



PLEASE NOTE!

This Facility 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 facilities; for applications for physicians without CAQH access, 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



Physicians United Plan FACILITY APPLICATION

(Please Type or Print Legibly)

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Select applicable specialty or services to be provided to PUP members (directory listing): Additional information attached

- | | |
|---|---|
| <input type="checkbox"/> Ambulatory Surgical Center | <input type="checkbox"/> Diagnostic Imaging Center |
| <input type="checkbox"/> DME: <input type="checkbox"/> medical <input type="checkbox"/> diabetic <input type="checkbox"/> respiratory | <input type="checkbox"/> Home Health Agency |
| <input type="checkbox"/> Infusion Therapy | <input type="checkbox"/> Orthotic & Prosthetics |
| <input type="checkbox"/> Outpatient Diagnostic Lab | <input type="checkbox"/> Outpatient Rehab Facility (services provided: _____) |
| <input type="checkbox"/> Skilled Nursing Facility | <input type="checkbox"/> Sleep Diagnostics |
| <input type="checkbox"/> Urgent Care | <input type="checkbox"/> Walk In Clinic |
| <input type="checkbox"/> Other (Type: _____) see last page for specific list of services | |

Facility Name

County (or counties serviced – see last page for details)

PRIMARY FACILITY ADDRESS

Total number of Locations: _____

Street, Suite

State License Number

City, State Zip

Tax ID Number

Main Telephone Number

Medicare Provider Number

NPI Number

Fax Number

Chief Administrator (Name & Title)

Tax Status and type of organization control:
 Public/Government Private/Non-Profit Investor/For Profit

Contact Person (Name & Title)

When was your:
Organization established? _____ Facility opened? _____

BILLING ADDRESS

Street, Suite

List all Owners/Investors

Percent of Stock

City, State Zip

Main Telephone Number

Fax Number

Contact Person (Name & Title)

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Indicated your facility's accrediting agency by checking the appropriate box below:

- | | |
|--|---|
| <input type="checkbox"/> Accreditation Association for Ambulatory Health Care (AAAHCC) | <input type="checkbox"/> American Osteopathic Association (AAA) |
| <input type="checkbox"/> Community Health Accreditation Program (CHAP) | <input type="checkbox"/> American College of Radiology (ACR) |
| <input type="checkbox"/> Joint Commission on Accreditation of HealthCare Org (JCAHO) | |
| <input type="checkbox"/> Commission on Accreditation of Rehabilitation Facilities (CARF) | |
| <input type="checkbox"/> Other _____ | |

Submit a copy of current accreditation letter and certificate

Date of last accreditation review: _____

Duration of accreditation/next review date: _____

Were there any contingencies or significant recommendation(s) from your last survey? No Yes – if yes, please describe and submit an action plan for addressing recommendation(s): _____

Not Accredited – if not accredited, what is your expected date of accreditation? _____



Physicians United Plan

F A C I L I T Y R E V I E W	<p>Number of prior judgements or settlements against the facility in the past five years: _____ (If none, please write none.)</p> <p>Please list, by year, the number of suits in which you were a defendant with allegations at malpractice for the past ten years. Also indicate if a case is pending, or if there was a settlement or judgment and the amount of same.</p> <p>Has the facility had:</p> <p>1) Revocations or suspensions as a Medicare and Medicaid provider? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2) Malpractice liability insurance cancellation in the last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3) General liability insurance cancellation in the past five years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4) State licensing investigations or actions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>QUALITY REVIEW</p> <p>1) Are the credentials and/or certifications of professional staff members and admitting physicians verified? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2) Are the credentials and/or certifications of professional staff members and admitting physicians verified biennially thereafter? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3) Is continuing education and/or recertification required of your staff? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
E N C L O S U R E S	<p>Check below to confirm the following documents are submitted with your completed and signed application:</p> <p><input type="checkbox"/> A copy of the facility's state license to operate</p> <p><input type="checkbox"/> If applicable, a current copy of the facility's accreditation letter and certificate; <input type="checkbox"/> Not applicable</p> <p><input type="checkbox"/> If applicable, a copy of the facility's action plan addressing accreditation recommendations; <input type="checkbox"/> Not applicable</p> <p><input type="checkbox"/> Proof of current general liability and malpractice insurance coverage (the policy face sheets or certificates of insurance)</p> <p><input type="checkbox"/> Any explanation requested in this application, including a list of malpractice settlements and judgments</p> <p><input type="checkbox"/> If non-accredited, a copy of the facility's most recent HCFA evaluation (form 2567) and Quality Management Plan (Quality Assurance/Quality improvement Plan)</p> <p><input type="checkbox"/> Copy of your HCFA or UB92 (Completed)</p> <p><input type="checkbox"/> W-9</p> <p><input type="checkbox"/> Brochure if available</p> <p><input type="checkbox"/> List of additional service locations; <input type="checkbox"/> Not applicable</p> <p style="text-align: center;">INCOMPLETE APPLICATIONS (SUBMITTED WITHOUT THE REQUESTED ATTACHMENTS) WILL RESULT IN THE REJECTION OF YOUR APPLICATION OR DELAY OF CREDENTIALING/CONTRACTING.</p>
A T T E S T A T I O N	<p>All information provided on this application or in connection with this application is complete and accurate to the best of the facility's knowledge; The facility understands that this application does not entitle the facility to participation in PHYSICIANS UNITED PLAN's networks. The facility agrees that entitles providing information in good faith, pursuant to this release, shall not be liable for any act or omission related to the evaluation or verification of information contained in this application, All information submitted to PHYSICIANS UNITED PLAN by such entities will be treated as confidential, It is further understood that if the facility is accepted as a PHYSICIANS UNITED PLAN Participating Facility, it shall provide ready access and copies to PHYSICIANS UNITED PLAN, upon request, of any and all medical records that the facility maintains for any PHYSICIANS UNITED PLAN members. The facility further agrees to notify PHYSICIANS UNITED PLAN in a timely manner of any changes to the information provided on the application.</p> <p>The facility hereby authorizes any accrediting body, governmental entity, association, organization, person or insurance company to release the information requested herein and to provided confirmation of the answers contained herein to PHYSICIANS UNITED PLAN Inc., Or any affiliate or subsidiary of PHYSICIANS UNITED PLAN Inc. This authorization shall be valid for so long as the facility is a PHYSICIANS UNITED PLAN-contracted provided, A copy of the signature is as binding as the original.</p> <p>_____ Signature of Chief Administrator or Authorized Designee</p> <p style="text-align: right;">_____ Date</p> <p>_____ Print Name of Chief Administration or Authorized Designee</p> <p>_____ Facility Name</p>



Physicians United Plan

PLEASE INDICATE THE TYPE OF SERVICES YOUR FACILITY CAN PROVIDE:

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS Unit | <input type="checkbox"/> MRI Services | <input type="checkbox"/> Skilled Nursing/Long Term Care |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Neonatal | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Burn Unit | <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Telemetry |
| <input type="checkbox"/> Cardiac Cath Services | <input type="checkbox"/> Oncology Services | <input type="checkbox"/> Trauma Center |
| <input type="checkbox"/> Cardiac Rehabilitation | <input type="checkbox"/> Open Heart Surgery | <input type="checkbox"/> X-Ray/Radiation Therapy |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Organ/Tissue Transplant | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Outpatient Surgery | _____ |
| <input type="checkbox"/> Emergency Services | <input type="checkbox"/> Pediatrics | _____ |
| <input type="checkbox"/> Hemodialysis | <input type="checkbox"/> Psychiatric Services | _____ |
| <input type="checkbox"/> Home Infusion Services | <input type="checkbox"/> Rehabilitation - Inpatient | _____ |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Rehabilitation – Outpatient | _____ |
| <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Reproductive Health Services | _____ |

SERVICE LOCATIONS:

Please indicate coverage area:

Statewide (Florida) mail order

Statewide (Florida)

Primary Facility Address (from page 1) encompasses the following counties:

- | | | | | |
|----------------------------------|---------------------------------------|-------------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Alachua | <input type="checkbox"/> Lake | <input type="checkbox"/> Marion | <input type="checkbox"/> Pasco | <input type="checkbox"/> Sumter |
| <input type="checkbox"/> Brevard | <input type="checkbox"/> Hernando | <input type="checkbox"/> Orange | <input type="checkbox"/> Pinellas | |
| <input type="checkbox"/> Broward | <input type="checkbox"/> Hillsborough | <input type="checkbox"/> Osceola | <input type="checkbox"/> Polk | |
| <input type="checkbox"/> Dade | <input type="checkbox"/> Manatee | <input type="checkbox"/> Palm Beach | <input type="checkbox"/> Seminole | |

Facility Address: _____ encompasses the following counties:

- | | | | | |
|----------------------------------|---------------------------------------|-------------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Alachua | <input type="checkbox"/> Lake | <input type="checkbox"/> Marion | <input type="checkbox"/> Pasco | <input type="checkbox"/> Sumter |
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