INSPIRA MENTAL HEALTH MANAGEMENT

(787) 704-0705
www.inspirapr.com

Requisitos de Contratación Psiquiatras/ Psiquiatras de Niños y Adolescentes

☐ Completar la solicitud de contratación en su totalidad debe estar completada en todos los campos que apliquen.

☐ Licencia como psiquiatra o psiquiatra de niños y adolescentes que le autorice a para practicar la medicina en Puerto Rico emitida por la Junta de Licenciamiento y Disciplina Médica de PR (vigente).

☐ Seguro de Responsabilidad Profesional vigente con una cubierta mínima de $100,000 a $300,000 (Seguro de Impericia).

☐ Contar con una oficina para recibir pacientes. Deberá obtener un resultado de 80% de cumplimiento o más en la evaluación de la facilidad.

☐ Tener un número NPI (National Provider Identifier)

☐ Tener Medicaid ID (La dirección debe ser exacta a la que coloque en la solicitud de credencialización/ dirección de su práctica que desea contratar)

☐ Completar la lectura de los adiestramientos disponibles en la página proveedores y firmar el acuse de recibo. (una vez se les envié los contratos para firma)

☐ Firmar los contratos y tarifas que apliquen.

INSPIRA MENTAL HEALTH MANAGEMENT

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Documentos Requeridos para la Credencialización

Psiquiatras/ Psiquiatras de Niños y Adolescentes

☐ Solicitud - INSPIRA Mental Health Management Credentialing And Re-Credentialing Application Form" completamente llena, con la firma y la fecha

☐ Evidencia de Carta de Aprobación de Medicaid -debe indicar ID de Medicaid, dirección y fecha de efectividad. (La dirección debe ser exacta a la que coloque en la solicitud de credencialización/ dirección de su práctica que desea contratar)

☐ Carta de Medicare con número de PTAN- expedida en o antes de 5 años (si aplica)

☐ Resume Actualizado – debe incluir mes y año en sus experiencias de trabajo y en la educación

☐ Certificado de Registro

☐ Copia de Licencia Profesional

☐ Colegiación

☐ Copia de Licencia de Narcóticos Federal (DEA)

☐ Copia Licencia de Narcóticos Estatal (ASSMCA)

☐ Copia de diploma Escuela Medicina

☐ Internado

☐ Residencia

☐ Fellowship (si aplica)

☐ Certificado de Buena Conducta– no más de 30 días de vigencia

☐ Good Standing – original endosado a INSPIRA y enviado a la siguiente dirección postal:

INSPIRA
Departamento de Proveedores
PO Box 9809
Caguas, P.R. 00726-9809

- ✓ Debe ser solicitado a la **Junta Examinadora de la Junta de Licenciamiento y Disciplina Médica de PR** una vez la especialista de proveedores de INSPIRA le envíe un acuse de recibo de la totalidad de los documentos.
- ✓ Debe enviar evidencia de la solicitud del Good Standing dentro de los próximos **cinco (5) días, después de recibir contestación del recibo de documentos por parte de la especialista a cargo de su caso.**
- ✓ Debemos recibir el Good Standing directamente de la **Junta de Licenciamiento y Disciplina Médica de PR** en sobre sellado por la Junta. No se aceptarán **Good Standing** en sobres abiertos.

☐ Copia de Póliza Profesional – endosada a INSPIRA (limites $100,000 a $300,0000). Si está incluido en el seguro de impericia del grupo debe someter evidencia del listado de los profesionales que están cubiertos dentro de la póliza.

☐ Evidencia del National Provider Identifier Number (NPI)

Si usted factura bajo corporación debe incluir la siguiente documentación:

☐ NPI (National Provider Identifier) a nombre de la corporación

☐ Good Standing Corporativo- vigente de no tener documento vigente

☐ Certificado de Existencia de la corporación- vigente

☐ Certificado de Incorporación

☐ Enviar evidencia del seguro social patronal otorgado por el IRS.

