



INSPIRA MENTAL HEALTH  
MANAGEMENT

(787) 704-0705  
www.inspirapr.com

## Documentos Requeridos para la re-credencialización de los Grupos

- Solicitud- “INSPIRA Mental Health Management Credentialing and Re-credentialing Group Application Form” **es una solicitud por cada localidad de servicio.** completamente llena, con la firma y la fecha
- Evidencia de Carta de Aprobación de Medicaid de cada facilidad -debe indicar ID de Medicaid, dirección y fecha de efectividad.
- W-9
- Listado de los proveedores de salud mental que ofrecen servicios en la facilidad
  - ✓ Debe completar el proceso de credencialización de cada proveedor que desee afilar
- Certificado del Seguro de Responsabilidad Profesional cubierta mínima de \$100,000 a \$300,000 vigente y endosado a Inspira

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

- Certificado del Seguro de Responsabilidad Pública de la Localidad vigente y endosado

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

- Permiso de Único (copia) – incluye bomberos y licencia sanitaria
- Licencia para Operar de ASSMCA vigente (copia)
  - ✓ Clasificación CASM para ambulatorio
  - ✓ Clasificación CB para facilidades que incluyan buprenorfina
- Patente Municipal por cada facilidad



## INSPIRA MENTAL HEALTH MANAGEMENT

 (787) 704-0705  
 [www.inspirapr.com](http://www.inspirapr.com)

- Good Standing Corporativo- vigente
- Certificado de Existencia- vigente

**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 GROUP 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     Change of ownership or Group Name

### GROUP INFORMATION

**PRIMARY OFFICE** Practice Date: \_\_\_\_\_

Legal Business Name: \_\_\_\_\_  
(as reported to IRS)

Doing Business As Name: \_\_\_\_\_  N/A

Name of Office Contact: \_\_\_\_\_

Location Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_ Web Page Address: \_\_\_\_\_

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: _____						
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 #: \_\_\_\_\_



# INSPIRA Mental Health Management

## CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

Medicare Number:		NPI:				
24/7 Phone Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, select one option: <input type="checkbox"/> Answering Service <input type="checkbox"/> Voicemail w/message to call Answering Service <input type="checkbox"/> Voicemail w/other instructions		Telephone Number:				
		Fax Number:				
Billing Address:						
City:		State:	Zip Code:			
<b>OPEN PRACTICE</b>						
Are you currently accepting new patients into practice? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you accepting existing patients with charge of payer practice? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you currently accepting new patients with physician referral? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you currently accepting all new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you currently accepting new Medicare patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you currently accepting new Medicaid patients? <input type="checkbox"/> Yes <input type="checkbox"/> No				
SECONDARY OFFICE <input type="checkbox"/> N/A			Practice Date:			
Name of Clinical Practice:						
Name of Office Contact:						
Location Physical Address:						
City:		State:	Zip Code:			
Telephone Number:		Fax Number:				
Emergency Telephone Number:		Appointment Telephone Number:				
<b>Hours of Operation</b> (Actual practice hours each day at this location, e.g. 8:00am to 4:30pm)						
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>	<b>Saturday</b>	<b>Sunday</b>
From:	From:	From:	From:	From:	From:	From:
To:	To:	To:	To:	To:	To:	To:
Is this office handicapped available? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is this office accessible to public transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is this office accessible via train? <input type="checkbox"/> Yes <input type="checkbox"/> No			Does this office meet ADA Accessibility Requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is this office accessible via bus? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, which public transit routes:			
<b>Billing Information</b>						
Make checks payable to:						
Name of Billing Contact:						
Medicaid Number:				Tax ID #:		



# INSPIRA Mental Health Management

## CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

Medicare Number:		NPI:	
24/7 Phone Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Telephone Number:	
If Yes, select one option:		Fax Number:	
<input type="checkbox"/> Answering Service			
<input type="checkbox"/> Voicemail w/message to call Answering Service			
<input type="checkbox"/> Voicemail w/other instructions			
Billing Address:			
City:		State:	Zip Code:
<b>ORGANIZATIONAL STAFF INFORMATION</b>			
<b>Executive Director/Administrator:</b>			<input type="checkbox"/> N/A
Name:		Email:	
Telephone Number:		Fax Number:	
Address:			
City:		State:	Zip Code:
<b>Clinical Services Director:</b>			<input type="checkbox"/> N/A
Name:		Email:	
Telephone Number:		Fax Number:	
Address:			
City:		State:	Zip Code:
<b>Staff Supervisor:</b>			<input type="checkbox"/> N/A
Name:		Email:	
Telephone Number:		Fax Number:	
Address:			
City:		State:	Zip Code:
<b>Billing Staff Manager:</b>			<input type="checkbox"/> N/A
Name:		Email:	
Telephone Number:		Fax Number:	



