AvMed

CREDENTIALING APPLICATION

Please complete all sections. Incomplete applications may delay the credentialing process.

PERSONAL IDENTIFICATION DATA

Last Name: _____ First: _____ MI: ____ Degree: _____

Date of Birth: _____ Social Security #: _____

Please list all other legal names you have used: _____

Applying As: ☐ Primary Care Physician ☐ Specialist Physician:

In the specialty of: _____ In the specialty of: _____

☐ Hospital-based Physician ☐ Allied Health Practitioner

In the specialty of: _____ In the specialty of: _____

Submission of the following information is voluntary. Please be assured that you will not be subjected to any adverse treatment if you do not provide the following:

Gender Classification: ☐ Male ☐ Female

EEO Classification: ☐ White (not of Hispanic origin) ☐ Hispanic ☐ Asian or Pacific Islander

☐ African American ☐ American Indian or Alaskan Native ☐ Eastern Indian

☐ Other:_____

Medicare Number: _____ Medicaid Number: _____ NPI Number: _____

OFFICE / PRACTICE INFORMATION

Primary Location

Your practice is (please check one): ☐ Solo ☐ Corporation ☐ Association

Do you offer 24-hour coverage for your patients? ☐ Yes ☐ No

If yes, how? _____

Group Practice Name *(if applicable)*: _____

Start Date _____ Tax ID # _____ Age Limits _____

Street: _____ Office Hours: What hours/days are you available to see patients:

City: _____ Mon. _____ _____

State: _____ Zip: _____ Tue. _____ _____

County: _____ Wed. _____ _____

Telephone: _____ Thu. _____ _____

Backline Telephone Number *(not for publication)*: Fri. _____ _____

_____ Sat. _____ _____

Fax: _____ Sun. _____ _____

After Hours Telephone: _____

Office Access: Other languages spoken: _____

☐ Bus ☐ Other Public Transportation _____

Is your office Handicap Accessible? ☐ Yes ☐ No

Credentialing Contact: _____ Ph: _____ Fax: _____ Email: _____

Office Manager: _____ Ph: _____ Fax: _____ Email: _____

AvMed requires written notification of address, phone, fax, and Tax ID changes. Notification of Tax ID changes must be submitted with a revised W-9 form as registered with the Internal Revenue Service. Failure to submit notification of changes immediately will result in a delay of claims adjudication.

Additional Location #1

Billing only ☐ Administration only ☐ Other office where patients are treated

Group Practice Name *(if applicable)*: _____

Tax ID Number: _____

Street: _____ Office Hours: What hours/days are you available to see patients:

City: _____ Mon. _____ _____

State: _____ Zip: _____ Tue. _____ _____

County: _____ Wed. _____ _____

Telephone: _____ Thu. _____ _____

Backline Telephone Number *(not for publication)*: Fri. _____ _____

_____ Sat. _____ _____

Fax: _____ Sun. _____ _____

After Hours Telephone: _____

Credentialing Contact: _____ Ph: _____ Fax: _____ Email: _____

Office Manager: _____ Ph: _____ Fax: _____ Email: _____

Additional Location #2

Billing only ☐ Administration only ☐ Other office where patients are treated

Group Practice Name *(if applicable)*: _____

Tax ID Number: _____

Street: _____ Office Hours: What hours/days are you available to see patients:

City: _____ Mon. _____ _____

State: _____ Zip: _____ Tue. _____ _____

County: _____ Wed. _____ _____

Telephone: _____ Thu. _____ _____

Backline Telephone Number *(not for publication)*: Fri. _____ _____

_____ Sat. _____ _____

Fax: _____ Sun. _____ _____

After Hours Telephone: _____

Credentialing Contact: _____ Ph: _____ Fax: _____ Email: _____

Office Manager: _____ Ph: _____ Fax: _____ Email: _____

OFFICE / PRACTICE INFORMATION (cont'd.)

