ANCILLARY PROVIDER
APPLICATION FOR PARTICIPATION
PHYSICIANS HEALTH PLAN
PO Box 30377, Lansing, MI 48909-7877
517.364.8312

INSTRUCTIONS: Please provide answers to all questions. If the answer is none, or if the question is not applicable to you or your organization, please so indicate. Please print or type your answers. If further space is needed for you to provide complete answers, please attach additional sheets of paper for such answers and indicate on the sheet the applicable question number. The Provider Organization has the right to review information submitted in support of their credentialing application and the right to correct erroneous information. PHP does not discriminate consideration for application based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or types of patients the applicant specializes in. Upon request, the provider organization has the right to be notified of the status of their application.

I. IDENTIFICATION INFORMATION

A. Name of Applicant: _____
Name of Company and/or Subsidiary (Legal name of entity with which the agreement will be executed)

_____
Street City State Zip Phone

B. Specialty or Type of Services Provided: _____

C. Name of Executive Officer and Title: _____

D. Name of Medical Director/Director: _____
(May require separate credentialing)

Is he/she involved in patient care directly Yes _____ No _____

Is he/she providing oversight of patient care? Yes _____ No _____

E. In accordance with Title 42 CFR § 455.104, list the names, addresses and social security number of all owners with 5% of more ownership of control interest:

_____ _____
Legal Name, Title Social Security Number (SSN)

_____ _____
Legal Name, Title Social Security Number (SSN)

_____ _____
Legal Name, Title Social Security Number (SSN)

F. In accordance with Title 42 CFR 455.106, list the names and social security number of any managing employee (such as general manager, business manager, administrators, directors or other individuals) who exercises operational or managerial control over or who directly or indirectly conducts day-to-day operation of your office or facility.

_____ _____
Legal Name, Title Social Security Number (SSN)

II. LICENSING INFORMATION – Please attach a copy of all current licenses and/or Medicare certification.

A. Is the organization in good standing with the state and CMS? Yes _____ No _____

If **NO**, please explain: _____

_____

B. Please provide the following information as to each State in which you are licensed:

State	Date of License	License Number	Expiration Date

C. Medicaid Provider #: _____ Medicare Provider #: _____

Drug Enforcement Administration (DEA) License #: _____

Clinical Laboratory Improvement Amendment (CLIA) #: _____

D. Has your Facility been accredited by any national accreditation organization? Yes _____ No ____

If **YES**, supply the name of the accreditation organization and relevant documentation. Include a copy of the survey report for accrediting body. _____

E. Has the organization been sanctioned and/or disciplined by CMS or any Federal or State agency?

Yes _____ No _____ If **YES**, please explain: _____

_____

III. LIABILITY INSURANCE INFORMATION – Please attach a copy of the Declaration Face Page of your present policy of professional, business/general, and product liability insurance policies.

A. NAME OF PRESENT CARRIER EXPIRATION DATE

_____

_____

	Limits of Coverage		
	Per Occurrence	Aggregate	Remaining
Professional Liability Claims	$	$	$
Business/General Liability	$	$	$
Product Liability Claims	$	$	$

B. Has insurance ever been cancelled or denied? Yes _____ No _____ If **YES**, please explain: _____

_____

_____

C. NAME OF PRIOR CARRIER(S)

_____

_____

D. HAVE THERE EVER BEEN, OR ARE THERE CURRENTLY PENDING, ANY MALPRACTICE CLAIMS, SUITS, JUDGEMENTS, SETTLEMENTS OR ARBITRATION PROCEEDINGS? Yes _____ No _____

IF YES, PLEASE COMPLETE THE ATTACHED MALPRACTICE SUIT INFORMATION FORM.

IV. OTHER INFORMATION

A. Current number of professional staff members: Full Time _____ Part Time _____

B. Current number of non-professional staff members: Full Time _____ Part Time _____

C. Is the agency bonded? Yes _____ No _____ Are the agency personnel bonded? Yes _____ No _____

If **YES**, to either, please attach relevant documentation.

D. If a facility, number of beds: _____

E. What mechanism is available within the organization to identify HMO Members, and to assure that prior authorization and eligibility issues are addressed prior to rendering services? _____

_____

_____

F. How do you objectively monitor the quality of service you provide? **Please attach documentation sufficient to summarize a description of your Quality Management Program and associated activities for monitoring the quality of service you provide.** _____

_____

Please attach a copy of your Confidentiality Policies and Procedures.

G. In which Michigan communities/counties do you provide services? _____

_____

H. Which other HMOs have utilized your services? _____

I. Do you provide 24 hours/day, 365-days/year service? Yes _____ No _____

If **NO**, how many hours/days is service available? _____

If **YES**, describe how after normal business-hours service is provided: _____

_____

What arrangements are available to your clients for those circumstances when they need to reach your organization after normal business hours?