# INSPIRA Mental Health Management

## CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

Address:					
City:		State:		Zip Code:	

### CORPORATION INFORMATION & PROFILE

Identify what type of organization is the group:

- |  |   |
|--|---|
| <input type="checkbox"/> Corporation (including non-profit organization) | <input type="checkbox"/> Charitable and/or Religious Organization |
| <input type="checkbox"/> Partnership and Limited Partnership             | <input type="checkbox"/> Governmental and/or Tribal Organization  |
| <input type="checkbox"/> Limited Liability Company                       | <input type="checkbox"/> Other: _____                             |

The organization has a government body and an organized professional staff?  Yes  No

Is the organization a legal business entity and has it been in operation and been admitting patients for six months or greater?  Yes  No

The organization has a multidisciplinary staff that includes at least one psychiatrist, psychologists and licensed masters level mental health clinicians?  Yes  No

Are all outpatient professional services provided billed under the organization's name and tax id number?  Yes  No

Does your organization provide the following?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Written credentialing criteria for all clinical staff | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Written criteria for screening and referral?          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Written comprehensive individualized treatment plans? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Coverage for crisis assessment/intervention?          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Centralized Intake and Billing?                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Individual, group and family therapy?                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Written Quality Improvement Program?                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Oversight by a medical director?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If answered no to any of the questions above, please provide a brief explanation:

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### CORPORATION ADVERSE LEGAL HISTORY

Has this group or any shareholders/owners/partners, ever had an adverse legal action imposed against it, been named in any malpractice action or convicted of a crime excluding misdemeanors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has this group or any shareholders/owners/partners, ever been fined, suspended or expelled from participation, or had criminal charges brought against it by a Medicare, Medicaid or TRICARE program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has this group or any shareholders/owners/partners, ever had professional liability refused, declined, canceled or accepted on special terms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any government agency ever investigated, suspended, revoked, or taken action against this group's license to conduct business?	<input type="checkbox"/> Yes <input type="checkbox"/> No

*If Yes to any of the above, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative*



# INSPIRA Mental Health Management

## CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

*body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).*

Adverse Legal Action	Date	Taken by	Resolution

### OWNER(S) INFORMATION

*(Please copy and fill this page for every person that has ownership interest and/or managing control over the group)*

The group MUST have at least ONE owner and or managing employee.

The following individuals must be reported in this section:

- All persons who have 5 percent or greater direct or indirect ownership interest in the group.
- If (and only if) the group is a corporation (whether for-profit or non-profit), all officers and directors of the group.
- Authorized and delegated officials.

What is this individual's relationship with the group? (check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> 5 Percent or Greater Direct/Indirect Owner | <input type="checkbox"/> Director / Officer           |
| <input type="checkbox"/> Partner                                    | <input type="checkbox"/> Contracted Managing Employee |
| <input type="checkbox"/> Managing Employee (W-2)                    | <input type="checkbox"/> Other: _____                 |

Last Name:		Mother's Maiden Name:	
First Name:		Initial:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M
Telephone Number:		Mobile:	
Email:		Social Security Number:	

Specialty (If is a provider that offers services for the group)		% of Participation:	
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### OWNER(S) ADVERSE LEGAL HISTORY

Has this person, under any current or former name or business identity, ever had an adverse legal action imposed against them?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has this person, ever been fined, suspended or expelled from participation, or had criminal charges brought against it by a Medicare, Medicaid or TRICARE program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has this person ever been arrested, charged with or convicted of a felony or involved in charges relating to moral or ethical turpitude, including crimes with children?	<input type="checkbox"/> Yes <input type="checkbox"/> No

*If Yes to any of the above, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).*

Adverse Legal Action	Date	Taken by	Resolution
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# INSPIRA Mental Health Management

## CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

CLINICAL MODALITIES – TREATMENT SPECIALTIES			
<b>Age Range</b> <i>(You can select more than one)</i>			
<input type="checkbox"/> Young Children (0 – 5)	<input type="checkbox"/> Children (6 – 12)	<input type="checkbox"/> Adolescent (13 – 17)	<input type="checkbox"/> Adult (18 – 64) <input type="checkbox"/> Geriatric (65+)
<b>Gender</b> <i>(You can select more than one)</i>			
<input type="checkbox"/> Male Only	<input type="checkbox"/> Female Only	<input type="checkbox"/> No limitations	
<b>Areas of Expertise</b> <i>(You can select more than one)</i>			
<input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> Addictions, Non-Chemical	<input type="checkbox"/> Alcohol/Chemical Dependency	
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Autism	<input type="checkbox"/> Child Abuse	
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Crisis Stabilization	<input type="checkbox"/> Dissociative Identity Disorder	
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Gay / Lesbian / Bisexual Issues	
<input type="checkbox"/> Grief / Separation and Loss	<input type="checkbox"/> Head Trauma	<input type="checkbox"/> Hearing Impaired	
<input type="checkbox"/> Infertility	<input type="checkbox"/> Marital / Separation / Divorce	<input type="checkbox"/> Men’s Issues	
<input type="checkbox"/> Mental Retardation / Developmental	<input type="checkbox"/> Obsessive Compulsive Disorder	<input type="checkbox"/> Personality Disorder	
<input type="checkbox"/> PTSD	<input type="checkbox"/> Rape Crisis	<input type="checkbox"/> Schizophrenic Disorder	
<input type="checkbox"/> Sex Offender Treatment	<input type="checkbox"/> Sexual Dysfunction	<input type="checkbox"/> Sexual Abuse / Sexual Disorder	
<input type="checkbox"/> Severe & Persistent Mental Illness	<input type="checkbox"/> Sleep Disorder	<input type="checkbox"/> Smoking Cessation	
<input type="checkbox"/> Stress Management	<input type="checkbox"/> Terminal Illness/ Death	<input type="checkbox"/> Trauma & Relief Recovery	
<input type="checkbox"/> Women’s Issues	<input type="checkbox"/> Other:		
<b>Type of Therapy</b> <i>(You can select more than one)</i>			
<input type="checkbox"/> Brief Therapy	<input type="checkbox"/> Child Therapy	<input type="checkbox"/> Christian/Faith Based Therapy	
<input type="checkbox"/> Cognitive Behavioral Therapy	<input type="checkbox"/> Couples Therapy	<input type="checkbox"/> Critical Incident Stress Debriefing (CISD)	
<input type="checkbox"/> Dialectical Behavior Therapy	<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Group Therapy	
<input type="checkbox"/> Hypnotherapy	<input type="checkbox"/> Multi-Cultural Issues	<input type="checkbox"/> Neuropsychology Testing	
<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Psychopharmacology	<input type="checkbox"/> Psychosomatic Therapy	
<input type="checkbox"/> Short Term Problem Counseling	<input type="checkbox"/> Systematic Desensitization	<input type="checkbox"/> Other:	
<b>Description of Services</b> <i>(You can select more than one)</i>			
<input type="checkbox"/> 23- Hour Hold	<input type="checkbox"/> Inpatient – Mental Health	<input type="checkbox"/> Inpatient - Detoxification	
<input type="checkbox"/> Partial Hospitalization	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Intensive Outpatient Program	
<input type="checkbox"/> Reverse Colocation	<input type="checkbox"/> Buprenorphine/Suboxone	<input type="checkbox"/> Other:	
<b>Home Visits</b> <i>(Home Visit includes house, home care, and any place that represents affiliate’s home)</i>			<input type="checkbox"/> N/A
<b>Indicate the geographic areas or municipalities where you will be offering services:</b>			
1.	2.	3.	
4.	5.	6.	
<b>Additional Abilities</b> <i>(You can select more than one)</i>			<input type="checkbox"/> N/A
<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Braille writing method	<input type="checkbox"/> Other:	
<b>OTHER INFORMATION</b>			
1. Have provisions been made for afterhours coverage?			<input type="checkbox"/> Yes <input type="checkbox"/> No



