27 Corporate Hill Drive
Little Rock, AR 72205
(800) 376-5940 Ext. 1996

Provider Application

A. PERSONAL INFORMATION

Name (Last)	(First)	(Middle)	Degree

Other Names Used Maiden / Married	Date of Birth (REQUIRED)	Social Security Number (REQUIRED)

Gender? ☐ Female ☐ Male	U.S. Citizenship? ☐ Yes ☐ No	Preferred Method of Contact: ☐EMAIL ☐FAX ☐MAIL ☐PHONE Credentialing Contact Person:

B. PRIMARY PRACTICE LOCATION:

Business Name:	Contact Person / Title	Contact's Phone / Ext.
Mailing Address	Street Location Address County	
City State Zip Code	City State Zip Code	

Phone Number	Fax Number	E-mail Address:
Office Hours:	Weekend Hours:	☒ Handicap Accessible? Yes No

C. SATELLITE PRACTICE LOCATION

Business Name:	Contact Person / Title	Contact's Phone / Ext.
Mailing Address	Street Location Address County	
City State Zip Code	City State Zip Code	

Phone Number	E-mail Address:	Fax Number
Office Hours	Weekend Hours:	☒ Handicap Accessible? Yes No

List any additional locations on a separate attachment.

D. PATIENT ACTIVITY

☒ Will you be accepting new patients? YES NO	☒ Any age restrictions? YES NO	If Yes, → provide:	Minimum age	Maximum age	☒ Which of the following do you accept?	Medicare Neither	Medicaid

E. BILLING INFORMATION

Taxpayer identification number (TIN) used when billing services: (Must match tax ID owner name on file with IRS).	Business name used when billing services:
TIN#:	
☒ appropriate box: Attached a W-9 ☐ Individual/Sole Proprietor	☐ Corporation ☐ Partnership
Billing services address: City State Zip Code	Make check payable to owners name on file with IRS • Taxpayer identification number (TIN) –

F. LANGUAGE PROFICIENCIES

List any foreign language(s) or sign that you speak fluently in treating patients (select no more than 5)

☐ Arabic	☐ Chinese	☐ Spanish	☐ French	☐ German
☐ Hebrew	☐ Hindi	☐ Italian	☐ Japanese	☐ Other (specify):

G. EDUCATION INFORMATION

Educational Institution (include name, address, city, state and zip)	Degree	From (mm/yy)	To (mm/yy)
Undergraduate			
Graduate/Medical School			
Internship			
Residency			
Fellowship			

(List below all work history for a five- (5) year period beginning with the current and include an explanation of any gap(s) (6) months or greater).

Practice / Employer Name	Street, City and State	Start Date (Month/Year)	End Date (Month/Year)

HealthSCOPE BENEFITS

H. IPA/PHO/PO AFFILIATIONS:

1) Business Name:			2) Business Name:		
☐ IPA	☐ PHO	☐ PO	☐ IPA	☐ PHO	☐ PO
Mailing Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code
List any additional locations on a separate attachment.					

I. HOSPITAL MEDICAL AFFILIATIONS

List primary hospital first where you have medical staff memberships or clinical privileges (☒ status).

Primary Admitting Facility	Other Hospital Affiliation	Other Hospital Affiliation
Address	Address	Address
City / State/ Zip	City / State/Zip	City / State/Zip
Active, Courtesy, Associate, Provisional, Consulting, Temporary, Allied Health, Surgical, Other	Active, Courtesy, Associate, Provisional, Consulting, Temporary, Allied Health, Surgical, Other	Active, Courtesy, Associate, Provisional, Consulting, Temporary, Allied Health, Surgical, Other
Do You Have Hospital Privileges At This Facility? ☐ YES ☐ NO	Do You Have Hospital Privileges At This Facility? ☐ YES ☐ NO	Do You Have Hospital Privileges At This Facility? ☐ YES ☐ NO

