



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

**ARKANSAS**  
**WHP MD/DO CHECKLIST**  
**Credentialing Application-Medicare*Extra***

- Signed and completed Application/Attestation Statement
- Signed and completed AR CCVS Provider Release of Information
- Signed and completed State Volunteer Authorization Release (If applicable)
- Copy of current DEA License
- Explanation of Malpractice History (**for any case within past 5 years**)
- Signed and completed W-9 form

**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.**

**Windsor Health Plan**  
**Practitioner Credentialing Application-Medicare*Extra***

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**All information must be filled in on application.**  
**All Blanks must be filled in.**

**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: \_\_\_\_\_

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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: \_\_\_\_\_

**THE FOLLOWING QUESTION REQUIRES AN ANSWER:**

**Are you proficient in any languages other than English? : Yes\*: \_\_\_\_\_ No: \_\_\_\_\_**

\*If YES, please list: \_\_\_\_\_

**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 \_\_\_\_

**Current Healthcare Facility Arrangements:**

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

**\*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: \_\_\_\_\_

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List diagnostic facilities or reference labs you use: \_\_\_\_\_

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*Please also provide explanations of any professional liability incidents, sanctions, restrictions or investigations you have been subject to.*

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 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 accurate and complete. 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.**

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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

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

**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: \_\_\_\_\_

# 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.

**BEFORE YOU FAX YOUR AUTHORIZATION & RELEASE FORM TO CCVS,  
PLEASE MAKE SURE THE FOLLOWING GUIDELINES ARE MET**

**Wording**

If you wish to incorporate the Arkansas State Medical Board Authorization and Release into your organization's medical staff application or consent form, you are welcome to do so, but be advised that the wording **MUST** match the wording on our form, including the effective period (2 years). In addition, the text **MUST** be easily identifiable by our staff (indented, bolded, underlined, or in a text box, for example and must be located above the signature line).

**Organization Name**

Your organization name **MUST** match the name listed in the sign-up process. Since the CCVS has organizations with the same abbreviations, the CCVS will not enter A&R's with any type of abbreviation in the blank organization line. If you list multiple names on the form, all organizations listed on the form will be entered. If only one organization on a multiple listing should be used, you must circle the appropriate organization. Organizations may pre-print their name on the A&Rs before giving to the physician to sign in order to save time and ensure the correct name is listed in the blank.

**Physician Name**

The physician's name **MUST** be complete—including middle initial, Jr., Sr., etc. when applicable—**and legible**, either typed or printed. The CCVS may have more than one physician with the same first and last name.

**Arkansas License Number**

Please ensure that the physician is an M.D. or D.O. and is currently licensed in Arkansas. The CCVS cannot post A&Rs on physicians whose licenses are inactive, still pending, or have not yet applied for an Arkansas license.

**Signature of Physician**

DO NOT use a signature stamp, and please encourage the physician to sign in **BLACK** ink; it comes through more clearly on the fax.

**Date Signed**

The date the physician signed the form **MUST** be included on this form, and **MUST** be complete with month, day, and year signed. Encourage the physician to write the date **CLEARLY**; we cannot accept A&Rs where the date is at all questionable.

**Alterations**

Any alterations or changes made to the Authorization & Release form after the original signature date **MUST** be initialed and dated by the Physician. No one but the physician may alter this form after the physician signs it. We cannot accept A&Rs with scratch-outs or overwrites unless they are initialed and dated by the physician.