_____

_____

J. In accordance with Title 42 CFR § 455.106 has any person who has ownership or control interest in the organization, is an agent or managing employee of the organization, ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs?

Yes _____ No _____

If yes, please list the names and social security numbers of these individuals below:

_____ _____
Legal Name, Title Social Security Number (SSN)

_____ _____
Legal Name, Title Social Security Number (SSN)

_____ _____
Legal Name, Title Social Security Number (SSN)

K. Has the organization, or employee of agent of organization, been convicted of a felony or other act involving dishonesty, fraud, deceit or misrepresentation; or has the organization, or employee or agent of the organization been under investigation by appropriate legal authority with respect to such conduct?

Yes _____ No _____

If **YES**, please explain: _____

_____

_____

L. Has the organization engaged in or been under investigation, with respect to conduct, in violation of state or federal law or standards of ethical conduct governing the business practice or conduct for which the organization is or might have been disciplined or otherwise censured?

Yes _____ No _____

If **YES**, please provide relevant documentation: _____

_____

M. Has the organization had restrictions placed on its business practices by a review board or other similar body or governmental agency?

Yes _____ No _____

If **YES**, please provide relevant documentation: _____

N. _____

_____The organization has external contracts for the following services: _____

_____

_____

_____

O. For skilled nursing facilities: are you able to provide the following services:

TPN	Yes _____	No _____
Ventilator Care	Yes _____	No _____
Tracheotomy Care	Yes _____	No _____
I.V. Therapy	Yes _____	No _____
Respiratory Therapy	Yes _____	No _____
Rehabilitation Therapy	Yes _____	No _____
Pharmacy Services	Yes _____	No _____

Other: _____

_____

V. GENERAL INFORMATION FOR CLAIMS PROCESSING AND PROVIDER DIRECTORY

Please complete the attachment for each site where you provide services. Attach an additional copy for **each** site where you provide services

Please circle the appropriate site:

Site One Site Two Site Three Site _____ Hours of Operation: _____

Street Address: _____ Phone: _____ Fax: _____

City, State, Zip Code: _____

Check Name: _____

Taxpayer ID #: _____

Street Address to which checks should be mailed: _____

_____

Type of claim form used: CMS 1500 _____ UB 92 _____

National Provider Identifier (NPI): _____

Person to contact concerning claims/administrative questions:

_____

Name Title Phone E-Mail Address

Hours of Operation: _____

Accepting New Commercial Patients: _Yes ____NO

Accepting New Medicaid Patients: _____Yes _____No

Malpractice Suit Information
CONFIDENTIAL

SUBMIT INDIVIDUAL SHEET FOR EACH CASE - REPRODUCE FORM AS NECESSARY

1. Name of Case: _____

   Case Number: _____

   Date of occurrence: _____ Date case filed: _____

2. Allegations which are the basis for the claim: _____

   _____

3. Disposition of claim: _____

   Date of Disposition: _____

   Amount of judgment or settlement: _____

4. Insurance company(s) involved (if any): _____

   _____

5. Name(s) of other defendant(s) names in the claim or suit (if any): _____

   _____

   _____

6. Disposition of other defendants: _____

   Amount of judgment or settlement: _____

7. Description of circumstances and defenses in the case: _____

   _____

   _____

8. To whom may we refer for further legal information about the suit: _____

   _____

I hereby certify that the above information is accurate and true and understand the information included in this form will be kept confidential and will only be used for credentialing within Physicians Health Plan. I understand that any information submitted on or with this form which is found to be false or intentionally misleading may result in rejection or termination with Physicians Health Plan.

Organization: _____

By: _____ Date: _____

ATTESTATION, RELEASE, AND SIGNATURE

I THE UNDERSIGNED, AS AUTHORIZED REPRESENTATIVE OF THE ANCILLARY PROVIDER, HEREBY CERTIFY THAT ALL INFORMATION CONTAINED IN THIS APPLICATION AND ALL THE ATTACHMENTS, ARE ACCURATE, COMPLETE AND TRUE.

THE ANCILLARY PROVIDER understands that:

(a) the information contained in this application will be kept confidential and will only be used for credentialing within Physicians Health Plan;

(b) any information contained in this application which subsequently is found to be false or intentionally misleading may result in denial of the application or termination of ancillary provider's participation in Physicians Health Plan;

(c) it is the ancillary provider's responsibility to promptly advise Physicians Health Plan of any changes or additions to the information contained in this application;

(d) all of the information contained in this application or its attachments is subject to Physicians Health Plan's investigation and review;

(e) this is an application only and the ancillary provider's submission of this application does not automatically result in participation with Physicians Health Plan; and

(f) investigation of any information contained in this application or its attachments may be performed by a Credentials Verification Organization (CVO) designated by Physicians Health Plan and any authorization or release hereunder made is also given to any such CVO of Physicians Health Plan.