☐ Permiso de Único (copia) – incluye bomberos y licencia sanitaria

☐ Evidencia de Carta de Aprobación de Medicaid de la corporación y la carta de Medicaid del individuo afiliada a la corporación-debe indicar ID de Medicaid, dirección y fecha de efectividad. (La dirección debe ser exacta a la que coloque en la solicitud de credencialización/ dirección de su práctica que desea contratar)

☐ Patente Municipal

☐ W9

INSPIRA comenzará el proceso de acreditación formal a partir de la fecha de recibida la solicitud. Sólo se procesarán solicitudes que estén completamente llenas y que incluyan la totalidad de los documentos requeridos. Puede enviar los mismos a través de nuestra página https://www.inspirapr.com/proveedores , o por correo regular a la siguiente dirección postal:

INSPIRA
Departamento de Proveedores
PO Box 9809
Caguas, P.R. 00726-9809

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING APPLICATION FORM

GENERAL INSTRUCTIONS
• All information requested must be **fully** and **truthfully** provided and type or print legibly your responses. • Any changes to your responses must be lined through and initialed. Use of any form of correctional fluid or tape is not acceptable. • **Complete all sections. If a section is no filled out, the application will be returned, thus, delaying the credentialing process.** Use N/A if not applicable. • If more space is needed in order to answer a question completely, use the attached Explanation Form as necessary. • Please sign and date the Application and Schedule A.

TYPE OF APPLICATION:	☐Credentialing	☐Re-credentialing

LICENSED SPECIALTY AND DEGREE			
☐Psychiatry	☐Psychology	☐Social Work	☐Counseling
☐Other Professional Specialty:			

DEGREE AND SUB-SPECIALTY							
☐MSW	☐MA	☐MS	☐PhD	☐PsyD	☐MD	☐Other:	
Sub-specialty:							

INDIVIDUAL GENERAL INFORMATION					
Last Name:		Mother's Maiden Name:			
First Name:		Middle Initial:		Gender:	☐F ☐M
Mailing Address:					
City:		State:		Zip Code:	
Telephone Number:		Mobile:			
Email:		Social Security Number:			
Date of Birth:		Place of Birth:		NPI:	
#Medicaid Provider.		#Medicare Provider:			
License Number:		Expiration Date: mm/dd/yy			
# DEA:		Expiration Date: mm/dd/yy			
#ASSMCA:		Expiration Date: mm/dd/yy			
# Driver's License		Issued Date: mm/dd/yy		Expiration Date: mm/dd/yy	
Languages in which you are fluent:	☐ English	☐ Spanish	☐ Other:		

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING APPLICATION FORM

OPEN PRACTICE	
Are you currently accepting new patients into practice? ☐Yes ☐No	**Are you accepting existing patients with charge of payer practice?** ☐Yes ☐No
Are you currently accepting new patients with physician referral? ☐Yes ☐No	**Are you currently accepting all new patients?** ☐Yes ☐No
Are you currently accepting new Medicare patients? ☐Yes ☐No	**Are you currently accepting new Medicaid patients?** ☐Yes ☐No

PRACTICE INFORMATION

PRIMARY OFFICE	Type of Setting: ☐ Individual ☐ Group	Practice Date:	
Name of Clinical Practice:			
Name of Office Contact:			
Physical Address:			

City:		State:		Zip Code:	
Telephone Number:		Fax Number:			
Emergency Telephone Number:		Appointment Telephone Number:			

Hours of Operation *(Actual practice hours each day at this location, e.g. 8:00am to 4:30pm)*

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	From:	From:	From:	From:	From:	From:
To:	To:	To:	To:	To:	To:	To:

Is this office handicapped available? ☐Yes ☐No	**Is this office accessible to public transportation?** ☐Yes ☐No
Is this office accessible via train? ☐Yes ☐No	**Does this office meet ADA Accessibility Requirements?** ☐Yes ☐No
Is this office accessible via bus? ☐Yes ☐No	**If Yes, which public transit routes:**

Billing Information			
Make checks payable to:			
Name of Billing Contact:			
Medicaid Number:		Tax ID #:	
Medicare Number:		NPI:	
24/7 Phone Coverage? ☐Yes ☐No If Yes, select one option: ☐ Answering Service ☐ Voicemail w/message to call Answering Service ☐ Voicemail w/other instructions		Telephone Number: Fax Number:	
Billing Address:			

City:		State:		Zip Code:	

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING APPLICATION FORM

SECONDARY OFFICE ☐N/A	Type of Setting: ☐ Individual ☐ Group	Practice Date:	
Name of Clinical Practice:			
Name of Office Contact:			
Physical Address:			
City:		State:		Zip Code:	
Telephone Number:		Fax Number:	
Emergency Telephone Number:		Appointment Telephone Number:	

