

**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
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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 \_\_\_\_\_

If yes, Medical Director will require credentialing/recredentialing.  
 Please provide CAQH Application ID # \_\_\_\_\_.

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)
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Legal Name, Title	Social Security Number (SSN)
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Legal Name, Title	Social Security Number (SSN)
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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)
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**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 current copy/copies of your professional business/general and (where applicable) product liability insurance policies.

A. NAME OF PRESENT CARRIER EXPIRATION DATE

\_\_\_\_\_

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

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

C. NAME OF PRIOR CARRIER(S)  
\_\_\_\_\_  
\_\_\_\_\_

**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. Please **attach** a copy of your Quality Management Program and associated activities for monitoring the quality of service you provide.

G. Please **attach** a copy of your Confidentiality Policy and associated activities for monitoring patient confidentiality.

H. In which Michigan communities/counties do you provide services? \_\_\_\_\_

\_\_\_\_\_

I. Which other HMOs have utilized your services? \_\_\_\_\_

J. 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?

\_\_\_\_\_

\_\_\_\_\_

K. 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)

- L. 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: \_\_\_\_\_

\_\_\_\_\_

- M. 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: \_\_\_\_\_

\_\_\_\_\_

- N. 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: \_\_\_\_\_

- O. The organization has external contracts for the following services: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- P. 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# (Attach copy of W9): \_\_\_\_\_

Street Address to which checks should be mailed:

\_\_\_\_\_

Type of claim form used:    CMS 1500 \_\_\_\_\_    UB 92 \_\_\_\_\_

\*National Provider Identifier (Type 2 NPI): \_\_\_\_\_

Person to contact concerning claims/administrative questions:

Name	Title	Phone	E-Mail Address
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Hours of Operation: \_\_\_\_\_

Accepting New Commercial Patients: \_\_\_Yes      \_\_\_No

\*Required data for claims adjudication

**Malpractice Suit Information  
CONFIDENTIAL**

**SUBMIT INDIVIDUAL SHEET FOR EACH CASE - REPRODUCE FORM AS NECESSARY**

No malpractice data exists (please check box, sign below and continue with remainder of application).

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: \_\_\_\_\_

**CHECKLIST**

**(Please be sure to attach all applicable items before forwarding to PHP)**

**ANCILLARY PROVIDER  
APPLICATION FOR PARTICIPATION**

<b>CHECK OFF</b>	<b>COPY ENCLOSED OF:</b>	<b>REFERENCE</b>
	Current license, Medicare certification, DEA license, CLIA License, for organization	<b>II. B &amp; C</b>
	Survey Report from national accreditation organization (if applicable)	<b>II. D</b>
	Copy of current Professional, Business/General and Product Liability insurance policies <i>showing amount of coverage and dates of policy period</i>	<b>III. A</b>
	Relevant bonding documentation (as applicable)	<b>IV. E</b>
	Documentation of Quality Management Program	<b>IV. Please Attach Policy</b>
	Confidentiality Policy and Procedures	<b>IV. Please Attach Policy</b>
	Completed/Signed Malpractice Suit Information – If applicable	Page 7
	Signed Certificate and Release Form	Page 8
	Copy of W-9	Please Attach