Participating Provider Application

Thank you for your interest in the Calvo's SelectCare Participating Provider Network. **To ensure appropriate referrals and to facilitate timely payment of claims, we ask that you complete all items on this form.** Items marked with an asterisk (*) will be kept confidential.

The items listed below are also required and must accompany this application:

- Letter of Intent (please indicate anticipated/ effective date of practice)
- Copy of current state(s) license
- Copy of current DEA (federal) certificate
- Copy of current CSR certificate
- Copy of current Board Certification(s) – If Applicable
- Copy of current professional liability insurance (face sheet) – If Applicable
- Current Curriculum Vitae (CV) / Resume
- Completed W-9 Form
- Copy of Government issued picture ID
- Proposed Fee Schedule
- Authorization for Agent/Representative – If Applicable

Upon the submission of all the required documents, Calvo's SelectCare will review your application and will inform you of the status via mail, email, or phone. If erroneous information or documents are provided, corrections must be submitted to our office in writing.

If you need assistance completing this form, please contact our Provider Relations Department via email at providers@calvos.com or via phone at (671) 477-9808.

Please type or print.

I. Provider Identification

Please provide practice information for each office in which you see patients and billing information for each tax identification number under which you currently bill. Attach additional sheets if necessary.

A. Please indicate if applying as a group or individual practice. ☐ Group ☐ Individual

B. Group/Practice Name _____

C. Tax ID No. * _____

D. Provider's Name _____ ☐ Male ☐ Female
(First) (M.I.) (Last)

Former/ Other Names _____
(First) (M.I.) (Last)

E. Date of Birth * _____

F. Social Security No.* _____

G. Medicare Provider No. _____

H. Medicaid Provider No. _____

I. National Provider Identifier (NPI)* (Individual Provider) _____

(Organizational Provider) _____

J. Physical Address _____

_____

K. Mailing Address (if different from physical address) _____

_____

L. Contact Numbers: Phone _____ Fax _____

II. Practice and Billing Information

A. Practice Information

1. Common Name of Group / Practice _____
2. If this a **group practice**, please indicate the practice types provided. _____

   _____
3. Is your practice at this office open to new patients? ☐ Yes ☐ No
4. Are you accepting new Medicare Patients? ☐ Yes ☐ No ☐ N/A
5. Are you accepting new Medicaid Patients? ☐ Yes ☐ No ☐ N/A
6. Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

7. Urgent Care Hours (if applicable)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

8. Clinic Manager/ Contact Person * _____

   E-mail address * _____
9. Preferred Payment Delivery Method *

   ☐ Mailed to the address indicated above

   ☐ Pick-up by authorized personnel (Please provide an authorization letter listing such personnel)

B. Billing Company Information (Complete only if contracted with a billing agency) *

1. Name of Billing Company _____

   Contact Person/ Title _____

   E-mail address _____
2. Mailing Address _____

   _____
3. Contact Numbers: Phone _____ Fax _____

III. Credentialing

Complete the following information regarding your education, licensure and training.

A. Professional degree (e.g., M.D., M.A., and D.M.D.) _____

B. Name of college or university which corresponds with the professional degree indicated above:

_____
College or University City/State

_____
Country Year of Graduation

C. Complete the following information regarding your training:

1. Internship _____

   Address _____

   Attended from (MM/YY) _____ to (MM/YY) _____ Specialty _____

2. Residency/ Post _____

   Address _____

   Attended from (MM/YY) _____ to (MM/YY) _____ Specialty _____

3. Fellowship _____

   Address _____

   Attended from (MM/YY) _____ to (MM/YY) _____ Specialty _____

D. Complete the following information regarding your Board Certification(s):

Certifying Board _____

Specialty _____ Expiration Date _____

Certifying Board _____

Specialty _____ Expiration Date _____

E. List professional license(s) for those states in which you currently practice. Please enclose a copy of your license(s):

State _____ Number _____ Expiration Date _____

State _____ Number _____ Expiration Date _____

F. List all hospitals or other facilities at which you practice and the privilege type (i.e. Full, Visiting, Courtesy, Consulting or Affiliate) for each.

_____
Hospital or Facility Privilege Type

_____
Hospital or Facility Privilege Type

G. Do you administer or prescribe controlled substance (Schedule II, III, or V medications)?

☐ Yes, DEA License# _____ ☐ No, I do not have a DEA license.

H. If you are a physician provider, select your primary specialty to determine how you will be listed in the directory.

- ☐ **Cardiology**
- ☐ **Family Practice**
- ☐ **Geriatrics**
- ☐ **Internal Medicine**
- ☐ **Nephrology**
- ☐ **Neurology**
- ☐ **Obstetrics & Gynecology**
  - ☐ Gynecology
  - ☐ Gynecological Surgery
  - ☐ Obstetrics
- ☐ **Oncology**
- ☐ **Ophthalmology**
- ☐ **Orthopedic Surgery**
  - ☐ Orthopedic Surgery/ Sports Medicine
  - ☐ Pediatric Orthopedics
- ☐ **Otolaryngology**
  - ☐ Pediatric Otolaryngology
  - ☐ Maxillofacial Surgery
- ☐ **Pediatrics**
- ☐ **Psychiatry**
- ☐ **Radiology**
- ☐ **Surgery**
  - ☐ Cardiac & Thoracic
  - ☐ General
  - ☐ Head & Neck
  - ☐ Surgical Oncology
  - ☐ Other _____
- ☐ **Urology**
- ☐ **Other** _____

