

WHP PRACTITIONER CHECKLIST Credentialing Application-MedicareExtra

- 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 with month and yrs.
- ALLIED PROFESSIONALS – PLEASE INCLUDE CURRENT PROTOCOL**

In order to expedite the credentialing process please be sure to include all documents required. Thank You.

**Windsor Health Plan
Practitioner Credentialing Application-MedicareExtra**

**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)
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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)
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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

Name of Supervising Physician

Phone:

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)

- 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
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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/Attestation Page

IMPORTANT: Applicant must initial answers. Do not use "check marks" as responses.
Failure to initial each response will result in rejected application.

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 the State's 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 Windsor Health Plan (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 Windsor Health Plan (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 Windsor Health Plan (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

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: _____