NPI#_____

APS Healthcare, Inc.
Provider Application

INSTRUCTIONS

Please complete all sections. If one is not applicable, mark it N/A. Print or type information.

* Return applications to: **APS Healthcare Puerto Rico, Inc.**
P.O. Box 71474
San Juan, PR 00936-8574
Attention: Provider Relations Department.

- Please print neatly or type application.
- Please **sign and date** the application and authorization forms.
  We must have signatures on the application and authorization form in order to obtain the necessary
- verifications.
- Applications must be returned within 15 business days of the date received by the provider.
  Providers whose applications are returned late or incomplete will not be credentialed.
- **Complete all sections. <u>If a section is not filled out, the application will be returned, thus, delaying the credentialing process</u>.** Use N/A if not applicable.

CHECKLIST

Please be sure to include the following documents along with your application. Copies must be legible and the expiration date must be clearly indicated.

1. ___ ***Signed*** Authorizations on pages 14 and 15.
2. ___ A **current** copy of your Curriculum Vitae that must include your **5 years of work history in a (Month/Year) format** and the proper completion of the *Work History* section on page 5 of this application. You are required to explain any gaps in employment over six months.
3. ___ **Certificate of Malpractice Insurance** issued to *APS Healthcare Puerto Rico, Inc.* and completion of the *Professional Liability Insurance* section on page 7 of this application. (MD/DO $100,000/$300,000 and non-MD $100,0000/$300,000).
4. ___ ***<u>A copy of your Current State License.</u>***
5. ___ Good Standing (original no older than 6 months).
6. ___ A copy of your current **DEA** registration (Physicians only).
7. ___ A copy of your current **ASSMCA** registration (Physicians only).
8. ___ Current College Membership (Physicians and Social Workers only).
9. ___ Board Specialty Certification (Physicians only).
10. ___ Copy of Residency (Physicians only).
11. ___ Buprenorphine Certification (if applicable, Physicians only).
12. ___ If you are an MD or DO **<u>WITHOUT</u>** hospital admitting privileges, a written document must be submitted that explains the procedure that you follow when a patient must be admitted.
13. ___ **ECFMG** or VQE, for **foreign** graduates.
14. ___ Signed APS agreements**.**
15. ___ If you answer yes to any of the questions on page 8 to 11, you must **<u>include a written explanation and any supporting court documents. This only applies to the past five years.</u>**

GENERAL INFORMATION

Last Name:_____First Name:_____ Middle Initial:_____

Social Security Number: _____ Birth date:_____

Previous Name/Maiden Name Used: _____ Sex: M____ F____

Degree (s)_____ Number of years in private practice: _____

<u>**Email information****</u> If you have an email address please list below.**

_____

Optional**:**
Please fill out the section below. This information will assist in the referral process. Members often request providers with a specific ethnic background. The information does not affect your provider status.

ETHNIC BACKGROUND:

American Indian or Alaska Native_____ Asian or Pacific Islander_____
African-American_____ Caucasian_____
Hispanic_____ Other_____

PRIMARY OFFICE INFORMATION

Address: _____ Tax ID Number:_____

City, State, Zip Code:_____ County:_____

Is this your mailing address? (please indicate only one address as your mailing address) Yes____ No____

Daytime Telephone:_____ Daytime Fax Number:_____

Emergency Telephone:_____ Office Manager/Contact:_____

SECONDARY OFFICE INFORMATION

Address: _____ Tax ID Number:_____

City, State, Zip Code:_____County:_____

Daytime Telephone:_____ Daytime Fax Number:_____

Emergency Telephone:_____ Office Manager/Contact:_____

BILLING NAME AND BILLING OFFICE ADDRESS

(Please complete if different from the main office address.) This is for claims reimbursement only. This information must match location #33 of the HCFA 1500 form.