I. If you are a non-physician provider, please choose a field or title that best describes your clinical practice.

- ☐ **Chiropractic**
- ☐ **Dentistry**
  - ☐ Endodontic
  - ☐ General Dentistry
  - ☐ Orthodontics
  - ☐ Pediatric Dentistry
  - ☐ Periodontics
- ☐ **Diet/Nutrition**
- ☐ **Medical Transport**
- ☐ **Mental Health**
  - ☐ Addiction Counseling
  - ☐ Chemical Dependency
  - ☐ Child & Adolescent
  - ☐ Psychology
  - ☐ Marriage & Family
  - ☐ Mental Health Counseling
- ☐ **Nurse**
  - ☐ Certified Nurse Anesthetist
  - ☐ Certified Nurse Specialist
  - ☐ Midwifery/Nursing
  - ☐ Nurse Practitioner
- ☐ **Occupational Therapy**
- ☐ **Optometry**
- ☐ **Physical Therapy**
- ☐ **Physician's Assistant**
- ☐ **Podiatry**
- ☐ **Other** _____

IV. Professional Liability Insurance (Please provide copy of face sheet)

Insurance carrier name: _____

Name/Entity to whom policy is issued _____

Policy number _____ Expiration date _____

Amount of coverage (per occurrence/aggregate)_____

V. Referral Patterns

List providers to whom you regularly refer patients.

Name	Specialty	Facility

VI. Attestation Questions

This section is to be completed by the Provider. Modification to the wording or format of these Attestation Questions will invalidate this application.

If your answer to any of the following questions is "yes," please provide details and reasons, as specified in each question, on a separate sheet. **Please sign and date each additional sheet.**

Attestation Questions	**YES**	**NO**
1. Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you **ever been** fined or received a letter of reprimand or is any such action pending or under review?		
2. Have you **ever been** suspended, fined disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?		
3. Have you **ever been** denied clinical privileges, membership, or contractual participation by any health care related organization*, or have clinical privileges, membership, participation or employment at any such organization **ever been** placed on probation, suspended, restricted, revoked, or voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?		
4. Have you **ever** surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from a health care related organization* while under investigation or potential review?		
5. Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* **ever been** withdrawn on your request prior to the organization's final action?		
6. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?		
7. Have you **ever** voluntarily or involuntarily left or been discharged from medical school or subsequent training programs?		
8. Have you **ever** had board certification revoked?		
9. Have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?		
10. Have you **ever been** charged with or convicted of a crime (other than a minor traffic offense) in any state or country and/or do you have any criminal charges pending other than minor traffic offenses in any state or country?		
11. Do you presently use any illegal drugs?		
12. Do you now have, or have had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested?		
13. Have you, under any current or former name or business entity, ever had adverse legal actions imposed against you? If yes, attach a copy of the adverse legal action documentation(s), including the resolution(s).		
14. Has your professional liability insurance **ever been** terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you **ever been** denied professional liability insurance.		
15. Have any professional liability lawsuits been filed against you during the past ten years (including those closed)?		
16. Has any judgment or payment of claim or settlement ever been made against you in any professional liability cases?		

E.g.** ***hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system

VII. Contact Information

Please list the name of the individual completing application or the person to be contracted if clarifying information is needed about this application.

Last Name	First Name	M.I.	Phone

VIII. Testimonial and Information Release

I am submitting an application for credentialing with Calvo's SelectCare. In submitting my application to Calvo's SelectCare, I agree to the following:

- I certify that all information in my application is accurate and complete. I understand that falsification of any information on this application may result in denial or termination of affiliation.
- During the application process and during any period in which I am an affiliated provider, I agree to immediately update Calvo's SelectCare on any changes in the information submitted in my application and agree to provide and execute such additional information as may be requested by Calvo's SelectCare to evaluate my professional qualifications, competence and conduct.
- In addition, I agree to notify Calvo's SelectCare of any circumstances that would change my status in licensure, DEA, Medicare participation, liability insurance coverage, board certification status, or hospital privileges.
- I hereby signify my willingness to appear for interviews in regard to my application and I authorize Calvo's SelectCare, its agents, representatives, and employees to consult with any third party that I have been associated with who may have information about me including references named in my application and persons, hospitals, institutions, or practices with which I have been associated to obtain information regarding my professional competence, ability to deliver safe and efficient quality care, professional education and training, licensing, certification, character, ethical qualifications, ability to work cooperatively with others, professional liability claims history, and/ or insurance or other qualifications for the purpose of evaluating my initial application and for ongoing evaluation. This authorization includes the right to inspect all records and documents that may be pertinent to an evaluation of my qualifications and competence.
- I hereby release from liability all representatives of Calvo's SelectCare in their individual and collective capabilities for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications. I hereby release from any liability any and all individuals and organizations who provide information to Calvo's SelectCare in good faith and without malice concerning my professional competence, ethics, character, and other qualifications.
- As an applicant for credentialing with Calvo's SelectCare, I have the right to review the information submitted in support of my credentialing application. I acknowledge that Calvo's SelectCare will notify me if there are discrepancies in the information received during the credentialing process, and I will be allowed an opportunity to add information to my application.
- I agree to administer Calvo's SelectCare policies without regard to race, color, national origin, ancestry, handicap, sex, marital status, age or sexual orientation.
- I agree to provide continuous care for Calvo's SelectCare members, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.
- I further authorize a photocopy or facsimile of the requests, authorizations and releases to this application to serve as the original.

Signature of Provider Date

Name (please type or print)