

Windsor Health Plan
ARKANSAS MD/DO PROVIDER APPLICATION
MedicareExtra

The following application will be accepted for Arkansas MD or DO Providers Only

Initial Application

Recredentialing Application

- [] Completed Provider Application
- [] Signed and completed Arkansas CCVS Release
- [] Signed and completed WHP Provider Release of Information
- [] Signed and completed State Volunteer Authorization Release *if applicable*
- [] Copy of **current** Professional Licenses
- [] If not Board Certified – We will need a two letters of recommendation from peers
- [] Chemical Substances or Alcohol Abuse Information Form completed if there are any issues
- [] Health Information Form completed if there are any issues
- [] Explanation of Malpractice History if applicable
- [] 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

In order to expedite the credentialing process please be sure all requested documents are provided. Thank You.



Provider Application – ARKANSAS MD/DO ONLY

Last Name: _____ First Name: _____ MI: _____
 Degree: _____ Date of Birth: _____ SS#: _____
 NPI: _____ Medical License No: _____ DEA Cert. No. _____
 Tax ID: _____ Male Female
All information used for identification purposes only

Primary Office Location

Secondary Office Location

Clinic Name _____

Clinic Name _____

Street Address _____

Street Address _____

City, State Zip _____

City, State Zip _____

() ()
Telephone Number Fax Number

() ()
Telephone Number Fax Number

Email Address _____

Email Address _____

Office Manager
 Are you accepting New Patients? Yes No
 Any Restrictions? Yes No

Office Manager
 If yes, please define: _____

Billing Information: This information must match locator 33 on the HCFA 1500 Form – Please submit a W-9

Street Address _____ City _____ State _____ Zip _____ Telephone Number _____
 Fax Number _____ Electronic Billing: Currently file claims electronically: Yes No

Please list how you would like to be listed in the Windsor Health Plan directory

Primary Care Provider: Yes No Specialty: _____ Board Certified? Yes No

Specialty Care Provider: Yes No Specialty: _____ Board Certified? Yes No

Any Sub-Specialty: Yes No Sub-Specialty: _____ Board Certified? Yes No

If not Board Certified are you Board Eligible and if so when? Yes No Date: _____

If you are not Board Certified and do not have Hospital Privileges in your Specialty, WHP will need two Peer References

Appointment Availability: Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Times: _____

After Hours Availability: _____ Phone Number for After Hours: _____

Call Coverage: _____

Name	Specialty	Telephone Number
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Services provided in your offices:

Lab Services	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Radiology	Yes <input type="checkbox"/>	No <input type="checkbox"/>
EKG	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Audiology	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Treadmill	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sigmoidoscopy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other:	_____	

Malpractice Claims History: *All information is held in strict confidence and will be used for credentialing and recredentialing purposes only. Failure to supply sufficient details may delay or prevent its approval.*

In the last five (5) years, have there been any malpractice claims or judgments either settled, dismissed or currently pending involving your professional practice? Yes No

If you answered Yes to the question above, please supply the following information on the attached form. (Attachment 1) Make copies if additional pages are needed.

- Name of Insurance Carrier
- Date of Incident
- Date Suit or Claim was filed
- Your Involvement in Patient's Care
- Nature and Substance of Claim
- Describe any Other Pertinent Details to the Case
- Current Status of the Case
- Total Amount of Settlement/Judgment
- Amount Paid on Your Behalf

Health Status Question: You Must attach a detailed explanation for any question to which you respond Yes (forms attached)

1. Are you currently or have you ever been under the care of a physician for a continuing health problem? Yes No
 (Attachment 1)
2. Are you currently or have you ever been enrolled in a Monitoring program for any type of substance abuse? Yes No
 (Attachment 2)



Practitioner Attestation and Release Authorization:

I, _____, (print name) 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.

I grant WHP or its credentialing delegate permission to contact any individual, institution, agency or other entity identified or relative to this application.

I 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

I hereby authorize the Arkansas State Medical Board to provide my credentialing information gathered by the Board to WINDSOR HEALTH GROUP, INC.
(A Credentialing Organization) with whom I am affiliating and seeking privileges.

This Authorization shall remain in effect for a period not to exceed two (2) years unless revoked by me in writing.

Typed or Printed Name of Physician: _____

Licensure Number: _____

Signature of Physician: _____ Date Signed: ___/___/___

(Stamped signature is not acceptable)

* This document does not authorize the Arkansas State Medical Board to release information collected to third parties except as later authorized by the above physician and Arkansas law.



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 (open or closed).

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



**Malpractice Claim Information
(Attachment 1)**

Please complete a sheet for each claim made against you in the last five (5) years.

Carrier Name: _____

Date of Incident: _____

Date Filed: _____

Your Status in the Case: Primary Defendant Co-Defendant Other _____

Nature and Substance of Claim: _____

Your Involvement with Patient's Care: _____

Describe Any Other Details Relevant to the Case: _____

Identify Any Other Parties Named in the Suit: _____

Current Status of Case: Dropped Pending Found for the Defendant Dismissed
Settled out of Court Found for the Plaintiff

If pending: What is the likely outcome of the case? _____

If damages were paid, what was the amount? Total: _____ Paid on your Behalf: _____

Date Suit Resolved: _____

If none, check here and sign & date below

Name: _____
Print or Type

Signature: _____

Date: _____



MEDICAL CONDITION INFORMATION FORM
(Attachment 2)

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 [checkbox]

Applicant Signature: Date:



CHEMICAL SUBSTANCES OR ALCOHOL ABUSE INFORMATION FORM (Attachment 3)

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: _____