J. MALPRACTICE LIABILITY INSURANCE COVERAGE

PLEASE SUBMIT A COPY OF YOUR CURRENT MALPRACTICE INS CERT

K. PROFESSIONAL ID'S (LICENSES)

TYPE **(ONE ONLY):** ☐ STATE LICENSE ☐ DEA ☐ STATE CONTROLLED SUBSTANCE

STATE ____LICENSE NO.__________________ ____ DATE ISSUE___________EXP DATE__________STATUS_____________

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE ☐ YES ☐ NO

TYPE **(ONE ONLY):** ☐ STATE LICENSE ☐ DEA ☐ STATE CONTROLLED SUBSTANCE

STATE ____LICENSE NO.__________________ ____ DATE ISSUE___________EXP DATE__________STATUS_____________

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE ☐ YES ☐ NO

TYPE **(ONE ONLY):** ☐ STATE LICENSE ☐ DEA ☐ STATE CONTROLLED SUBSTANCE

STATE ____LICENSE NO.__________________ ____ DATE ISSUE___________EXP DATE__________STATUS_____________

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE ☐ YES ☐ NO

TYPE **(ONE ONLY):** ☐ STATE LICENSE ☐ DEA ☐ STATE CONTROLLED SUBSTANCE

STATE ____LICENSE NO.__________________ ____ DATE ISSUE___________EXP DATE__________STATUS_____________

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE ☐ YES ☐ NO

L. OTHER ID'S NUMBERS

ARE YOU A PARTICIPATING MEDICARE PROVIDER ☐ YES ☐ NO MEDICARE NUMBER ____________________ UPIN __________________

ARE YOU A PARTICIPATING MEDICAID PROVIDER ☐ YES ☐ NO MEDICAID NUMBER_____________________

NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI) __________________________________

☒ **If you have graduated from a foreign medical school, are you certified by the Education Commission for Foreign Medical Graduates (ECFMG)?** ☐ **YES** ☐ **NO**

ECFMG NUMBER ____ ECFMG CERTIFICATION ISSUE DATE___________________________
(NON –US/CANADIAN GRADUATE ONLY) (NON –US/CANADIAN GRADUATE ONLY)

HealthSCOPE BENEFITS

M. SPECIALTY ASSIGNMENT

PRIMARY CARE PHYSICIANS ☒ **appropriate box:**		SPECIALTY CARE PHYSICIANS
General Practice	☐ Family Practice	State your primary specialty:
General Internal Medicine	☐ Pediatrics	
☒ Do you, as a primary care physician, maintain a subspecialty?	☐ Yes ☐ No	
➢ At least 75% of your practice time must be spent in the delivery of primary care?	☐ Yes ☐ No ☐ n/a - no subspecialty	NON-PHYSICIAN PROFESSIONS State your primary profession:

N. CERTIFICATION

Are you Board Certified? ☐ YES ☐ NO

Certifying Board:

Primary Care Physicians are defined as:

- Family Practice;
- General Practice;
- General Internal Medicine or;
- Pediatrics.

- Specialty:
- Subspecialty:
- Certification Number:
- Issue Date: Expiration Date:

If you are not board certified (select one)

☐ I have taken exam, results pending for:

Certified Board:

☐ I am eligible to sit for an exam on:

Date:

O. CALL COVERAGE: **(This information is necessary for proper reimbursement of claims).**

List call coverage providers and/or groups: This provider does not have to be an HSB, Inc. participating provider

1) Name	2) Name	3) Name	4) Name
City State	City State	City State	City State
Specialty	Specialty	Specialty	Specialty
TIN (Taxpayer identification number)	TIN	TIN	TIN

List any additional providers on a separate attachment.