Hours of Operation *(Actual practice hours each day at this location, e.g. 8:00am to 4:30pm)*

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	From:	From:	From:	From:	From:	From:
To:	To:	To:	To:	To:	To:	To:

Is this office handicapped available? ☐Yes ☐No	**Is this office accessible to public transportation?** ☐Yes ☐No
Is this office accessible via train? ☐Yes ☐No	**Does this office meet ADA Accessibility Requirements?** ☐Yes ☐No
Is this office accessible via bus? ☐Yes ☐No	**If Yes, which public transit routes:**

Billing Information			
Make checks payable to:			
Name of Billing Contact:			
Medicaid Number:		Tax ID #:	
Medicare Number:		NPI:	
24/7 Phone Coverage? ☐Yes ☐No If Yes, select one option: ☐ Answering Service ☐ Voicemail w/message to call Answering Service ☐ Voicemail w/other instructions		Telephone Number:	
		Fax Number:	
Billing Address:			
City:		State:		Zip Code:	

ORGANIZATIONAL STAFF INFORMATION

Staff Manager: ☐N/A			
Name:		Email:	
Telephone Number:		Fax Number:	
Address:			
City:		State:		Zip Code:	

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING APPLICATION FORM

Staff Supervisor:					☐N/A
Name:			Email:		
Telephone Number:			Fax Number:		
Address:					
City:		State:		Zip Code:	
Billing Staff:					☐N/A
Name:			Email:		
Telephone Number:			Fax Number:		
Address:					
City:		State:		Zip Code:	
Administrative Staff:					☐N/A
Name:			Email:		
Telephone Number:			Fax Number:		
Address:					
City:		State:		Zip Code:	

EDUCATION & TRAINING INFORMATION
(This information must match with your professional Resume or Curriculum Vitae)

Training Institution				**Degree or Certification**	**From (year)**	**To (year)**
Undergraduate or Graduate School		Institution:				
		Address:				
☐ N/A	Internship	Institution:				
		Address:				
☐ N/A	Residency	Institution:				
		Address:				
☐ N/A	Fellowship or Post Doctoral	Institution:				
		Address:				
☐ N/A	Other	Institution:				
		Address:				

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING APPLICATION FORM

IF YOU ARE A PHYSICIAN, PLEASE ANSWER THE FOLLOWING QUESTION				☐N/A
Are you board certified?	☐ Yes ☐ No			
Name of Issuing Board	**Specialty**	**Date Certified (mm/dd/yy):**	**Re-certified Date (mm/dd/yy)**	**Exp. Date: (mm/dd/yy)**

OTHER LICENSES *(Please check N/A if not applicable)*				☐N/A
Type of License	**Number**	**State/Country**	**Date Certified (mm/dd/yy):**	**Exp. Date (mm/dd/yy)**

Membership of College of Physicians and Surgeons of Puerto Rico					☐N/A
Certificate Number		**Expedition Date (mm/dd/yy)**		**Exp. Date (mm/dd/yy)**	

Substance Abuse and Mental Health Services Administration ***(SAMHSA)***				☐N/A
Certificate Number		**Exp. Date (mm/dd/yy)**		

CLINICAL PRIVILEGES / HOSPITAL AFFILIATION *(Please check N/A if not applicable)*		☐N/A
Hospital or Facility Name:		
Address:		
Type of Privilege:	☐ Admitting ☐ Courtesy ☐ Emergency ☐ Consulting ☐ Other:	
Current Status:	☐ Active ☐ Inactive ☐ Temporary ☐ Restricted ☐ Other:	Effective Date: Expiration Date:
Hospital or Facility Name:		
Address:		
Type of Privilege:	☐ Admitting ☐ Courtesy ☐ Emergency ☐ Consulting ☐ Other:	
Current Status:	☐ Active ☐ Inactive ☐ Temporary ☐ Restricted ☐ Other:	Effective Date: Expiration Date:

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING APPLICATION FORM

WORK HISTORY			
Indicate at least five (5) years of your work history in a descending order (must specify month and year). This information needs to match the Curriculum Vitae or Resume. (Attach an additional sheet if necessary.)			
From (Month / Year)	**To** (Month / Year)	**Private Practice or Workplace Name and Address**	**Position and Responsibilities**

Please provide an explanation for any gaps of six (6) months or more in your professional career. (Attach an additional sheet if necessary.)		
From (Month / Year)	**To** (Month / Year)	**Description of Activities**

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING APPLICATION FORM

PROFESSIONAL LIABILITY INSURANCE					
Current Insurance Carrier	Policy Number	Dates of Coverage (MM/DD/YY)		Coverage Limits	
		Original Eff.		Each	
		Eff.		Aggr.	
		Exp.			