You bill as: Independent Practitioner_____ Group Practice_____ Other_____

Practice Group Name (if applicable): _____

Tax Identification # or Social Security # that is being used for billing:_____

Billing Address:_____

City:_____ State:_____ Zip:_____

Telephone Number:_____ Fax Number:_____

Medicare Number (**Required if Registered**):_____
NPI Number (National Provider Indentifier): _____

HOSPITAL AFFILIATIONS

Hospital Privileges: **MD/DO only: Physicians must list each of the primary hospitals in which they have privileges. Physicians must also list all other hospitals where they may have admitting, courtesy, active, consulting privileges etc., although they may not be considered their "primary" facility. If you are a MD or DO with hospital privileges, this section must be filled in or the application will be returned.**

Please Note: **If you are a MD or DO who does NOT have hospital privileges, you must include a written statement with the application stating what your procedure is if one of your patients must be admitted or the application will be returned.**

HOSPITAL Name	**Phone (w/ area code) & Address**	**TYPE OF PRIVILEGES** (ACTIVE, PENDING, COURTESY, PROVISIONAL, ETC.)	APROX # OF ADMISSIONS PER MONTH	RESTRICTIONS?
List primary hospital location(s) first:				

EDUCATION AND TRAINING

Medical/Graduate School *Please include the institution address below.*

Institution Name:_____ Degree (s):_____

City/State:_____

Attended **From** (Mo/Yr)_____ **To** (Mo/Yr)_____ Graduated (Mo/Yr)_____

Foreign Medical School Graduates

Are you a graduate from a foreign medical school? Yes_____ No_____

Are you certified by the Education Council for Foreign Medical Graduates? Yes_____ No_____

EFCMG/VQE#_____ Please provide a copy of your certificate.

Physician Applicants Only:

Residency:

Residency Institution Name:_____ Affiliated Hospital:_____
Mailing Address:_____
City:_____ State:_____ Zip:_____ **Phone:_____**
Attended From (Mo/Yr.):_____ To (Mo/Yr.):_____ Type of Residency:_____

SCHEDULED OFFICE HOURS

Please list hours for additional office locations on a second page.

OFFICE	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**	**TOTAL HOURS PER WK. THAT YOU SEE PATIENTS.**
Primary								
Secondary								
List after hour #'s & contacts								

WORK HISTORY

Please list your last five-year of work history including the format: month / year. You are required to explain any gaps in employment.

Company:	***Period: Month / Year***	***Responsibilities:***
1.		
2		
3.		
4.		
5.		

Physician Applicants Only: (Please include a copy of each certificate. Note: MD and DO applicants can not be considered if the copy of the DEA certificate is not included with their application).

DEA#:_____ Expiration date: _____
(Federal)

Other applicable narcotic registration: (**CDS** if applicable and required by your state)

Certification Number:_____ State:_____ Expiration Date:_____

Physician applicants only. (Please forward a copy of each certificate.)

Are you board certified? Yes:_____ No:_____

Name of specialty:_____ Certification Number:_____ Issue Date:_____

Second specialty board:_____ Certification Number:_____ Issue Date:_____

If not board certified, have you taken an examination? Yes:_____ No:_____

If yes, when was the examination taken:_____

Results of examination: Pass:_____ Fail:_____ Other:_____

If no, when do you plan to take the examination:_____

STATE PROFESSIONAL LICENSURE/CERTIFICATION

Please include a current copy of each: *Your provider license must have your signature present*
If applicable in your state.

1. License/Certification Type:_____

License/Certification Number:_____ State:_____ Expiration Date:_____

2. License/Certification Type:_____

License/Certification Number:_____ State:_____ Expiration Date:_____

3. License /Certification Type:_____

License/Certification Number:_____ State:_____ Expiration Date:_____

PROFESSIONAL LIABILITY INSURANCE

******This section must be filled out in order to complete the credentialing process.**
****** Please submit the current malpractice face sheet.******

Carrier:_____ **Policy Number**:_____

Coverage Dates:_____ to _____ **Coverage Amounts**:_____

Is this policy covered under a compensation fund? Yes_____ No_____
If yes, the name of the compensation fund:_____

Are you able to provide:

1. Services for the hearing impaired? Yes:_____ No:_____
2. Services for non-Spanish speaking patients? Yes:_____ No:_____

***If yes, what languages do you speak fluently**:_____
_____

AREAS OF INTEREST

Please check the areas of interest that you would like to be considered for. By checking off the areas if interest with which you work we are able to match patients to providers with greater accuracy.