Additional Location #3 ***(Please attach additional sheet for other locations)***

☐ Billing only ☐ Administration only ☐ Other office where patients are treated

Group Practice Name *(if applicable)*: _____

Tax ID Number: _____

Street: _____ Office Hours: What hours/days are you available to see patients:

City: _____ Mon. _____ _____

State: _____ Zip: _____ Tue. _____ _____

County: _____ Wed. _____ _____

Telephone: _____ Thu. _____ _____

Backline Telephone Number *(not for publication)*: Fri. _____ _____

_____ Sat. _____ _____

Fax: _____ Sun. _____ _____

After Hours Telephone: _____

Credentialing Contact: _____ Ph: _____ Fax: _____ Email: _____

Office Manager: _____ Ph: _____ Fax: _____ Email: _____

Please list covering practitioner(s).

Covering practitioners should be participating with AvMed, or be in the process of becoming practitioners in the AvMed Health Plans Network (please attach separate sheet as needed).

1. Name: _____
   Street: _____ City: _____ State: _____ Zip: _____
   Telephone: _____
   Hospital Affiliations _____

2. Name: _____
   Street: _____ City: _____ State: _____ Zip: _____
   Telephone: _____
   Hospital Affiliations _____

3. Name: _____
   Street: _____ City: _____ State: _____ Zip: _____
   Telephone: _____
   Hospital Affiliations _____

OFFICE / PRACTICE INFORMATION (cont'd.)

Do you perform surgery in your office? ☐ Yes ☐ No If 'Yes', please list the types of surgery: _____

_____

Do you have any allied health professionals providing patient care in your practice (i.e., physician assistant, advanced registered nurse practitioners)?

☐ Yes ☐ No

If yes, do you allow patients to be cared for by allied health professionals when you or your associates are not in the office?

☐ Yes ☐ No

Do you maintain their current credentials? ☐ Yes ☐ No

Do you maintain their current licenses? ☐ Yes ☐ No

Do you maintain their current malpractice information? ☐ Yes ☐ No

Do you recredential them? ☐ Yes ☐ No ☐ annually or ☐ biannually?

If you have ARNP's, do you file protocols annually with the Board of Medicine and Nursing? ☐ Yes ☐ No

Please identify all allied health professionals in your practice:

1. Name: _____ Type: _____

   Florida Professional License Number: _____ Expiration Date: _____

2. Name: _____ Type: _____

   Florida Professional License Number: _____ Expiration Date: _____

3. Name: _____ Type: _____

   Florida Professional License Number: _____ Expiration Date: _____

4. Name: _____ Type: _____

   Florida Professional License Number: _____ Expiration Date:

Does your practice provide laboratory services? ☐ Yes ☐ No

If yes, please describe the type(s) of services provided: _____

_____

Are you in compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA)? ☐ Yes ☐ No

If yes, please provide a copy of your Certificate of Waiver or Certificate of Registration.

CLIA Certification number: _____

What outside labs, if any, do you use? _____

_____

Does your practice provide radiology or imaging services? ☐ Yes ☐ No

If yes, please describe the type(s) of services provided: _____

_____

_____

What outside radiology facility do you use? _____

OFFICE / PRACTICE INFORMATION (cont'd.)

Do you perform any other types of procedures in your office utilizing equipment which requires proper instruction and inspection (i.e. pulmonary function tests, etc.)? ☐ Yes ☐ No

If yes, please list the procedures: _____

_____

_____

Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic, or testing center, hospital, surgicenter, or other business dealing with the provision of ancillary health services, equipment or supplies?

☐ Yes ☐ No

If yes, please provide the following information: (*If others, please attach separate sheets.)*

Name of organization: _____ Tax ID #: _____ Telephone _____

Street _____ City: _____ State: _____ Zip: _____

Type of organization: _____ Size of organization: _____ % of business owned: _____

Invested by practitioners or hospitals: _____ Invested by applicant: _____

Type of business interest (i.e. owner, partner, or investor): _____

PROFESSIONAL LICENSE

List all current licenses

State: _____ Type: _____

Number: _____ Original Date of Issue: _____

Expiration Date: _____

State: _____ Type: _____

Number: _____ Original Date of Issue: _____

Expiration Date: _____

FEDERAL DEA REGISTRATION

Federal DEA Number: _____ Date Issued: _____

Expiration Date: _____

BOARD CERTIFICATION

1. Are you Board Certified? ☐Yes ☐No (If No, please respond to 1b. below)

1a. List the names of specialty boards by which you are certified.