ATTESTATION	
If you answer to any of the following questions is "yes", please provide details and reasons, as specified in each question on the Explanation Form and attach it to the Application.	
1. **Health Status**: Do you have any inability including physical, mental or emotional condition which impairs your ability to render the professional services which are the subject of this Application?	☐Yes ☐No
a. Have you ever been convicted for the use of illegal or controlled substances?	☐Yes ☐No
b. Are you currently engaged in the illegal use of drugs or alcohol abuse?	☐Yes ☐No
2. **License:** Has your medical or professional license, in any state, ever been revoked, suspended, placed on probation, conditional status or limited?	☐Yes ☐No
a. Have you ever voluntarily surrendered your licensed?	☐Yes ☐No
b. Are formal charges pending against you at this time?	☐Yes ☐No
c. Has any state or federal agency registration certificate (i.e DEA, etc.) ever been suspended, revoked, subjected to probation, placed on conditional status or limited?	☐Yes ☐No
3. **Medicare**: Have you ever been suspended, fined, disciplined, sanctioned or otherwise restricted or excluded from participation in any federal or state health insurance program (for example Medicare or Medicaid)?	☐Yes ☐No
4. **Criminal Offenses:** Have you ever been arrested, charged with or convicted of a felony involved in charges relating to moral or ethical turpitude, including crimes with children?	☐Yes ☐No
a. Have you ever been convicted of, or entered a plea for any criminal offense?	☐Yes ☐No
b. Are any criminal charges currently pending against you?	☐Yes ☐No
c. Have you ever been arrested for, or charged with a sexual offense or for an act of violence?	☐Yes ☐No
d. Are you currently using illegal drugs or legal drugs in an illegal manner?	☐Yes ☐No
5. **Professional Insurance**: Have there ever been any professional liability (i.e. malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you?	☐Yes ☐No
a. To your knowledge, is any malpractice action against you currently pending?	☐Yes ☐No
6. **Hospital Privileges**: Has any hospital ever dismissed you from its staff?	☐Yes ☐No
a. Has any hospital ever revoked, suspended or limited you privileges?	☐Yes ☐No
b. Has any hospital refused or denied your privileges?	☐Yes ☐No
c. Have you ever voluntarily surrendered your hospital privileges?	☐Yes ☐No

7. **Professional Membership**: Has your membership in any professional society or association ever been cancelled, revoked or censured?	☐Yes ☐No
8. **Board Discipline:** Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e. state licensing board; county, state or national professional society; hospital medical or clinical staff)?	☐Yes ☐No
OTHER INFORMATION	
1. Have provisions been made for afterhours coverage?	☐Yes ☐No
2. Who normally covers you when you are away or unavailable?	Name: Phone Number:
3. If you do not have after hours coverage, would you be willing to participate in an afterhours nurse advice service?	☐Yes ☐No
4. How do patients contact you afterhours?	
5. Approximatively how many active patients make up your total practice?	
6. Approximatively how Government Health Plan enrollees do you currently have as patients?	
7. Do you serve as a PCP in the Government Health Plan Program?	☐Yes ☐No
8. How many Medicare beneficiaries do you currently have as patients?	
9. Do you make appointments and in what manner (day only, no set hours)?	
10. What is the expected waiting time for an appointment to see patients who have: a. An emergent situation: b. An urgent situation: c. A routine situation:	A: B: C:

11. Check the following procedures performed in your office (attach any required certifications):

- ☐ Therapy Service (Physical/Occupational/Speech)
- ☐ Chest X Rays
- ☐ Endoscopic Procedures
- ☐ Mammograms
- ☐ Immunizations (Influenza (Flu) / Hepatitis B / Pneumonia/H1N1)
- ☐ Extremity X Rays
- ☐ Pap Smears
- ☐ Non-invasive cardiology test
- ☐ EKG's
- ☐ Other Procedures (Specify): ____________________ e.g. PHQ-9 or GAD7