Areas of Interest

____ Anxiety (3)
____ Phobias (1003)
____ Autism (4)
____ Brain Injury (7)
____ Bipolar Disorder (5)
____ Borderline Personality (6)
____ Child Abuse (8)
____ Chronically Mentally Ill (9)
____ Crisis Intervention (11)
____ Cultural/Ethnic Issues: identify_____ (14)
____ Grief Issues (26)
____ Terminal Illness (15)
____ Depression (17)
____ Developmental Disabilities (19)
____ Dual Diagnosis (21)
____ ADHD (115)
____ HIV (27)
____ Eating Disorders (22)
____ Gay Lesbian Issues (25)
____ Men's Issues (102)
____ Women's Issues (47)
____ Infertility (140)
____ Pain Management (32)
____ Obsessive Compulsive Disorder (31)
____ Personality Disorders (34)
____ Parenting (33)
____ Adoption (107)
____ ECT (105)
____ Alcohol Abuse (48)
____ Drug Abuse (49)
____ Schizophrenia (37)
____ Sleep Disorders (40)
____ Rape/Incest (50)
____ Spouse Abuse (44)
____ Psychosomatic Disorders
____ Gender Issues (106)
____ Sexual Disorders (104)
____ Victims of Trauma (46)
____ Post Traumatic Stress Syndrome (54)
____ Child Custody (103)
____ Tourette's Syndrome (1001)
____ Christian Therapy (113)
____ Neuropsychological Testing (114)
____ Criminal Offenders (10)
____ **Psychological Testing (adult) (111)**
____ **Psychological Testing (child) (112)**
____ Other _____

Please list clinical areas of <u>least</u> comfort and familiarity:

_____

_____

<u>Patient Population</u>

1. What **percentage** of your current patient population is treated using the following modality?

individual____% family_____% group_____% marital/couple_____%

2. What **percentage** of your current patient population is made of the following age classifications?

children (ages1-11) _____% adults(ages 18-59) _____%
adolescents(ages12-17) _____% geriatric(ages 60+) _____%

MALPRACTICE HISTORY

Within the past <u>five</u> years:

1. Has your professional liability insurance coverage ever been denied or canceled? Yes:___ No:___
(If yes, please provide a personal statement describing what occurred)

2. Has your current or any previous malpractice carrier ever made an out-of-court settlement or paid a judgment of professional liability claim on your behalf? Yes:___ No:___

3. Are you or have you ever been involved in a malpractice suit(s) or grievance(s) filed with a county or state medical society or licensing agency? Yes:___ No:___

4. Are you or have you ever been named in a malpractice suit(s), either open or closed? Yes:___ No:___

<u>If you have answered "Yes" to question 2, 3 or 4 supply the following information. If more than one case exist, please explain completely on a separate sheet and include all documentation along with this application.</u> **<u>You must include all supporting documentation pertaining to all or any cases that you have listed.</u>**

Case Number: _____ Carrier Name: _____

Date of Incident: ___/___/___ Date Filled: ___/___/___ Date Closed: ___/___/___

What was/is your role in the case?

❒ Primary Defendant ❒ Co-Defendant ❒ Other, please explain

What is the status?