P. CLAIMS ACTIVITY: REQUIRED ➢ This information is necessary to process application.			
☐ Yes ☐ No	Have you ever been or are you currently involved in a liability suit and/or arbitration, or have any other proceedings been instituted against you?		
☐ Yes ☐ No	Have there ever been any settlements or judgments, not involving litigation or arbitration involving your professional pra		
If you answered "Yes" to the questions above, please supply The following information for: Each professional liability action you have had in the past (5) years. Each settlement, or decision for the plaintiff that has ever occurred on your behalf			
All information is held in strict confidence and will be used for credentialing and recredentialing purposes only. Failure to supply sufficient details may prevent your application from being approved, or in recredentialing being delayed.			
Case#:	Carrier Name:	Date of Incident: Date of Filed:	
1. What was/is your status in the case?	☐ Primary Defendant	☐ Co-Defendant	☐ Other, please explain
2. What is the status of the case?	☐ Dropped ☐ Pending	☐ Settled out of Court ☐ Found for Defendant	☐ Dismissed ☐ Found for Plaintiff
3. If pending, when was the last contact with the Plaintiff's attorney?			
4. If damages were paid, either by settlement or court award, what was the amount $___________Attributed to your involvement $________Paid			
5. Your role in the incident.			
6. Patient outcome.			
7. Amount paid as an out-of-court settlement or amount of jury award or court award. (Obtain this information from your present or past insurance carrier, if necessary.			
Additional Information:			

Q. PROVIDER ATTESTATION QUESTIONS			
Please answer the following questions "yes" or "no". If your answer to any questions is **"YES",** please provide full details **on a** separate sheet of paper.			
1.	**Insurance Coverage:** a. Has your professional liability insurance coverage ever been denied, canceled, or non-renewed or initially refused upon application?	☐ **Yes**	☐ **No**
2.	**License:** Has your medical license or professional license to practice in the state or any other state Ever been investigated, reviewed, limited, restricted, reduced, suspended, surrendered, revoked, denied or placed on probation, conditional status?	☐ **Yes**	☐ **No**
	a. Have you ever been under investigation and/or reprimanded by a state licensing agency or + regulatory agency?	☐ **Yes**	☐ **No**
	b. Are formal charges pending against you at this time?	☐ **Yes**	☐ **No**
	c. Have you voluntarily surrendered your license?	☐ **Yes**	☐ **No**
3.	**DEA:** Has your DEA Registration Certificate ever been suspended, revoked, subjected to probation, placed on conditional status, or limited?	☐ **Yes**	☐ **No**
4.	**Hospital Privileges**: Has any hospital ever dismissed you from its staff?	☐ **Yes**	☐ **No**
	a. Has any hospital ever revoked, suspended, or limited your privileges?	☐ **Yes**	☐ **No**
	b. Has any hospital refused or denied you privileges?	☐ **Yes**	☐ **No**
	c. Has any hospital initiated either type of aforementioned action by formal notice to you	☐ **Yes**	☐ **No**
	d. Have you ever voluntarily surrendered your hospital privileges?	☐ **Yes**	☐ **No**
5.	**Hospital Sanctions:** Have you ever surrendered your clinical privileges upon threat of censure, restriction, suspension or revocation of such privileges?	☐ **Yes**	☐ **No**
6.	**Criminal Offenses:** Have you ever been convicted of a felony or involved in charges relating to moral or ethical turpitude?	☐ **Yes**	☐ **No**
	a. Have you ever been named as a defendant in any criminal proceeding?	☐ **Yes**	☐ **No**
7.	**Board Discipline:** Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board; county; state or national professional society hospital medical or clinical staff)?	☐ **Yes**	☐ **No**
8.	**Malpractice Action:** Has any malpractice action against you been brought or settled in the last five (5) years or has there been any unfavorable judgment(s) against you in a malpractice action?	☐ **Yes**	☐ **No**
	a. To your knowledge, is any malpractice action against you currently pending?	☐ **Yes**	☐ **No**
Health Status Questions <u>You MUST Give an explanation for any questions marked "Yes"</u>			
1.	Are you currently under the care of a physician for a continuing health problem?	☐ **Yes**	☐ **No**
2.	Do you **currently** have any physical or mental health condition, treated or untreated which in any way impairs your ability to practice to the fullest extent of your licensure and qualifications or in any way poses a risk of harm to your patients?	☐ **Yes**	☐ **No**
3.	Have you **in the past** had any physical or mental health condition, treated or untreated which in any way impairs your ability to practice to the fullest extent of your licensure and qualifications or in any way poses a risk of harm to your patients?	☐ **Yes**	☐ **No**
4.	Do you now have or have you ever had a chemical dependency/substance abuse problem, treated or untreated, which affect your ability to perform professional and or medical duties appropriately?	☐ **Yes**	☐ **No**
5.	Are you currently taking any medications that may affect either your clinical judgment or motor skill?	☐ **Yes**	☐ **No**