12. What laboratory services are provided in your office? *(Please check N/A if not applicable)*	☐N/A
• *Is your laboratory Medicare approved?*	☐Yes ☐No
• *Is your office computerized?*	☐Yes ☐No
• *Do you have Internet access in your medical office?*	☐Yes ☐No

AUTHORIZATION AND RELEASE OF INFORMATION FORM

For purposes of making this application for participation in the INSPIRA Mental Health Management, Inc. provider network, I authorize INSPIRA and/or its Credentialing Verification Organization (CVO) to consult with the National Practitioner Data Bank, and associate Data Banks, State Licensing Board(s), educational institutions, specialty boards, malpractice insurance carriers, Educational Commission for Foreign Medical Graduates, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competences, character, moral and ethical qualifications. I understand that INSPIRA may be required by the federal government or its clients to perform a criminal record check as a condition for participation and that INSPIRA has the right to obtain a copy of a criminal history report. I also authorize all of them to release such information to INSPIRA Mental Health Management, Inc. I release INSPIRA and/or its CVO and employees and agents and all those whom INSPIRA and its contacts from any and all liability for their acts performed in good fight and without malice in obtaining and verifying such information and in evaluating my application.

I consent to the release by any person to INSPIRA and/or its CVO, all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualifications, including any information relating to any disciplinary action or suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

I further understand and agree that I am responsible for producing all information required or requested by INSPIRA in connection with this application and that INSPIRA shall not complete the processing of this application until such information is provided by me. I agree to notify INSPIRA promptly if there are any material changes in the information provided, whether prior to or after my acceptance as an INSPIRA participating provider. I understand and agree that if INSPIRA discovers that my application contains any significant misstatement, misrepresentation or omissions, INSPIRA may void, in its sole discretion, this application and any related participating provider agreements. I also understand that this application does not entitle my business to any participation agreements in any of the network of INSPIRA.

I certify that I'm being notified about my rights to: (a) review information submitted to support credentialing application, (b) correct erroneous information INSPIRA collected during the credentialing and/or re-credentialing process and, (c) request and receive the status of my credentialing and/or re-credentialing application. I understand that I am not precluded from pursuit of any separate rights that I may have under state or federal laws.

By submitting this application, I acknowledge, understand, consent and agree that a photocopy of the Authorization and Release of Information Form shall be as effective as the original and shall constitute my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

By signing this Authorization and Release of Information Form, I certify the completeness of the application and that all information provided to INSPIRA is true and correct to the best of my knowledge and belief.

Printed Name	**Date (mm/dd/yyyy)**
Signature	

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING APPLICATION FORM

CLINICAL MODALITIES – TREATMENT SPECIALTIES				
Age Range *(You can select more than one)*				
☐ Young Children (0 – 5)	☐ Children (6 – 12)	☐ Adolescent (13 – 17)	☐ Adult (18 – 64)	☐ Geriatric (65+)
Gender *(You can select more than one)*				
☐ Male Only	☐ Female Only	☐ No limitations		

Areas of Expertise *(You can select more than one)*		
☐ ADD / ADHD	☐ Addictions, Non-Chemical	☐ Alcohol/Chemical Dependency
☐ Anger Management	☐ Autism	☐ Child Abuse
☐ Chronic Pain	☐ Crisis Stabilization	☐ Dissociative Identity Disorder
☐ Domestic Violence	☐ Eating Disorders	☐ Gay / Lesbian / Bisexual Issues
☐ Grief / Separation and Loss	☐ Head Trauma	☐ Hearing Impaired
☐ Infertility	☐ Marital / Separation / Divorce	☐ Men's Issues
☐ Mental Retardation / Developmental	☐ Obsessive Compulsive Disorder	☐ Personality Disorder
☐ PTSD	☐ Rape Crisis	☐ Schizophrenic Disorder
☐ Sex Offender Treatment	☐ Sexual Dysfunction	☐ Sexual Abuse / Sexual Disorder
☐ Severe & Persistent Mental Illness	☐ Sleep Disorder	☐ Smoking Cessation
☐ Stress Management	☐ Terminal Illness/ Death	☐ Trauma & Relief Recovery
☐ Women's Issues	☐ Other:	