Specialty board	*Date of initial certification*	*Date of most recent certification*	*Expiration Date*
Specialty board	*Date of initial certification*	*Date of most recent certification*	*Expiration Date*

1b. **If not certified,** have you applied for the certification examination? ☐Yes ☐No

Have you been accepted to take the certification examination? ☐Yes ☐No

If no, do you intend to apply for the certification examination? ☐Yes ☐No

EDUCATION

Schools

Medical/Professional School	*Degree*	*From (MM/YY)*	*To (MM/YY)*
Medical/Professional School	*Degree*	*From (MM/YY)*	*To (MM/YY)*

If foreign medical school graduate, ECFMG #: _____ **Date** _____

Internships ***(list every internship begun or completed)***

Institution	*Address*	*Department/Specialty*	*From (MM/YY)*	*To (MM/YY)*
Institution	*Address*	*Department/Specialty*	*From (MM/YY)*	*To (MM/YY)*
Institution	*Address*	*Department/Specialty*	*From (MM/YY)*	*To (MM/YY)*

Residencies ***(list every Residency begun or completed)***

Institution	*Address*	*Department/Specialty*	*From (MM/YY)*	*To (MM/YY)*
Institution	*Address*	*Department/Specialty*	*From (MM/YY)*	*To (MM/YY)*
Institution	*Address*	*Department/Specialty*	*From (MM/YY)*	*To (MM/YY)*

Fellowships *(list every Fellowship begun or completed)*

Institution	*Address*	*Department/Specialty*	*From (MM/YY)*	*To (MM/YY)*
Institution	*Address*	*Department/Specialty*	*From (MM/YY)*	*To (MM/YY)*
Institution	*Address*	*Department/Specialty*	*From (MM/YY)*	*To (MM/YY)*

WORK HISTORY

Please provide relevant work history, beginning with current practice.

For all gaps in practice history greater than six months, please explain below.

Relevant experience includes work as a health professional.

Practice/Facility Name:	Location (City and State)	From (Month/Year)	To (Month/Year)
Practice/Facility Name:	Location (City and State)	From (Month/Year)	To (Month/Year)
Practice/Facility Name:	Location (City and State)	From (Month/Year)	To (Month/Year)
Practice/Facility Name:	Location (City and State)	From (Month/Year)	To (Month/Year)
Practice/Facility Name:	Location (City and State)	From (Month/Year)	To (Month/Year)
Practice/Facility Name:	Location (City and State)	From (Month/Year)	To (Month/Year)
Practice/Facility Name:	Location (City and State)	From (Month/Year)	To (Month/Year)
Practice/Facility Name:	Location (City and State)	From (Month/Year)	To (Month/Year)
Practice/Facility Name:	Location (City and State)	From (Month/Year)	To (Month/Year)

GAPS GREATER THAN 6 MONTHS:

From *(Month/Year)*	**To** *(Month/Year)*	**Explanation**

HOSPITAL AND MEDICAL STAFF ACTIVITIES

(Not applicable for Allied, Hospital-Based, and Non-Admitting Specialty)

List all hospitals where you currently hold privileges (List Primary Admitting first)

Hospital Name	Department	Type of Privileges	Date of Privileges

If you do not have admitting privileges, please indicate who will admit on your behalf.

