MICHIGAN ASSOCIATION OF HEALTH PLANS
Standard Re-Appointment Application

PERSONAL INFORMATION:

Name *(as shown on license) – Last, First, Middle, Suffix and Degree*

Social Security # | Date of Birth | Gender | UPIN | NPI (National Provider Identifier)

E-mail Address | Language(s) Spoken

LICENSE INFORMATION:
Please attach copies of all current professional licenses including DEA certificates and controlled substance license(s).

MI State License Number / Date Expires | MI State Controlled Substance / Date Expires | MI State Drug Control / Date Expires

DEA Number / Date Expires | Other State / License Number / Date Expires | Other State / License Number / Date Expires

SPECIALTY INFORMATION: ***List additional specialty types on a separate sheet.***

If you have received new certifications and/or recertification, please attach copies.

☐ Include In Directory — Specialty Name — ☐ Board Certified ☐ Residency ☐ Fellowship — Date

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Is this information the same for all health plans? ☐ Yes ☐ No If no, please explain:

ADDITIONAL TRAINING AND EDUCATION:
If you have received additional training and education since appointment or last reappointment (last 3 years), attach copies of certificate(s). If you are non-board certified in your area of practice, please attach copies of CME credits for the past 3 years for your area of practice.

HOSPITAL AFFILIATION(S): ***List additional hospital affiliations on a separate sheet.***

Hospital Name, City and State — Type of Privileges: ☐ Active ☐ Courtesy ☐ Provisional ☐ Consulting ☐ Temporary ☐ Pending

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MALPRACTICE INFORMATION: ***List additional carriers on a separate sheet.***

Please attach a current copy of your malpractice facesheet from insurance carrier, which includes name(s) covered under policy, effective date(s), and amount(s) of coverage. List all other carriers within the last 3 years.

Current Carrier Name, Address, Phone, Years with Carrier, Policy Number, and Amount of Coverage

Previous Carrier Name, Address, Phone, Years with Carrier, Policy Number, and Amount of Coverage

COPY THIS PAGE FOR MORE THAN ONE OFFICE

OFFICE PRACTICE INFORMATION: *Information will be published unless box checked:* ☐

List the health plans this office location accepts: _____

_____

Provider Type: ☐ Primary Care Specialty:_____ ☐ Specialist Specialty:_____ ☐ Allied Health Specialty:_____

_____ _____
Group Practice Name (as appears on SS4 or W-9 Form) Federal Tax ID No.

_____
Address Suite City State County Zip

_____
Mailing address if different than above: newsletters, etc.

(_____) _____ (_____) _____ (_____) _____
Telephone No. Fax No. Emergency On-Call No.

(_____) _____ _____ Internet Access: ☐ Yes ☐ No
Beeper No. Office E-mail Address

Clinic Website:_____

_____ (_____) _____ (_____) _____
Office Manager Telephone No. Fax No.

_____
EDI Vendor

_____
Billing address where payments are to be sent Suite City State Zip

_____
Claims Payable to

_____
Languages other than English spoken by staff

Medicaid No. _____ Effective Dt. _____ Medicare No. _____ Effective Dt. _____

Have you "opted out" of Medicare? ☐ Yes ☐ No

Is office Handicap accessible: ☐ Yes ☐ No

List physicians practicing at this location:_____ Specialty: _____

_____ Specialty: _____

Office Hours:

	OFFICE HOURS			**PRIMARY CARE APPOINTMENT HOURS AVAILABLE FOR PATIENT CARE**	
	FROM	**TO**		**FROM**	**TO**
Monday			Monday		
Tuesday			Tuesday		
Wednesday			Wednesday		
Thursday			Thursday		
Friday			Friday		
Saturday			Saturday		
Sunday			Sunday		

Indicate the waiting time to obtain an appointment in your office for each of the following:
Routine visits _____ days Well exams _____ days Urgent problems _____ days

Do you currently? (Check response)	Yes	No		Yes	No
Place an age limit on your patients? Minimum Age: ___ Maximum Age: ___			Accept Medicare Assignment?		
			Accept Medicaid Assignment?		
Accept new patients into practice?			Have 24-hour phone coverage?		
Accept new patients by physician referral only?			Have electronic medical record keeping system?		
Place limitation on patient gender? If "Yes", I only accept : ☐ Males ☐ Females			Have capability for electronic billing? Electronic Billing Code: _____		

List current accreditations, certifications or special recognitions: ☐ NCQA ☐ JCAHO ☐ URAC ☐ OTHER: _____

ATTESTATION FORM (CONFIDENTIAL INFORMATION):

*The following questions pertain to the **LAST THREE (3) YEARS ONLY.** Provide documentation of any yes answers.*

CLAIM / LAWSUIT HISTORY - 3 YEAR HISTORY

If you answer "YES" to any of the following questions, please provide details per the attached claims information sheet. Please explain any surcharge to your professional liability coverage on a separate sheet.

Within the last three (3) years, have you ever been a defendant in a malpractice suit?	☐ Yes ☐ No
Within the last three (3) years, have any judgments been made against you or settlements been agreed to in any professional liability cases?	☐ Yes ☐ No
Are there any professional liability lawsuits pending against you at the present time?	☐ Yes ☐ No
Has your professional liability insurance ever been terminated or restricted or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?	☐ Yes ☐ No

HEALTH STATUS

If the answer to any question is "YES", reference the question on a separate sheet. Please provide a full explanation and attach.

Are you currently using any chemical substance(s), which in any way may impair or limit your ability to practice medicine with reasonable skill and safety?	☐ Yes ☐ No
Are you currently engaged in the illegal use of controlled substances?	☐ Yes ☐ No
Do you have a mental or physical condition, which in any way may impair or limit your ability to practice medicine with reasonable skill and safety with or without reasonable accommodation?	☐ Yes ☐ No

PROFESSIONAL PRACTICE

Within the last three (3) years, have any of the following been or are currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, reviewed, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state, territory or country? If "YES", provide full explanation and attach.

Medical or professional license	☐ Yes ☐ No
DEA Registration or Controlled Substance license	☐ Yes ☐ No
Hospital medical staff membership	☐ Yes ☐ No
Clinical privileges or other rights on any hospital medical staff	☐ Yes ☐ No
Employment by any hospital, institution or the military	☐ Yes ☐ No
Professional society membership	☐ Yes ☐ No
Participation in any private, federal, or state health insurance program (i.e. Medicare, CHAMPUS, Medicaid)	☐ Yes ☐ No
Participation in an HMO, PPO, or any other managed care organization	☐ Yes ☐ No
Board Certification	☐ Yes ☐ No

OTHER DISCLOSURES

Within the last three (3) years, have you been:

Convicted of any criminal offense in any jurisdiction	☐ Yes ☐ No
Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of trial, or an accelerated rehabilitation disposition of felony charges in any state, territory or country	☐ Yes ☐ No

Within the last three (3) years, have you been or are you currently:

Under audit by a Health Care Agency (i.e. Medicare, Medicaid, MDCH, or any insurance)	☐ Yes ☐ No
Under indictment for any crime	☐ Yes ☐ No
The subject of an investigation by any private, federal or state health insurance program or state, territory or country licensing board	☐ Yes ☐ No
The subject of any adverse action reports to a state or federal agency	☐ Yes ☐ No
Sanctioned by a government program or agency for any reason	☐ Yes ☐ No

Within the last three (3) years, have you either voluntarily or involuntarily:

Withdrawn your application for medical staff membership at any facility	☐ Yes ☐ No
Withdrawn your request for any clinical privileges at any facility	☐ Yes ☐ No

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Practitioner's Printed Name: _____

Practitioner's Signature: _____ Date: _____

Michigan Association of Health Plans
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CONSENT TO RELEASE OF INFORMATION

I understand that each individual Plan is responsible for the evaluation of my professional training, experience, professional conduct and judgment. All information submitted by me or on my behalf pursuant to this Consent to Release Information is true and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission related thereto may constitute cause for the summary dismissal/denial of such participation in the Plan. I understand and agree that as an applicant for participation with the Plan, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I hereby authorize the Plan(s) and its representatives to contact and/or consult with any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and professional liability carriers) which I have been affiliated, have used for liability insurance or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as references by me. I consent to the release and communication of information and documents between the Plan(s) and persons, entities or institutions in jurisdictions in which I have trained, resided, practiced, or applied for professional licensure, privileges or membership in plans for the purpose of evaluation of my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice insurance claims history.

I also authorize and direct persons contacted by the Plan(s) to provide such information regarding my character and/or professional competence and qualifications, my professional liability insurance and/or malpractice insurance claims history to representatives of the Plan(s) and I understand in doing so, I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, or institutions who, in good faith and without malice for acts performed in gathering or exchanging information in this recredentialing process. This release and hold harmless provision applies to all persons, entities and institutions who will provide and/or receive, as part of the Plans' recredentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency and mental health information.

I further authorize the release of the above information or any other information obtained from the application by a credentialing verification organization (CVO) to any health care organization designated by me or one that has entered into an agreement with the CVO where I currently have, am currently applying, or in the future will be applying for participation. I also authorize the CVO or the Plan(s) to allow my file to be reviewed by the organizations' state or national accrediting and licensing bodies.

A photocopy of this consent shall be as effective as an original when presented.

Practitioner's Printed Name: _____

Practitioner's Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____

SUPPLEMENTAL CLAIMS INFORMATION FORM

(PLEASE COMPLETE A SEPARATE FORM FOR EACH CLAIM)

N/A ☐ If no claims

Claim Number or Patient Initials: _____ Age: _____ Gender: _____

Incident Is: ☐ Pending Closed Date: _____

☐ Dismissed Date _____

☐ Settlement Date _____ $ _____

☐ Judgment Date _____ $ _____

You Are: ☐ Solo Defendant

☐ Co-Defendant With _____

☐ Other _____

Were the Settlement Terms Confidential? ☐ Yes ☐ No

Settlement/Judgment Details: _____

Amount Paid on Your Behalf: _____

Date of Incident: _____ Date Suit Filed: _____ Case No.: _____

Court: _____

Name and Address of Insurance Carrier at Time of Incident: _____

_____

Name of Additional Defendant(s): _____

_____

Explain in Detail the Plaintiff's Allegations: _____

_____

_____

Explain in Detail your Defenses to These Allegations: _____

_____

_____

Patient's Condition Post-Incident: _____

_____

_____

Whom may we consult for further legal information about the suit: _____

_____

_____

Practitioner's Printed Name: _____

Practitioner's Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____