Type of Therapy *(You can select more than one)*		
☐ Brief Therapy	☐ Child Therapy	☐ Christian/Faith Based Therapy
☐ Cognitive Behavioral Therapy	☐ Couples Therapy	☐ Critical Incident Stress Debriefing (CISD)
☐ Dialectical Behavior Therapy	☐ Family Therapy	☐ Group Therapy
☐ Hypnotherapy	☐ Multi-Cultural Issues	☐ Neuropsychology Testing
☐ Psychological Testing	☐ Psychopharmacology	☐ Psychosomatic Therapy
☐ Short Term Problem Counseling	☐ Systematic Desensitization	☐ Other:

Description of Services *(You can select more than one)*		
☐ 23- Hour Hold	☐ Inpatient – Mental Health	☐ Inpatient - Detoxification
☐ Partial Hospitalization	☐ Outpatient	☐ Other:
Home Visits *(Home Visit includes house, home care, and any place that represents affiliate's home)*		☐ N/A
Indicate the geographic areas or municipalities where you will be offering services:		
1.	2.	3.
4.	5.	6.

Hours of Operation *(Actual practice hours each day at this location, e.g. 8:00am to 4:30pm)*						
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
From:	From:	From:	From:	From:	From:	From:
To:	To:	To:	To:	To:	To:	To:

Additional Abilities *(You can select more than one)*		☐ N/A
☐ American Sign Language	☐ Braille writing method	☐ Other:

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING APPLICATION FORM

OWNERSHIP/CONTROLLING INTEREST DISCLOSURE FORM	☐ N/A
All information disclosed in this section will remain entirely confidential and will only be used for the purposes specified in Federal Law (42 CFR, SECTION 455).	

Section One:

1. Have you or any person who has ownership or control interest in your practice who is an agent or managing employee been convicted of a criminal offense related to the involvement of your practice in any program under Medicare, Medicaid or the Title XX services since the inception of those programs? (42 CFR §455.106) If yes, give the name(s) of person(s) and description(s) of offenses(s). Please use additional pages if necessary.	☐Yes ☐No

Name	Social Security No.	Tax ID No.	Date of Birth	Description

2. Federal regulation requires the following information to be disclosed on all managing employees. (42 CFR §455.101). Please use additional pages if necessary. A managing employee is a "general manager, business manager, administrator, director, officer, governing board member, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency". (42 CFR §455.101).	☐ N/A

Name	Social Security No.	Tax ID No.	Date of Birth	Address / Telephone No.

3. Provide the name and address of each person or organization with a direct or indirect ownership or control interest of five percent or more (5%+) of your practice. (42 CFR §455.104). Please use additional pages if necessary.	☐ N/A

Name	Social Security No.	Tax ID No.	Date of Birth	Address / Telephone No.

4. Please provide the ownership name and address of any subcontractor with whom you have had business transaction totaling more than $25,000 during the most recent 12-month period.	☐ N/A

Name	Social Security No.	Tax ID No.	Date of Birth	Address / Telephone No.

Section Two:

1. Are you an Out-of-Network provider? If yes, please complete the questions in section two.	☐Yes ☐No
2. Do you have any current of previous affiliations with a provider or supplier that has uncollected debt or has been subject to a payment suspension? If yes, give the name(s) of person(s) and description(s) of uncollected debt or payment suspension. Please use additional pages if necessary.	☐ N/A

Name	Social Security No.	Tax ID No.	Date of Birth	Description

3. Do you have any current of previous affiliations with a provider or supplier that has been excluded from Federal Health Care programs? If yes, give the name(s) of person(s) and description(s) of exclusions. Please use additional pages if necessary.	☐Yes ☐No

Name	Social Security No.	Tax ID No.	Date of Birth	Description

4. Do you have any current of previous affiliations with a provider or supplier that has had its billing privileges denied or revoked? If yes, give the name(s) of person(s) and description(s) of denial(s) or revocation(s). Please use additional pages if necessary.	☐ N/A

Name	Social Security No.	Tax ID No.	Date of Birth	Description

EXPLANATION FORM	
Please make as many copies of this page as needed to fully respond each question. For each response/explanation, please provide the corresponding page and section name from the Application.	
Section Name:	**Page #:**