_____

_____

PROFESSIONAL LIABILITY

Insurance

Identify present carrier. **If none, please submit a signed and dated Financial Responsibility Form****

Carrier Name: _____

Policy #: _____

Policy Period: _____ _____

From **To**

Levels of Coverage: _____

***** To request a blank Financial Responsibility Form, please call (800) 346-0231 x40544***

DISCLOSURE QUESTIONS

LICENSURE

1. Has your license to practice in any state ever been relinquished, denied, limited, suspended, or revoked? ☐Yes* ☐No
2. Have you ever voluntarily relinquished or been asked to surrender your license? ☐Yes* ☐No
3. Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (e.g., Medicare or Medicaid)? ☐Yes* ☐No
4. Have you ever been the subject of an investigation by any private, federal, or state agency? ☐Yes* ☐No
   4a. Are any such investigations pending? ☐Yes* ☐No
5. Have any disciplinary actions or investigations been initiated against you by any state regulatory agency or medical society? ☐Yes* ☐No
   5a. Are any such investigations pending? ☐Yes* ☐No
6. Have you ever been disciplined or given a letter of guidance by any state regulatory agency or medical society? ☐Yes* ☐No

DEA

1. Has your DEA registration ever been limited, suspended, revoked, restricted, or denied? ☐Yes* ☐No
2. Have you ever voluntarily relinquished your DEA registration? ☐Yes* ☐No

BOARD CERTIFICATON

1. Has your board status ever been — on a voluntary or involuntary basis — denied, revoked, suspended, reduced, limited, placed on probation, or relinquished for disciplinary reasons? ☐Yes* ☐No

PRIVILEGES

1. Has your membership status, clinical privileges, and/or application ever been denied, suspended, reduced, or not renewed at any hospital, managed care organization, or any other institution? ☐Yes* ☐No
2. Have you ever voluntarily relinquished membership status and/or clinical privileges at any hospital, managed care organization, or any other institution? ☐Yes* ☐No
3. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the medical staff before a decision was made by a hospital's or healthcare facility's governing board? ☐Yes* ☐No
4. Have you ever been the subject of disciplinary proceedings or investigations at any hospital, healthcare facility, or managed care organization? ☐Yes* ☐No

PERSONAL HISTORY

1. Do you have a physical or mental condition that could affect your ability to exercise the privileges requested or would require an accommodation for you to exercise those privileges safely and competently? ☐Yes* ☐No
2. Do you have any current or prior physical or mental condition(s) that include, but are not limited to, alcohol or drug dependency, participation in aftercare programs for alcohol or drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills? ☐Yes* ☐No
3. Are you currently using any illegal drugs or controlled or dangerous substances? ☐Yes* ☐No
4. Have you ever been convicted of a crime (other than a minor traffic offense) or a felony, or do you have any criminal or civil charges pending against you or your practice? ☐Yes* ☐No
5. Have you ever been named as a defendant in any criminal proceeding or entered a plea for any criminal offense, including but not limited to, domestic violence or driving while under the influence? ☐Yes* ☐No
6. Have you ever been arrested for or charged with a sexual offense? ☐Yes* ☐No
7. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank? ☐Yes* ☐No

**** For any Yes responses to questions on this page, please include a detailed explanation.***

PROFESSIONAL LIABILTY

1. Has your present professional liability insurance carrier excluded any specific area of practice (e.g., obstetrics, surgery) from your coverage? ☐Yes ☐No

   If yes, list the excluded clinical activities: _____

   Provide a full explanation on a separate sheet, including the name of the carrier, the date, and specific information concerning any limitation.

2. Has your professional liability insurance coverage ever been terminated by action of any insurance company? ☐Yes ☐No

   If yes, state when and by what company. _____

3. Have any professional liability claims or suits, including dismissals, ever been filed against you? ☐Yes* ☐No

4. Have any professional liability suits been filed against you that are presently pending? ☐Yes* ☐No

5. Have any judgments or settlements been made against you in professional liability cases? ☐Yes* ☐No

**** For any Yes responses to questions 3, 4 or 5 above, please complete the attached Professional Liability Claims form.***

Required Documents

Copies of the following documents are required with this application in order to facilitate the credentialing process. Your application will not be processed without this information.

