



PLEASE NOTE!

This Credentialing Application is PART TWO of Physician United Plan's Credentialing Process. Please contact PUP Provider Relations at 866-427-9152 or via email to vharrison@pupcorp.com to request PART ONE: Contract, **if available for specialty offered.**

This application is intended for physicians without CAQH access; for facility applications, please see website at www.pupcorp.com or contact PUP Provider Relations.

Please submit application and contract to:

Veronica Harrison, PUP Contracting
Physicians United Plan Inc.
1124 1st Street South
Winter Haven, FL 33880



PHYSICIAN CREDENTIALING APPLICATION

Provider Name: _____ **Specialty:** _____

To initiate your request for participation as a provider for *Physicians United Plan, Inc.*, the following information must be submitted to the **Provider Relations Department**. **Please print clearly or type** to ensure that we can process your request efficiently. Should your response(s) warrant the submission of additional detail, explanation or documentation, please attach such to the application and reference to which section/question it applies. Missing information will delay the credentialing process.

All information must be completed in full with the application signed and dated by applicant. Indicate any areas that do not apply with N/A.

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| CREDENTIALING APPLICATION CHECKLIST |
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All items below MUST be provided and checked accordingly in order for the credentialing package to be accepted.

- _____ Credentialing Application - ALL sections. **Complete and legible.**
- _____ Current Curriculum Vitae (if any information has been omitted in the application).
- _____ Professional Historical Data Questionnaire. **All questions answered, signed and dated.**
- _____ For all "yes" answers please provide explanation(s).
- _____ Pending Malpractice Cases - copy of Complaint Notice of Intent with Affidavit.
- _____ Attestation, Consent and Release Form in application. **Sign and date.**
- _____ State Professional License. **Current copy.**
- _____ Federal DEA Certificate and State Controlled Substance Certificates. **Current copy.**
- _____ Malpractice Insurance Certificate with coverage of at least \$250,000 / \$750,000. **Current copy of face sheet.** If you are following the state statute for no malpractice insurance, **provide letter of credit.**
- _____ All Gastroenterology Specialists **must** be affiliated with an Ambulatory Surgery Center.
- _____ If there are any surgical procedures performed in the office, a copy of the AHCA certificate indicating the level of surgical procedures authorized to perform.
- _____ **Copy of completed W-9 Form.**
- _____ **Copy of sample claim forms with provider name, tax identification number and address included – paper and electronic. Please do NOT send a blank form.**

PROVIDER INFORMATION

PLEASE PRINT OR TYPE:

Privileges Requested: _____ (specialty which is being contracted)

Provider Name: _____
Last First Middle Degree

Date of Birth: _____ Place of Birth: _____ Gender: Male Female

Languages Spoken: _____ Maiden Name: _____
(Other than English)

Mailing Address _____
Street City State Zip

Residence Address _____
Street City State Zip

Telephone _____ Beeper _____

Cell _____ Tax Identification # _____

Social Security # _____ - _____ - _____ FL State License # _____

Medicare Provider # _____ Medicaid Provider # _____

DEA License # _____ UPIN # _____ ECFMG # _____
NPI # _____

OFFICE DEMOGRAPHICS

ATTACH A SEPARATE SHEET IF ADDITIONAL LOCATIONS

Location 1

Location 2

County _____

County _____

Group Name _____

Group Name _____

Street Address _____

Street Address _____

Suite # _____

Suite # _____

City, State, Zip _____

City, State, Zip _____

Office Telephone Number _____

Office Telephone Number _____

Fax Number _____

Fax Number _____

Office Back Line _____

Office Back Line _____

Age Group Serviced: _____

Age Group Serviced: _____

Office Hours:
Mon _____ Tue _____ Wed _____
Thu _____ Fri _____ Sat _____
Sun _____

Office Hours:
Mon _____ Tue _____ Wed _____
Thu _____ Fri _____ Sat _____
Sun _____

List ALL physicians and other professionals providing services at each location (include: ARNPs, PAs, etc.)

Location 1

Location 2

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Are you affiliated with any Ambulatory Surgical Centers?
If yes, please list below.

Yes No

Facility Name Phone Number

Address City State Zip Code

Facility Name Phone Number

Address City State Zip Code

Do you perform surgical or any other types of procedures in your office? Yes No

If yes, please list below. Also, you are required to include a copy of the **AHCA certificate** indicating the level of surgical procedures authorized to perform.

PRIMARY CARE PROVIDERS MUST COMPLETE THIS STATEMENT:

The total active patient load (patients who access my services three (3) or more times in a twelve (12) month period) for which I have personal responsibility is approximately _____.

COVERAGE

Every physician must arrange for twenty-four (24) hour coverage. It is required that your on-call coverage physician(s) be a participating provider fully credentialed or in the process of being credentialed with **Physicians United Plan**.

