



Documentos Requeridos para la re-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.
- Resume Actualizado
- Certificado de Registro
- Colegiación
- Copia de diploma (solo si ha ocurrido un cambio en su educación desde su última credencialización)
- Copia de Licencia de Narcóticos Federal (DEA)
- Copia Licencia de Narcóticos Estatal (ASSMCA)
- 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 INSPIRA.
- ✓ 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.



**INSPIRA MENTAL HEALTH
MANAGEMENT**

 (787) 704-0705
 www.inspirapr.com

Copia de Póliza Profesional – endosada a INSPIRA (límites \$100,000 a \$300,000). 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.

Si usted factura bajo corporación debe incluir la siguiente documentación:

- Good Standing Corporativo- vigente de no tener documento vigente
- Certificado de Existencia de la corporación- vigente
- 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
- 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? <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							
PRACTICE INFORMATION													
PRIMARY OFFICE		Type of Setting: <input type="checkbox"/> Individual <input type="checkbox"/> 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 <i>(Actual practice hours each day at this location, e.g. 8:00am to 4:30pm)</i>													
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? <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:							
Billing Information													
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 APPLICATION FORM

SECONDARY OFFICE <input type="checkbox"/> N/A		Type of Setting: <input type="checkbox"/> Individual <input type="checkbox"/> 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 (<i>Actual practice hours each day at this location, e.g. 8:00am to 4:30pm</i>)													
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? <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:							
Billing Information													
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:									
ORGANIZATIONAL STAFF INFORMATION													
Staff Manager:										<input type="checkbox"/> 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:				<input type="checkbox"/> N/A
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Name:		Email:	
Telephone Number:		Fax Number:	
Address:			
City:		State:	Zip Code:

Billing Staff:				<input type="checkbox"/> N/A
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Name:		Email:	
Telephone Number:		Fax Number:	
Address:			
City:		State:	Zip Code:

Administrative Staff:				<input type="checkbox"/> N/A
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Name:		Email:	
Telephone Number:		Fax Number:	
Address:			
City:		State:	Zip Code:

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

		Training Institution	Degree or Certification	From (year)	To (year)
	Undergraduate or Graduate School	Institution: _____ Address: _____			
<input type="checkbox"/> N/A	Internship	Institution: _____ Address: _____			
<input type="checkbox"/> N/A	Residency	Institution: _____ Address: _____			
<input type="checkbox"/> N/A	Fellowship or Post Doctoral	Institution: _____ Address: _____			
<input type="checkbox"/> 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					<input type="checkbox"/> N/A	
Are you board certified?	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Name of Issuing Board	Specialty	Date Certified (mm/dd/yy):	Re-certified Date (mm/dd/yy)	Exp. Date: (mm/dd/yy)		
OTHER LICENSES <i>(Please check N/A if not applicable)</i>					<input type="checkbox"/> 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					<input type="checkbox"/> N/A	
Certificate Number		Expedition Date (mm/dd/yy)		Exp. Date (mm/dd/yy)		
Substance Abuse and Mental Health Services Administration (SAMHSA)					<input type="checkbox"/> N/A	
Certificate Number			Exp. Date (mm/dd/yy)			
CLINICAL PRIVILEGES / HOSPITAL AFFILIATION <i>(Please check N/A if not applicable)</i>					<input type="checkbox"/> N/A	
Hospital or Facility Name:						
Address:						
Type of Privilege:	<input type="checkbox"/> Admitting <input type="checkbox"/> Courtesy <input type="checkbox"/> Emergency <input type="checkbox"/> Consulting <input type="checkbox"/> Other:					
Current Status:	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Temporary <input type="checkbox"/> Restricted <input type="checkbox"/> Other:			Effective Date:		
				Expiration Date:		
Hospital or Facility Name:						
Address:						
Type of Privilege:	<input type="checkbox"/> Admitting <input type="checkbox"/> Courtesy <input type="checkbox"/> Emergency <input type="checkbox"/> Consulting <input type="checkbox"/> Other:					
Current Status:	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Temporary <input type="checkbox"/> Restricted <input type="checkbox"/> 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.			
		Exp.		Aggr.	

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? a. Have you ever been convicted for the use of illegal or controlled substances? b. Are you currently engaged in the illegal use of drugs or alcohol abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2. License: Has your medical or professional license, in any state, ever been revoked, suspended, placed on probation, conditional status or limited? a. Have you ever voluntarily surrendered your licensed? b. Are formal charges pending against you at this time? 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? a. Have you ever been convicted of, or entered a plea for any criminal offense? b. Are any criminal charges currently pending against you? c. Have you ever been arrested for, or charged with a sexual offense or for an act of violence? d. Are you currently using illegal drugs or legal drugs in an illegal manner?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Professional Insurance: Have there ever been any professional liability (i.e. malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you? a. To your knowledge, is any malpractice action against you currently pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Hospital Privileges: Has any hospital ever dismissed you from its staff? a. Has any hospital ever revoked, suspended or limited you privileges? b. Has any hospital refused or denied your privileges? c. Have you ever voluntarily surrendered your hospital privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> No <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 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.

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



INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING APPLICATION FORM

CLINICAL MODALITIES – TREATMENT SPECIALTIES							
Age Range <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+)							
Gender <i>(You can select more than one)</i>							
<input type="checkbox"/> Male Only		<input type="checkbox"/> Female Only		<input type="checkbox"/> No limitations			
Areas of Expertise <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: _____					
Type of Therapy <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: _____			
Description of Services <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"/> Other: _____			
Home Visits <i>(Home Visit includes house, home care, and any place that represents affiliate’s home)</i>						<input type="checkbox"/> N/A	
Indicate the geographic areas or municipalities where you will be offering services:							
1.		2.		3.			
4.		5.		6.			
Hours of Operation <i>(Actual practice hours each day at this location, e.g. 8:00am to 4:30pm)</i>							
Monday		Tuesday		Wednesday		Thursday	
Friday		Saturday		Sunday			
From:		From:		From:		From:	
To:		To:		To:		To:	
Additional Abilities <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: _____			



INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING APPLICATION FORM

OWNERSHIP/CONTROLLING INTEREST DISCLOSURE FORM	<input type="checkbox"/> N/A
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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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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).	<input type="checkbox"/> N/A
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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.	<input type="checkbox"/> N/A
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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.	<input type="checkbox"/> N/A
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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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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.	<input type="checkbox"/> N/A
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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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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.	<input type="checkbox"/> N/A
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Name	Social Security No.	Tax ID No.	Date of Birth	Description

