LEON MEDICAL CENTERS HEALTH PLANS
8600 NW 41st Street, Suite 201, Doral, FL 33166
Network Operations Phone: 305-646-3776, Fax: 305-646-3781

Dear Provider,

Thank you for your interest in participating as a provider with Leon Medical Centers Health Plans. In order to comply with the credentialing guidelines of the plan, please complete, sign and date the enclosed provider application and return it with copies of the following documentation ("N/A" before an item indicates that it is not applicable to you):

_____ Current Curriculum Vitae
_____ Current Medical Professional License(s)
_____ Current DEA Certificate
_____ ECFMG Certificate
_____ Medicare # and Medicaid #
_____ Enrolled as Medicare Part D Prescriber
_____ Medical School, Internship and Residency Certificates
_____ Current Board Certification
_____ Copy of NPI and Taxonomies Numbers e-mail confirmations
_____ Current Malpractice Coverage Face Sheet
_____ *Financial Responsibility Form.* ***(enclosed)*** *If you* ***DO NOT*** *carry coverage, this form must be* ***completed****.*
_____ Copy of Valid State Driver's License
_____ Completed and signed W-9 form ***(enclosed)***
_____ Joinder for each Provider in a Group
_____ Two (2) Peer References ***(enclosed)***
_____ Scope of Privileges ***(enclosed)***

If you have any questions, please do not hesitate to contact me. Your prompt attention and cooperation will be greatly appreciated.

Sincerely,

Network Operations
Leon Medical Centers Health Plans

Initial Provider Credentialing Application

This form is for credentialing and peer review only. All information submitted herein will be kept confidential.

PRACTITIONER RIGHTS

In the event that information obtained during the verification process varies substantially from information received on or with the provider application, the Practitioner will be notified of the discrepancy by the Credentialing Department. Practitioner has the right to correct erroneous information and, upon written request, may review data obtained from any outside source used to evaluate his/her application, with the exception of peer-review protected information. A practitioner may also obtain the status of his/her application by contacting the health plan.

PERSONAL DATA

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Suffix (Jr., Sr., etc.): _____ **Maiden/Other Name Used:** _____

Degree: _____ **Social Security #:** _____ **Medicare #:** _____

NPI#: _____ **Medicaid #:** _____ **Enrolled as Medicare Part D Prescriber:** _____

Home Address (include City, State and ZIP): _____

Gender: _____ **Cell phone (required):** _____

Date of Birth: _____ **Place of Birth:** _____

Ethnicity (optional): ☐ **White** ☐ **Hispanic** ☐ **African-American** ☐ **Native American** ☐ **Asian**

Other _____

Languages (Other than English) spoken fluently: _____

PRACTICE LOCATION INFORMATION

Group Name: _____

Primary OFFICE Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____ **Fax:** _____

Office Contact: _____ **Contact E-mail:** _____

Provider Phone: _____ **Provider E-mail:** _____

Hours: **Mon.** _____ **Tue.** _____ **Wed.** _____ **Thur.** _____ **Fri.** _____

Sat. _____ **Sun.** _____

Tax ID Owner Name: _____ **Group Tax ID:** _____

Primary BILLING Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____ **Fax:** _____ **Group NPI (if applicable):** _____

Billing Contact: _____ **Contact E-mail:** _____

Contact Phone: _____ **Contact Fax:** _____

Credentialing Address: _____

City: _____ **State:** _____ **ZIP:** _____

Credentialing Contact: _____ **Contact E-mail:** _____

Contact Phone: _____ **Contact Fax:** _____

***Secondary OFFICE Address:** _____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____ **Fax:** _____ **Group NPI (if applicable):** _____

Office Contact: _____ **Contact E-mail:** _____

Contact Phone: _____ **Contact Fax:** _____

Hours: _____

***If this location bills under a different tax ID than the primary location, please provide additional tax ID and billing information in the following section. If you have more than two locations, please attach a separate sheet listing office and billing information for each location.**

Tax ID Owner Name: _____ **Group Tax ID:** _____

Secondary BILLING Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____ **Fax:** _____

Billing Contact: _____ **Contact E-mail:** _____

Contact Phone: _____ **Contact Fax:** _____

Do you employ physician extenders/allied health providers in your practice(s)? ☐ **Yes** ☐ **No**

If yes, please supply the information below for each employee you currently have under contract.

Name	License Number	Issuing State	Total Working Hours

AFTER-HOURS COVERAGE (Full name and phone number are required)

Describe your after-hours coverage arrangement, including how patients contact you or your coverage physician:

_____

_____

Covering Physicians: _____ **Phone:** _____

Covering Physicians: _____ **Phone:** _____

Answering Service: _____ **Phone:** _____ **Cellular #:** _____

SPECIALTY AND PARTICIPATION INFORMATION

Applying As: ☐ **PCP** ☐ **Specialist** ☐ **Behavioral Health** ☐ **Other (Please check all that apply)**

Primary Practice Specialty: _____ **Board Certified?:** ☐ **Yes** ☐ **No**

Board Name: _____ **Original Date of Certification:** _____ **Current Expiration Date:** _____

Practice Specialty 2: **Board Certified?:** ☐ **Yes** ☐ **No**

Board Name: _____ **Original Date of Certification:** _____ **Current Expiration Date:** _____

Practice Specialty 3: _____ **Board Certified?:** ☐ **Yes** ☐ **No**

Board Name: _____ **Original Date of Certification:** _____ **Current Expiration Date:** _____

If NOT board certified:

_____ **I have taken exam; results pending for the** _____ **Board.**

_____ **I have taken Part I and am eligible for Part II of the** _____ **Exam.**

_____ **I intend to sit for the Boards on** _____ **(date).**

_____ **I am not planning to take the Boards.**

If you perform surgery in your office, what type of anesthesia do you provide? Check all that apply:

☐ **Local** ☐ **Regional** ☐ **Conscious Sedation** ☐ **General** ☐ **None** ☐ **Other (specify):** _____

Is your office-based surgical suite licensed?: ☐ **Yes** ☐ **No** **If yes, License Number:** _____

Please attach a copy of the license.

If applying as Dentist, select: ☐ **Oral Surgeon** ☐ **General Dentistry**

If you are an Optometrist, do you hold a therapeutic certificate? ☐ **Yes** ☐ **No**

If applying as a Nurse Practitioner, Physician's Assistant or Other Allied Professional, please complete the following:

Supervising Physician: _____ **Physician's License Number:** _____

Physician Specialty: _____ **Physician Board Certified?:** ☐ **Yes** ☐ **No** ☐ **Eligible**

Is this Physician your employer?: ☐ **Yes** ☐ **No**

If no, please provide the following for this physician:

Full Address: _____

Phone: _____ **Fax:** _____

LICENSURE AND CERTIFICATIONS – Please list all license (active and inactive) for the past **5** years (attach additional sheets if necessary)

License #	License Type (Medical, DEA, etc.)	Issuing State	Expiration Date

ECFMG Number (if applicable): _____ **Issue Date:** _____

PROFESSIONAL LIABILITY PROTECTION

Current Insurance Carrier: _____ **Policy #:** _____

Complete Mailing Address: _____

Phone: _____ **Fax:** _____ **Original Effective Date:** _____

Per Claim Amount: _____ **Aggregate Amount:** _____ **Expiration Date:** _____

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference this section.

If you have had professional liability carriers in the last five years other than the one listed above, please list them below:

Name of Carrier: _____ **Policy #:** _____

Complete Mailing Address: _____

From: _____ **To:** _____

Name of Carrier: _____ **Policy #:** _____

Complete Mailing Address: _____

From: _____ **To:** _____

If you had additional carriers, please attach information regarding these carriers on a separate sheet.

For physicians practicing in FLORIDA, please select one of the following regarding your professional liability:

_____ **Professional liability coverage of at least $250,000 per claim and $750,000 aggregate. (Please enclose a copy of the policy face sheet.)**

_____ **Irrevocable letter of credit at least $250,000 per claim and $750,000 aggregate. (Please enclose a copy of the letter.)**

_____ **Escrow account for at least $250,000 per claim and $750,000 aggregate. (Please enclose a copy of the documents establishing the escrow account.)**

_____ **I have elected not to carry medical malpractice insurance. However, I agree to be personally responsible for the payment of any settlement or final judgment up to $250,000, including all court fees and accrued interest for which the physician is responsible. (Please enclose a copy of the completed certificate of financial responsibility filed with the Florida Department of Professional Regulation.)**

EDUCATION AND TRAINING INFORMATION

UNDERGRADUATE EDUCATION

College or University: _____ **Degree:** _____

City/State/Country: _____ **Graduation Date:** _____

GRADUATE EDUCATION

College or University: _____ **Degree:** _____

City/State/Country: _____ **Graduation Date:** _____

MEDICAL SCHOOL

College or University: _____ **Degree:** _____

City/State/Country: _____ **Graduation Date:** _____

INTERNSHIP

Institution: _____ **Specialty:** _____

City/State/Country: _____ **To/From:** _____

Program Director: _____ **Phone:** _____

RESIDENCY

Institution: _____ **Specialty:** _____

City/State/Country: _____ **To/From:** _____

Program Director: _____ **Phone:** _____

FELLOWSHIP #1

Institution: _____ **Specialty:** _____

City/State/Country: _____ **To/From:** _____

Program Director: _____ **Phone:** _____

FELLOWSHIP #2

Institution: _____ **Specialty:** _____

City/State/Country: _____ **To/From:** _____

Program Director: _____ **Phone:** _____

Please attach additional sheets if necessary to list all Internship, Residency and Fellowship information.

CLINICAL PRIVILEGES

Do you provide inpatient care? ☐ **Yes** ☐ **No**

If no, who admits for you? Name: _____

Contact Phone: _____ **Hospital:** _____

If yes, please list below all hospitals or ambulatory surgical centers where you have admitting privileges:

Facility Name	Admitting Category

WORK HISTORY – Please either complete the following listing all work history for the past five (5) years or attach a copy of your Curriculum Vitae containing all your work history. Please attach additional sheets if necessary to list all employment information.

Employer Name	Location (City/State)	Position Held	To/From (month + year)

PROFESSIONAL DISCLOSURE

ADVERSE OR OTHER ACTIONS

Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? ☐ Yes ☐ No

Have you ever been reprimanded and/or fined or been the subject of a complaint, and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers? ☐ Yes ☐ No

Have you lost any board certification(s) and/or failed to recertify? ☐ Yes ☐ No

Have you been examined by a Certifying Board but failed to pass? ☐ Yes ☐ No

Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank? ☐ Yes ☐ No

Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? ☐ Yes ☐ No

Have you or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed? ☐ Yes ☐ No

Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? ☐ Yes ☐ No

Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license? ☐ Yes ☐ No

Have you ever voluntarily withdrawn to avoid an investigation by or been reprimanded, censured, excluded, suspended, and/or disqualified from participating in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs or is any such issue currently pending? ☐ Yes ☐ No

Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues or are such charges currently pending? ☐ Yes ☐ No

Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization (e.g., hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO) or are any such actions pending? ☐ Yes ☐ No

Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision? ☐ Yes ☐ No

PROFESSIONAL LIABILITY ACTIONS

Have any professional liability judgments ever been entered against you? ☐ **Yes** ☐ **No**

Have any professional liability claim settlements ever been paid by you and/or paid on your behalf? ☐ **Yes** ☐ **No**

Are there any currently pending professional liability suits, actions and/or claims filed against you? ☐ **Yes** ☐ **No**

Has any person or entity ever been sued for your clinical actions? ☐ **Yes** ☐ **No**

LIABILITY INSURANCE

Have you ever been denied or have you voluntarily relinquished your professional liability insurance coverage, and/or have you had your professional liability insurance coverage canceled, non-renewed or limits reduced? ☐ **Yes** ☐ **No**

CRIMINAL ACTIONS

Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country, and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country? ☐ **Yes** ☐ **No**

Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse? ☐ **Yes** ☐ **No**

MEDICAL CONDITION

Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety? ☐ **Yes** ☐ **No**

CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

Are you currently engaged in illegal use of any legal or illegal substances? ☐ **Yes** ☐ **No**

Do you currently overuse and/or abuse alcohol or any other controlled substances? ☐ **Yes** ☐ **No**

If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety? ☐ **Yes** ☐ **No**

Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse? ☐ **Yes** ☐ **No**

INVESTMENTS

In the last five (5) years have you and/or a member of your family purchased or made an investment in (other than securities of a publicly traded company) or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, and/or other business dealing with the provision of ancillary health services, equipment or supplies? ☐ **Yes** ☐ **No**

If Yes, please provide explanation:

MALPRACTICE CLAIM INFORMATION

Please provide pertinent information on all professional liability claims which are currently open or resulted in a settlement or judgment paid by you or on your behalf within the past five (5) years. ***If there are no claims settled or pending, please check the N/A below.***

☐ Not Applicable

Name(s) of Plaintiff(s): _____

_____

Name(s) of Defendant(s): _____

_____

Date of Incident: _____ **Date Suit Filed:** _____

What was your involvement in caring for the Plaintiff (Medical Details):

_____

_____

_____

_____

What was the Plaintiff's complaint?:

_____

_____

_____

_____

Status of Case: ☐ **Resolved** ☐ **Pending**

If Resolved

Date resolved: _____

Resolution (select one):

_____ **Dismissal without payment on your behalf**

_____ **Settlement before trial**

What was the decision?: _____

_____

Amount paid to Plaintiff on your behalf: _____

Please attach additional relevant information about this case to this sheet.

ATTESTATION / INFORMATION RELEASE / ACKNOWLEDGEMENTS

I certify that the information in this application and any attached documents (including my curriculum-vitae) is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement. I agree that the Managed Care Entity to which this application is submitted, its representatives and any individuals or entities providing information to this Managed Care Entity in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this Provider Application. In order for participating Managed Care Entities or Healthcare Organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Managed Care Entity information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing.

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Managed Care Entity" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations [IPAs], health plans, health maintenance organizations [HMOs], preferred provider organizations [PPOs], other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies [with respect to certification of coverage and claims history]), licensing authorities, and businesses and individuals acting as their agents [collectively "Healthcare Organizations"]), for the purpose of evaluating this application and any re-credentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications for participation in this Managed Care Entity to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Managed Care Entity as may be required by state and federal law and regulation.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Managed Care Entity or Healthcare Organization, I agree to notify this Managed Care Entity immediately in writing of the occurrence of any of the following: (i) the stayed suspension, revocation or nonrenewal of my license to practice medicine; (ii) any suspensions, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellations or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Managed Care Entity in writing, promptly and NO later than fourteen (14) calendar days from the occurrence, of any of the following: (i) receipt of written notice of any adverse action against me by the state Board of Medical Licensure taken or pending, including by not limited to any accusations filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action by me by any Managed Care Entity or Healthcare Organization which has resulted in the filing of a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Managed Care Entity or Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations), or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I understand and acknowledge that the National Practitioner Data Bank may be queried on my behalf to secure information about my history.

A photocopy of facsimile of this document shall be as effective as the original.

Printed name: _____

Provider signature: _____ **Date:** _____

(stamped signature is NOT acceptable)

Please return completed application to: LEON MEDICAL CENTERS HEALTH PLANS
NETWORK OPERATIONS
8600 NW 41st STREET, Suite 201, Doral, FL 33166
PHONE: 305-646-3776 FAX: 305-646-3781