Name of Covering Physician _____

Telephone Number (_____) _____

BOARD CERTIFICATION

Please indicate below either General Practice or Specialties for which you are Board Trained* or Board Certified:

Primary Specialty: _____ BT BC

Subspecialty: _____ BT BC

Subspecialty: _____ BT BC

*Board Trained: Successful training in such areas and for such duration that fulfills the entire academic requirements to be eligible for the identified Board examination.

If you are not Board Certified, on what date will you be (or were) first eligible to complete your Board examination? _____
Date

EDUCATION

Please list all medical education and training.

| Name | State | Degree | Years |
|----------------------|-------|--------|---------------------|
| Medical School _____ | | | From _____ To _____ |
| Internship _____ | | | From _____ To _____ |
| Residency _____ | | | From _____ To _____ |
| Residency _____ | | | From _____ To _____ |
| Fellowship _____ | | | From _____ To _____ |

WORK HISTORY / PRACTICE EXPERIENCE

Please list employers since medical school graduation in chronological order. Current CV is acceptable. Explanation is required for gaps greater than 60 days.

Employer Name From To

Address City State Zip Code

Employer Name From To

Address City State Zip Code

Employer Name From To

Address City State Zip Code

HOSPITAL AFFILIATIONS

List all hospitals at which you have Medical Staff Privileges. If you do not have privileges with a hospital, you must submit a signed letter from another physician accepting responsibility for the admission and follow-up care of patients in a hospital setting on your behalf.

| Hospital Name / Location | Privilege Status |
|--------------------------|------------------|
| | |
| | |
| | |

PROFESSIONAL HISTORICAL DATA QUESTIONNAIRE

If you answer **yes** to any of the questions below, please complete the form on the following page or provide a letter of explanation with clinical details, settlement amounts and dates with this application.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily limited, suspended or revoked? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has your DEA certificate ever been involuntarily limited, revoked or suspended? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have there ever been any complaints or charges filed against you by the Department of Health, Board of Medicine, Agency for Health Care Administration (AHCA), HHS or any applicable regulating agency or have you ever received a Letter of Guidance, fine suspension, reprimand, or other disciplinary action from any such agencies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been indicted, convicted of a crime or charged with a violation of the Harrison Narcotics Act? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been or are at present involved in a malpractice suit? Have there been any professional liability claims filed against you? Has any malpractice carrier or similar insuring agency ever made an out-of-court settlement or paid judgment on a professional liability claim on your behalf? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has your malpractice coverage ever been denied, involuntarily limited or revoked? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been expelled, excluded or suspended from any federal program or from service reimbursement under Medicare or Medicaid? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been convicted or pled "nolo contendere" to a criminal offense related to Medicare, Medicaid or any other federal program? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has any hospital, managed care organization or other similar credentialing body ever censured, restricted, suspended or revoked your privileges? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you presently have, or have you ever had a physical or mental health condition, including alcohol or drug dependence, that may affect or that may reasonably be expected to progress within the next three (3) years to the point of affecting, your ability to perform the clinical privileges requested or other medical duties? | <input type="checkbox"/> | <input type="checkbox"/> |

I certify that I have answered the questions listed on this questionnaire truthfully, correctly and completely to the best of my knowledge:

Applicant's Signature: _____

Print Name: _____ Date: _____

ATTESTATION, CONSENT & RELEASE FORM

I, the undersigned, hereby acknowledge that the information submitted on this application is correct and complete to the best of my knowledge and belief. I fully understand that any significant misstatements or omissions on this application constitute cause for denial of privileges.

I understand and agree that I, as a Potential Provider*, have the responsibility of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and resolving any doubts about such qualifications.

I further understand that an investigative report may be made as to my professional abilities, character, and general reputation. I authorize all past employers, schools, Provider Recovery Network, hospitals, persons, financial institutions and organizations having relevant information to provide it to **Physicians United Plan, Inc.** and its affiliates for its use in making a decision on this application. I hereby release from liability all individuals and organizations who provide information to **Physicians United Plan, Inc.** and its affiliates or its staff, in good faith and without malice, concerning my professional competence, ethics, character credentials and other qualifications for provider status, and I hereby consent to the release of such information.

I understand and agree that the information submitted by me on this form, and the information provided to **Physicians United Plan, Inc.**, its affiliates, its officers, directors, employees and representatives may be used:

1. to evaluate my credentials for provider status; and
2. to re-evaluate my credentials at any time during my provider's relationship with **Physicians United Plan, Inc.** and its affiliates.

I hereby acknowledge that this Attestation, Consent and Release Form will be valid for a period of three (3) years from the date it is signed by me, and that a photocopy or fax will serve as an original.

* Potential Provider is defined as any and all parties who wish to be considered for participation with Physicians United Plan, Inc. and its affiliates, as a Primary Care physician or as a Specialty Care physician.

Name (Printed)

Signature

Date

Degree