I hereby affirm that ALL of the information provided by me in this application is true and correct. I understand that any misleading statement or material omission in my application may be considered cause for denial of participation.

Signature of Applicant____ **Date**_______________________

Print Applicant Name____

As a HEALTHSCOPE BENEFITS, INC. applicant, I fully understand that if any matter stated in this application is or becomes false, HealthSCOPE Benefits will be entitled to terminate my provider agreement for breach. All information submitted by me in this application is warranted to be true, correct and complete.

I authorize HealthSCOPE Benefits and/or its Credentials Verification Organization (CVO) to consult with the National Practitioners Data Bank, state licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, Educational Council 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 competence, character and moral and ethical qualifications, and I also authorize all of them to release such information to HealthSCOPE Benefits and/or its CVO. I release HealthSCOPE Benefits and its employees and/or its CVO and all those whom HealthSCOPE Benefits and/or its CVO 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 affirm that the answers contained in and given with this application are true and complete to the best of my knowledge. I agree to provide written notification of changes to this information within thirty (30) days of the change to HEALTHSCOPE BENEFITS, INC. Should I become a contracted provider, I understand that false or misleading information given in my application or interview(s) may result in contract termination.

I consent to the release by any person to HealthSCOPE Benefits and/or its CVO of all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualification, 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 acknowledge that I have read and understand the foregoing Authorization and Release. I understand and agree that a facsimile or photocopy of this Authorization and Release shall be as effective as the original.

______________________________ ______________

Signature Applicant **Date(mm/dd/yyyy)**

____

Name (Please Print)

RETURN COMPLETED APPLICATION TO:

HealthSCOPE Benefits, Inc.
Attn: Provider Relations
PO Box 3707
Little Rock, AR 72203
800-376-5940 Ext. 1996

The application must be completed in its entirety. Please note, incomplete applications will cause a delay in the credentialing process. For your convenience we have included a checklist of all items that are required to complete the contracting process.

☐ CLINIC/PROVIDER AGREEMENT (If Applicable)
- **Signed and dated**

☐ CLINIC/PROVIDER APPLICATION
- **A provider application must be completed for each individual provider**
- **If an item is not applicable, please indicate using "N/A"**

☐ ATTESTATION & AUTHORIZATION FOR RELEASE INFORMATION
- **Signed and dated**

☐ CURRENT STATE LICENSE
- **Include all state license certification numbers**

☐ DEA REGISTRATION AND STATE CONTROLLED DANGEROUS SUBSTANCE (CDS)
- **Include certification number**

☐ ECFMG- **if applicable**
- **Include certification number**

☐ MALPRACTICE INSURANCE CERTIFICATE
- **Include carrier name, limit amounts, effective date, and expiration date on the application**

(if less than 5 years with current carrier, please include previous carrier information)

☐ EDUCATION/TRAINING
- **Include school, address, city, state, degree, department and specialty**

☐ WORK HISTORY
- **Please list the work history for the past five (5) years, beginning with the current and include an explanation of any gap(s) six (6) months or greater**

☐ W-9
- **Include a copy of a current W-9 form with the application.**
  (This information must match IRS **registration)**

Please return completed applications and documents to: **HealthSCOPE Benefits, Inc.**
Attn: Provider Relations
PO Box 3707
Little Rock, AR 72203

If you have any questions regarding the application, agreement or the credentialing process, please contact the Provider Relations department, (800) 376-5940 Ext. 1996.