- ☐ AvMed Release of Information Form.
- ☐ Current Malpractice Insurance Face Sheet indicating effective dates and amount of coverage, or other means of compliance with state financial responsibility requirements.
- ☐ CV with Current Work History in month/year format.
- ☐ GP's only: CME Certificates for the past 2 years
- ☐ Narratives for positive responses (where indicated)
- ☐ Professional Liability Claims Form(s) (if applicable)

Affirmation

I represent that information provided in or attached to this application is correct and complete. I understand that a condition of this application is that any misrepresentation, misstatement, or ommission from this application—whether intentional or not—is cause for automatic and immediate rejection of this application and may result in the denial of appointment and clinical privileges. Upon subsequent discovery of such misrepresentation, misstatement, or omission, AvMed Health Plans may immediately terminate my appointment and privileges. I agree to provide AvMed Health Plans with updated information regarding all questions on the application form as new information becomes available. I also agree to provide AvMed Health Plans information that it or one of its authorized representatives may request. Failure to produce any requested information will prevent my application from being processed.

_____	_____	_____
Applicant's signature	*Date*	*Applicant's Name (printed or typed)*

AvMed

AUTHORIZATION FOR INVESTIGATION AND RELEASE OF INFORMATION

In order for AvMed Health Plan to verify, assess, or update my professional credentials, I:

- Authorize AvMed to make inquiries concerning such information about me to my previous employer(s), current employer, educational institutions, State Licensing boards, professional liability insurance carriers, American Medical Association, Federation of state Medical Boards, National Practitioner Data Bank, hospitals, health care facilities, health maintenance organizations, preferred provider organizations, and other professional organizations and/or persons, agencies, organizations, or institutions listed by me as references, and to any other appropriate sources to whom AvMed may be referred by those contacted;
- Authorize release of such information and copies of related records and/or documents to AvMed officials;
- Release from liability all those who provide information to AvMed in good faith and without malice in response to such inquiries;
- Authorize AvMed to disclose to such persons, employers, institutions, boards, or agencies identifying and other information about me sufficient to enable AvMed to make such inquiries.

I understand that:

- I have the right to review information obtained by AvMed during the primary verification process;
- This information is limited to data that I can obtain from the same primary sources utilized by AvMed (i.e., state licensing boards, National Practitioner Data Bank);
- I do not have the right to review information that is peer review protected (i.e., references, recommendations);
- Requests for review of information must be in writing, signed by me (original signature required), and submitted to the Credentialing Department;
- In the event that I discover erroneous information while reviewing data requested from the Credentialing Department, I will be afforded fifteen (15) calendar days from the receipt of the data in which to advise the Credentialing Department as to the correct information. I will be afforded an additional thirty (30) calendar days to correct the information with the appropriate agency(ies) and advise the Credentialing Department;
- If I was denied credentialing or recredentialing based on erroneous information, I will be afforded the right to submit corrected information for reconsideration by the Credentialing Committee no later than sixty (60) calendar days after receipt of the denial notice.
- I have the right, upon request, to be informed of the status of my application. Inquiries should be made by phone to AvMed Provider Services Call Center at 800-452-8633.

Signature _____ Date _____

Printed Name _____

PROFESSIONAL LIABILITY CLAIMS

Please list all past or current professional liability claims which have been filed against you or your practice. (Photocopy this page as needed for each claim.)

Date of Occurance: _____ Date Claim Filed: _____

Professional Liability Carrier Involved: _____

Patient Name: _____

Claimant / Plaintiff, if other than patient: _____

Describe your role in the claim: ☐ Primary Defendant ☐ Co-Defendant

Describe the allegations against you:

_____

_____

Clinical narrative describing your care and treatment of the patient:

_____

_____

_____

_____

_____

_____

_____

Present status of claim: ☐ Closed ☐ Open

If closed, please indicate the method:

☐ Verdict or judgment for the plaintiff in the amount of $ _____
The portion of the verdict or judgment attributed to me was $ _____
Verdict / Judgment Date _____

☐ Settled out of court for $ _____
The portion of the settlement paid on my behalf was $ _____
Settlement Date _____

☐ Dismissed by the Court (attach a copy of the dismissal)

☐ The claimant/plaintiff voluntarily withdrew the claim (attach documentation)

☐ The claimant/plaintiff voluntarily dismissed me from the lawsuit (attach a copy of the dismissal)