❒ Dropped ❒ Settled out of court ❒ Dismissed ❒ Other, please explain
❒ Pending ❒ Found for Defendant ❒ Found for Plaintiff

If pending, when was the last contact with plaintiff's attorney? _____

If damages were paid, either by settlement or court award, what was the amount:

Attributed to your involvement $ _____ Paid by all parties $ _____

Please explain in detail below:

1. What was the alleged harm to the patient?

_____
_____
_____
_____

2. What were you alleged to have done incorrectly or failed to do?

3. Describe the patient's illness and related effects to the alleged harm.

4. Describe any other details that you believe are pertinent to the case.

5. Identify any other parties named in the suit.

6. Actions Taken Against You:

7. Medical Practice Privileges Affected as a Result of this Situation:

DISCLOSURE OF INFORMATION RELATED TO MANAGING EMPLOYEES

According to the 42 CFR § 455.104 (d)(4) the provider shall list the name, address, date of birth, and Social Security Number of any managing employee. (*Managing Employee* means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.)

Name:	***Address:***	***Date of birth:***	***Social Security Number:***	***NPI Number:***
1.				
2.				
3.				
4.				
5.				

PROVIDER QUESTIONNAIRE

Please review each question carefully*:*

1. Have there been any misdemeanors of felony criminal charges brought against you? In answering this question, you may disregard most traffic offenses, but you should answer affirmatively if you have been charged with driving a motor vehicle under the influence of intoxicating liquor or narcotic substance, regardless of whether that charge was later reduced to a lesser offense. Yes:__ No__

2. Have you ever lost your Board certification, or failed to recertify? Yes:__ No:__

3. Have you ever had any of the following items involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or have you ever voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending:

A. State License Yes:__ No:__

B. DEA registration or other applicable narcotic registration Yes:__ No:__

C. Hospital or other health care facility staff membership or privileges Yes:__ No:__

D. Professional organization membership, regulatory agency or HMO/PPO panel (for cause only). Yes:__ No:__

E. Medicare, Medicaid, or other local, state, and/or federal government program participation Yes:__ No:__

4. Do you have any physical or mental health condition, with or without accommodation, which in any way impairs your ability to practice or in any way poses a risk of harm to your patients? Yes:__ No:__

If you have answered "Yes" to any of the questions #**1-4**, please explain completely on a separate sheet and include all documentation along with this application.

5. Are their any other individuals or subcontractors besides yourself that have an ownership control in your practice of more than (5%)? Yes:__ No:__

6. Do you have an ownership control of more than (5%) in any other practice or Sub-contractor? Yes:__ No:__

7. Are any of the individuals or subcontractors disclosed in questions 5 or 6 related to each other or yourself as spouse, parent, child or sibling? Yes:__ No:__

If you have answered "Yes" to any of the questions #**5-7**, please list the persons, addresses, phone numbers, relationships and percentages of control interest on a separate sheet and include all documentation along with this application.

8. Do you have an ownership in a subcontractor or other practice where you've had a business transaction of more than $25,000? Yes:__ No:__

9. Has any of the person's disclosed or yourself, within the last 10 years preceding enrollment or revalidation of enrollment, been convicted of a criminal offense related to an involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of these programs? Yes:__ No:__

If you have answered "Yes" to any of the questions #**8-9**, please list the persons, addresses, phone numbers, relationships and offenses on a separate sheet and include all documentation along with this application.

10. Please disclose in the ***SECTION 10.A*** all the information related to any person(s) having ownership control in your practice or is an agent or managing employee of your practice and state if any of these persons has 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.

SECTION 10.A – Disclosure of **persons has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program**				
Person Name	Type of Offense	Date of Conviction	SSN /EIN	NPI Number:

****

1. Are you currently free of any illegal drug use? Yes:__ No:__

2. Do you understand that subject to confidentiality restrictions and authorizations, medical records might be subject to on-site review by APS Healthcare, Inc.? Yes:__No:__

APPLICANTS STATEMENT

You MUST sign and date the certification statement below in order to be enrolled in the APS Healthcare, Inc. Providers Network. In doing so, you are attesting to meeting and maintaining the requirements stated below.

I, the undersigned, certify to the following:

1. I have read the contents of this application, and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify APS Healthcare, Inc. of this fact within 30 days.

2. I authorize APS Healthcare, Inc. to verify the information contained herein. I agree to notify APS Healthcare, Inc. of a change in ownership, practice location, Final Adverse Action and/or any other changes to the information in this application within 30 days of the reportable event by requesting and submitting a new provider application.

3. I understand that Federal Financial Participation (FFP) is not available to a provider or fiscal agent that fails to disclose ownership or control information as required by Medicare, Medicaid, Title V or Title XX Program.

4. I agree to furnish APS Healthcare, Inc. on request, information regarding: (1) the ownership of any subcontractor with whom I, the applicant, has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and (2) any *significant business transactions* between me and any wholly owned supplier, or between me and any subcontractor, during the 5-year period ending on the date of the request. (*Significant business transaction* means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.)

5. I understand that under Medicare, Medicaid, Title V or Title XX, Federal Financial Participation (FFP) is not available in expenditures for services furnished during the period beginning on the day following the date the information was due to APS Healthcare, Inc. and ending on the day before the date on which the information was supplied.

6. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to APS Healthcare, Inc., any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the termination, denial or revocation of billing privileges of APS Healthcare, Inc., and/or the imposition of fines, civil damages, and/or imprisonment.

7. I agree that any existing or future overpayment made to me (or the organization listed in this application) by the Medicare, Medicaid, Title V or Title XX program may be recouped by APS Healthcare Inc. through the withholding of future payments.

8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by APS Healthcare, Inc., and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

9. I understand that I am responsible for the claims that are submitted on my behalf.

10. Neither I, nor any managing employee listed on this application, is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Healthcare Program, e.g., Medicare, Medicaid, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.

I agree to adhere to all of the requirements listed therein and acknowledge that I may be denied entry to or revoked from APS Healthcare, Inc. Providers Network if any requirements are not met.

X_____ _____

Signature **Date**

Practitioner rights during the credentialing process are:

- The right to review the information in support of their credentialing application.
- The right to be notified of any information obtained during the organization's credentialing process that varies substantially from the information provided to the organization by the practitioner.
- The right to correct erroneous information.
- The right to confidentiality of all information obtained in the credentialing process except as otherwise provided by law.
- The right, upon request, to be informed of the status of their credentialing or recredentialing application.

APS Healthcare, Inc.
Provider Application

CONSENT FOR RELEASE OF INFORMATION/RELEASE FROM LIABILITY

I hereby give permission to APS Healthcare, Inc. including its affiliates and the employees, contracted entities, agents, representatives or its authorized designee thereof to obtain information about my professional education, training, licensing, competence, ethics, character and other qualifications. I consent to the release of such information, whether in the form of transcripts, records, tapes, letters, photocopies/duplications of any of the forgoing, or verbal statements by hospital administrators, chiefs of clinical departments of hospitals in which I have served on staff, state licensing boards or regulatory bodies (by whatever name known in their respective jurisdictions), physicians clinics or other individuals or organizations who or which possess information about me. Such information may be released to the above named entity and its affiliates or to representatives of such entity and its affiliates.

I hereby release from liability and agree to hold harmless any person or entity who or which provides the above described information as authorized herein.

I hereby release from liability and agree to hold harmless all employees, agents, representatives and authorized designee of the above named entity and its affiliates for their acts performed and statements made in connection with obtaining, reviewing, and evaluating my credentials and qualifications. I further acknowledge my cooperation by consenting to the production of such information about me as a provider of services to their insurers and enrollees. The determination of whether I am qualified to serve as a provider of services is the reason such information is needed for the review and evaluation by the above-named organization and their representatives.

This application shall not be considered complete until query is made to and received from the National Practitioners Data Bank by APS Healthcare, Inc.

In the event I am accepted for participation by APS Healthcare, Inc., I hereby consent to the inspection of my patient records by APS Healthcare, Inc. relating to APS Healthcare, Inc. covered members as necessary for its peer review, utilization review, quality management and quality improvement processes and agree to be bound by the APS Healthcare, Inc. Agreement and Provider manual.

I further agree that a photocopy of this document will serve as a duplicate original.

Print Name:_____

Signature:_____

Date:_____