# INSPIRA Mental Health Management

## CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

2. Who normally covers you when your locations are 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No										
4. How do patients contact you afterhours?											
5. Approximately how many active patients make up your total practice?											
6. Approximately how Government Health Plan enrollees do you currently have as patients?											
7. Any of your staff serve as a PCP in the Government Health Plan Program?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <ul style="list-style-type: none"> <li>a. An emergent situation:</li> <li>b. An urgent situation:</li> <li>c. A routine situation:</li> </ul>	a:  b:  c:										
11. Check the following procedures performed in your office (attach any required certifications): <table style="width: 100%; margin-top: 10px;"> <tr> <td><input type="checkbox"/> Therapy Service (Physical/Occupational/Speech)</td> <td><input type="checkbox"/> Extremity X Rays</td> </tr> <tr> <td><input type="checkbox"/> Chest X Rays</td> <td><input type="checkbox"/> Pap Smears</td> </tr> <tr> <td><input type="checkbox"/> Endoscopic Procedures</td> <td><input type="checkbox"/> Non-invasive cardiology test</td> </tr> <tr> <td><input type="checkbox"/> Mammograms</td> <td><input type="checkbox"/> EKG's</td> </tr> <tr> <td><input type="checkbox"/> Immunizations (Influenza (Flu) / Hepatitis B / Pneumonia/H1N1)</td> <td><input type="checkbox"/> Other Procedures (Specify):</td> </tr> </table> <p style="text-align: right; margin-top: 10px;">e.g. PHQ-9 or GAD7</p>		<input type="checkbox"/> Therapy Service (Physical/Occupational/Speech)	<input type="checkbox"/> Extremity X Rays	<input type="checkbox"/> Chest X Rays	<input type="checkbox"/> Pap Smears	<input type="checkbox"/> Endoscopic Procedures	<input type="checkbox"/> Non-invasive cardiology test	<input type="checkbox"/> Mammograms	<input type="checkbox"/> EKG's	<input type="checkbox"/> Immunizations (Influenza (Flu) / Hepatitis B / Pneumonia/H1N1)	<input type="checkbox"/> Other Procedures (Specify):
<input type="checkbox"/> Therapy Service (Physical/Occupational/Speech)	<input type="checkbox"/> Extremity X Rays										
<input type="checkbox"/> Chest X Rays	<input type="checkbox"/> Pap Smears										
<input type="checkbox"/> Endoscopic Procedures	<input type="checkbox"/> Non-invasive cardiology test										
<input type="checkbox"/> Mammograms	<input type="checkbox"/> EKG's										
<input type="checkbox"/> Immunizations (Influenza (Flu) / Hepatitis B / Pneumonia/H1N1)	<input type="checkbox"/> Other Procedures (Specify):										
12. What laboratory services are provided in your office? <i>(Please check N/A if not applicable)</i> <ul style="list-style-type: none"> <li>• Is your laboratory Medicare approved?</li> <li>• Is your office computerized?</li> <li>• Do you have Internet access in your medical office?</li> </ul>	<input type="checkbox"/> N/A  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No										



# INSPIRA Mental Health Management

## CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

<b>OTHER OFFICE/LOCATIONS</b> <input type="checkbox"/> N/A <i>(If you have more locations please copy this page and fill this section with information of other locations)</i>						Practice Date:									
Name of Clinical Practice:															
Name of Office Contact:															
Location Physical Address:															
City:		State:		Zip Code:											
Telephone Number:				Fax Number:											
Emergency Telephone Number:				Appointment Telephone Number:											
<b>Hours of Operation</b> <i>(Actual practice hours each day at this location, e.g. 8:00am to 4:30pm)</i>															
<b>Monday</b>		<b>Tuesday</b>		<b>Wednesday</b>		<b>Thursday</b>		<b>Friday</b>		<b>Saturday</b>		<b>Sunday</b>			
From:		From:		From:		From:		From:		From:		From:			
To:		To:		To:		To:		To:		To:		To:			
Is this office handicapped available? <input type="checkbox"/> Yes <input type="checkbox"/> No						Is this office accessible to public transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Is this office accessible via train? <input type="checkbox"/> Yes <input type="checkbox"/> No						Does this office meet ADA Accessibility Requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Is this office accessible via bus? <input type="checkbox"/> Yes <input type="checkbox"/> No						If Yes, which public transit routes:									
<b>Billing Information</b>															
Make checks payable to:															
Name of Billing Contact:															
Medicaid Number:								Tax ID #:							
Medicare Number:								NPI:							
24/7 Phone Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, select one option: <input type="checkbox"/> Answering Service <input type="checkbox"/> Voicemail w/message to call Answering Service <input type="checkbox"/> Voicemail w/other instructions						Telephone Number:									
						Fax Number:									
Billing Address:															
City:		State:		Zip Code:											



# INSPIRA Mental Health Management

## CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

**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 faith 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.

<p style="text-align: center;"><b>Printed Name</b></p>	<p style="text-align: center;"><b>Date (mm/dd/yyyy)</b></p>
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# INSPIRA Mental Health Management

## CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

Signature

### 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





# **INSPIRA Mental Health Management**

## **CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM**