



CREENTIALING DEPARTMENT
8600 NW 41St Street, Suite 201, Doral, FL 33166
Tel: (305) 644-2155 Fax: (305) 642-1150
Attn: ARDDY VALDES

Dear Provider,

All participating practitioners are required to re-credential at least once every 3 years in order to remain a network provider. Our records indicate that you are now due to be re-credentialed. *If you fail to complete re-credentialing by the due date, you will be deactivated from our network.*

Your completed Re-credentialing Application should be returned to the Credentialing Department either via fax 305-642-1150 or mail to 8600 NW 41 Street, Suite 201 Doral, FL 33166.

The following action is required:

- A. Review the pre-populated **Re-Credentialing Profile** form and note any changes or updates in the application;
- B. Answer the **Professional Disclosure** section (Application **pages 7 & 8**) and add explanations for any “Yes” responses;
- C. Complete Malpractice Claim Information (**page 9**);
- D. Sign and date Attestation/Acknowledgement (**page 10**);
- E. Complete, sign and date the Financial Responsibility Form (*enclosed*). **If you do not carry malpractice insurance, this form most be completed;**
- F. Complete, sign and date Scope of Privileges (*enclosed*);
- G. Please submit the required supplemental documents below:

- Current** Florida Medical / Professional License(s)
- Current** DEA / State Controlled Substance Certificate (if applicable)
- Current** Board Certification (if applicable)
- Current** Malpractice Liability Insurance Certificate (if applicable)

If you have questions regarding this, please contact the Credentialing Department at the above mentioned number. Your prompt attention and cooperation will be greatly appreciated.

Sincerely,
Arddy Valdes
Credentialing Department
Leon Medical Centers Health Plans



Provider Re-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, III): _____ Degree: _____ Birth Date: _____ Male Female
Medicare #(s): _____ Medicaid #: _____ Enrolled as Medicare Part D Prescriber: _____
Personal NPI #: _____ Taxonomy Code: _____
Languages you speak fluently: _____
Cell Phone (Required): _____ Email address: _____

PRACTICE LOCATION INFORMATION

Group Name: _____
Primary Office Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
Office Contact: _____ Contact E-mail: _____
Contact Phone: _____ Contact Fax: _____
Hours: Mon. _____ Tue. _____ Wed. _____ Thur. _____ Fri. _____
Sat. _____ Sun. _____

Tax ID Owner Name: _____ Tax ID #: _____

Primary BILLING Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Billing Contact: _____ Group NPI if applicable: _____

Credentialing Contact: _____ Email: _____

Contact Phone: _____ Fax: _____

Credentialing Address: _____

***Secondary OFFICE Address:** _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Office Contact: _____ Contact E-mail: _____

Contact Phone: _____ Contact Fax: _____

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

Sat. _____ Sun. _____

***If this location bills under a different tax ID than the primary location, please provide additional tax ID and billing information in the section below.**

Tax ID Owner Name: _____ Tax ID #: _____

Secondary BILLING Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Billing Contact: _____ Group NPI if applicable: _____

****If you have additional locations, please attach a separate sheet listing office and billing information for each location.**

Do you supervise or employ physician extenders/allied health providers in your practice? Yes No

If yes, please supply the information below for each employee you have a personal agreement to supervise.

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

Primary Practice Specialty 1: _____ Board Certified?: Yes No
Board Name: _____ Original Date of Certification: _____ Expiration Date: _____
Primary Practice Specialty 2: _____ Board Certified?: Yes No
Board Name: _____ Original Date of Certification: _____ Expiration Date: _____
Primary Practice Specialty 3: _____ Board Certified?: Yes No
Board Name: _____ Original Date of Certification: _____ 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 for Behavioral Health, please complete attachment for focus areas.

If applying as Dentist, select: Oral Surgeon General Dentistry

If you are an Optometrist, do you hold therapeutic certification? Yes No

If a Nurse Practitioner, Physician's Assistant or Other Allied Professional, please confirm 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 – confirm all current and active licensure

License #	License Type (Medical, DEA, etc.)	Issuing State	Expiration Date
License #	License Type (Medical, DEA, etc.)	Issuing State	Expiration 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 changed professional liability carriers in the last three years, please list previous carrier.

Name of Carrier: _____ Policy #: _____

Complete Mailing Address: _____

From: _____ To: _____

Name of Carrier: _____ Policy #: _____

Complete Mailing Address: _____

From: _____ To: _____

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.)

CLINICAL TRAINING UPDATE – please provide any updates to your medical or clinical training in the past 3 years. Do not duplicate internship, residency or fellowship information previously reported.

FIRST UPDATE

Residency Fellowship Other

Institution: _____
 City/State/Country: _____ To/From: _____
 Program Director: _____ Phone: _____

SECOND UPDATE

Residency Fellowship Other

Institution: _____
 City/State/Country: _____ To/From: _____
 Program Director: _____ Phone: _____

Check here if you have attached additional information for this section:

CLINICAL PRIVILEGES

Do you still 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

Has your work or employment history changed in the last three years? Yes No

*If you have had a change in employment or other work history, please provide information in the section below or submit a current curriculum vitae.

Employer Name	Location	Phone	To/From

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 payers 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, surgical center, and/or other business dealing with the provision of ancillary health services, equipment or supplies? Yes No

Please provide explanation for any "Yes" response

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 but 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, CREDENTIALING DEPARTMENT
8600 NW 41st Street, Suite 201, Doral, FL 33166 / Tel: (305) 644-2155 Fax: (305) 642-1150 / Attn.: Arddy Valdes**