requested to
> Windsor Health Plan, Inc.
> Attention: Credentialing Department
> 7100 Commerce Way, Suite 285
> Brentwood, TN 37027
> (fax) 615-782-7827

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 is 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 <u>and</u> sign & date below □

Applicant Signature: ______________________________ Date: _______________________

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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 is additional s pace 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:

____
Name of Monitoring Entity/Agency/Individual

____
Address City State ZIP code

(___) ______________________
Telephone

Monitored Voluntarily

____
Name of Monitoring Entity/Agency/Individual

____
Address City State Zip code

(___)______________________
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 <u>and</u> sign & date below □

Applicant Signature: ______________________ Date: ______________________

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