THE ANCILLARY PROVIDER certifies that the statement below is accurate, complete and true:

- The credentials of those physicians, podiatrists, dentists, and other allied health professionals who provide services on behalf of ancillary provider have been reviewed by ancillary provider, and ancillary provider has in place a process whereby it regularly reviews the credentials of health care professionals that provide services on behalf of ancillary provider.

THE ANCILLARY PROVIDER HEREBY RELEASES FROM LIABILITY ALL REPRESENTATIVES OF PHYSICIANS HEALTH PLAN, FOR THEIR ACTS PERFORMED IN GOOD FAITH AND WITHOUT MALICE IN CONNECTION WITH EVALUATING THIS APPLICATION. THE ANCILLARY PROVIDER RELEASES FROM ANY LIABILITY ANY AND ALL INDIVIDUALS AND ORGANIZATIONS WHO PROVIDE INFORMATION TO PHYSICIANS HEALTH PLAN, IN GOOD FAITH AND WITHOUT MALICE CONCERNING ITS APPLICATION. THE ANCILLARY PROVIDER HEREBY CONSENTS TO THE RELEASE AND EXCHANGE OF INFORMATION RELATING TO ANY DISCIPLINARY ACTION, SUSPENSION, OR CURTAILMENT OF PRIVILEGES TO PHYSICIANS HEALTH PLAN.

In the event the ancillary provider is accepted for participation in Physicians Health Plan, the ancillary provider consents to inspection of its patient records relating to Physicians Health Plan's enrollees as necessary for their peer review and utilization processes. The ancillary provider further consents to the inspection by representatives of Physicians Health Plan of all documents that may be material to an evaluation of the ancillary provider's professional competence and ethical qualifications.

The ancillary provider understands that if its application is rejected for reasons relating to professional conduct or competence, Physicians Health Plan may report the rejection to the appropriate state licensing board, National Practitioner Data Bank, and/or the Healthcare Integrity & Protection Data Bank.

A PHOTOCOPY OF THIS DOCUMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.

Organization Name:_____

By:_____ Date: _____

Its:_____

IMPORTANT TAX DOCUMENT
SUBSTITUTE FORM W-9

Request for Taxpayer Identification Number

The Internal Revenue Service requests that we obtain your Taxpayer Identification number (TIN) for information reporting requirements. We are required by law to obtain this information from you when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to a 31% federal income tax backup withholding. Also, if you do not provide us with this information, you may be subject to a $50 penalty imposed by the Internal Revenue Service under Section 6723 of the Internal Revenue Code. Please complete the remainder of this Substitute Form W-9.

1. Taxpayer Name
   (To whom the check is payable) _____ (A legal entity name if a corporation or partnership)

   Doing Business as:
   (A division name if a corporation or the name of the business if a sole proprietor) DBA _____

2. Taxpayer Address _____

   _____

   _____

3. Taxpayer Identification Number

   a. Corporation _____
      (List employer identification number)

   b. Partnership _____
      (List employer identification number)

   c. Sole Proprietorship _____
      (List social security number or employer identification number)

   d. Tax Exempt Entity _____
      (List employer identification number)

   e. Other - Please Explain _____

4. Form Completed By _____
   (Print name)

5. Signature _____
   (Signature)

6. Today's Date _____

7. Daytime Phone Number ( ) _____

PLEASE NOTE: INFORMATION REPORTED ON LINES 1-3 MUST BE CONSISTENT WITH DATA ON FILE WITH THE IRS AND SOCIAL SECURITY ADMINISTRATION.

CHECKLIST

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APPLICATION FOR PARTICIPATION

CHECK OFF	COPY ENCLOSED OF:	REFERENCE
	Current license, Medicare certification, DEA license, CLIA License, for organization	**II.** B & C
	Survey Report from national accreditation organization (if applicable)	**II.** D
	Declaration Face Page of present policy of Professional, Business/General and Product Liability insurance policies *showing amount of coverage and date of policy period*	**III.** A
	Relevant bonding documentation (as applicable)	**IV.** E
	Documentation of Quality Management Program	**IV.** H
	Confidentiality Policy and Procedure	**IV.** H
	Signed Certificate and Release Form	Attached Form
	Completed/Signed Malpractice Suit Information – If applicable	Attached Form
	Completed/Signed Request for Taxpayer Identification Number/Substitute Form W-9	Attached Form