Allied Health Practitioner Credentialing Application

This application is to be utilized exclusively by Allied Health Practitioners (also known as Independent Practitioners or Collaborative Practice Practitioners) who do not have an application available via CAQH.

Independent Practitioners - Acupuncturist, Audiologist, Dietitian, Doula, Massage Therapist, Occupational Therapist, Physical Therapist, Speech Language Pathologist/Therapist
Collaborative Practice Practitioners - Nurse Practitioner, Nurse Midwife, Physician Assistant

Instructions:
Please type or print legibly when completing this form. If you need more space or have more than three locations, attach additional sheets and reference the question being answered. Please do not write "see CV" or "refer to CV" in place of completing the required information. To assist in the timely processing of your application, we have provided the following checklist of documents necessary to complete your application packet for review.

Application Checklist:

- ☐ Valid, current State of Florida Practitioner License
- ☐ Current malpractice coverage
- ☐ Curriculum Vitae which includes work history for the past 5 years (month/year must be included)
- ☐ Current Board Certification if applicable
- ☐ A completed and signed Sunshine Health application and attestation forms
- ☐ Completed W-9 Form
- ☐ Disclosure of Ownership Statement

If information is missing, a Sunshine State Health Plan (Sunshine Health) Provider Representative will notify the applicant of receipt of missing or incomplete application elements. Applicants have thirty (30) days from the date of submission to provide all missing elements to Sunshine Health. If all elements have not been submitted within the 30-day timeframe, the application will be closed as incomplete. Once your credentials have been verified, the Sunshine Health Credentialing Committee will review your application and you will be notified of our decision in writing. The Credentialing Committee meets monthly to review completed files and determine provider participation status.

During the credentialing and recredentialing process, Sunshine Health obtains information from various outside sources to evaluate your application. You have the right to review any primary source information that Sunshine Health collected during this process such as the National Practitioner Data Bank (NPDB), Licensing and Board Certification. However, this does not include references or recommendations or other information that is peer review protected.

You also have the right to request the status of your application at any time during the credentialing/recredentialing process. Requests for primary source verification documentation must be submitted in writing directly to Sunshine Health, Attn: Credentialing Department at 1301 International Parkway, Suite 400 Sunrise, FL 33323.

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I. General Information

Last Name: _____ First Name: _____ MI: _____

Maiden or Other Names Used: _____

Gender ☐ Male ☐ Female DOB: _____ Social Security #: _____

Email Address: _____

Medicare Provider #: _____ Medicaid Provider #: _____

Federal Tax ID #: _____ National Provider ID # (NPI) _____

Degree: _____ Specialty: _____

Sunshine Health seeks to increase network developments' capacity to recruit providers of diverse racial and ethnic backgrounds. Please check the applicable boxes best describing your ethnicity, culture and race.

Ethnicity (Florida Statutes Compliance)	**Culture**		**Race**
☐ African American	☐ African American	☐ Greek	☐ Black
☐ Hispanic American	☐ Arabic	☐ Haitian	☐ White
☐ Asian American	☐ Asian or Pacific Islander	☐ Hindi	☐ Other _____
☐ Native American	☐ Black	☐ Hispanic	
☐ American Woman	☐ Black (Non-Hispanic)	☐ Indian	
☐ Other _____	Caucasian	☐ White (Non-Hispanic)	

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II. Primary Office Information

Practice Name: _____ Contact: _____

DBA: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Practice NPI #: _____ Practice Medicaid #: _____

Practice Medicare #: _____ Is the practice open at least five (5) days per week? ☐ Yes ☐ No

Accepting new patients? ☐ Yes ☐ No Only serving children through CMS? ☐ Yes ☐ No

Hours of Operation:

Mon	Tue	Wed	Thurs	Fri	Sat	Sun

Age Groups Treated

☐ 0 -12 years ☐ 13-17 years ☐ 18-64 years ☐ 65 + ☐all ages ☐ Other: _____

Is facility handicapped accessible? ☐ Yes ☐ No

Language(s) spoken by the practitioner or clinical staff *(other than English):*

_____

Identify the percentage of your practice dedicated to the following patient population:

Medicare FFS _____ Medicare Managed Care _____ Medicaid Managed Care _____

Medicaid FFS _____ Commercial HMO/PPO/POS _____ Self-Pay _____

Under what specialty do you choose to be listed in the directory at this location?

_____

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III. Secondary Office Information (If you have more than two locations, please attach additional sheets with the information below)

Practice Name: _____ Contact: _____

DBA: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Practice NPI #: _____ Practice Medicaid #: _____

Practice Medicare #: _____ Is the practice open at least five (5) days per week? ☐ Yes ☐ No

Accepting new patients? ☐ Yes ☐ No Only serving children through CMS? ☐ Yes ☐ No

Hours of Operation:

Mon	Tue	Wed	Thurs	Fri	Sat	Sun

Age Groups Treated

☐ 0 -12 years ☐ 13-17 years ☐ 18-64 years ☐ 65 + ☐all ages ☐ Other: _____

Is facility handicapped accessible? ☐ Yes ☐ No

Language(s) spoken by the practitioner or clinical staff *(other than English):*

_____

Identify the percentage of your practice dedicated to the following patient population:

Medicare FFS _____ Medicare Managed Care _____ Medicaid Managed Care _____

Medicaid FFS _____ Commercial HMO/PPO/POS _____ Self-Pay _____

Under what specialty do you choose to be listed in the directory at this location?

_____

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V. Professional Licenses - attach copies

State: ☐ License #: _____ Date Obtained: _____ Expiration Date: _____

If you are currently licensed in any other state, please complete the following:

State: ☐ License #: _____ Date Obtained: _____ Expiration Date: _____

State: ☐ License #: _____ Date Obtained: _____ Expiration Date: _____

DEA#: _____ Expiration Date: _____

VI. Malpractice Insurance - attach current copy of declaration page

Current Professional Carrier: _____

Address and phone number of carrier: _____

$ Amount per Occurrence: _____ $ Amount per Aggregate: _____

Date of Coverage from: _____ Date of Coverage to: _____

VII. Education, Training and Professional Experience

Undergraduate or Technical School					
Complete School Name:					
City:		State/Country:		Course of Study/ Major:	
Degree(s) Received:		Graduation Date (mm/yy):			
Post Graduate Degree					
Complete School Name:					
City:		State/Country:		Course of Study/ Major:	
Degree(s) Received:		Graduation Date (mm/yy):			
Professional Training					
Complete School Name:					
City:		State/Country:		Course of Study/ Major:	
Degree(s) Received:		Graduation Date (mm/yy):			

Did you complete the program? ☐ Yes ☐ No
(If you did not complete the program, please attach Explanation Form(s)

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VIII. Certification (Please attach a copy of your current Board Certificate)

Are you certified by any board in your profession? ☐ Yes ☐ No

List all current and past board certifications.

Name of Issuing Board	Specialty	Certification Date (mm/yy):	Recertification Date (mm/yy):	Expiration Date (mm/yy):

IX. Work History

List all work history/military experience in chronological order from most current to oldest for a five (5) year period beginning with the current year. **Please explain fully any gaps of six months or more in the space provided below.** A current Curriculum Vitae (must specify month and year) may be substituted.

From (Month/Year)	To (Month/Year)	Name & Address of Employer	Position Held

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X. Attestation

Please provide a complete explanation if any of the following questions are answered in the affirmative. Use a separate sheet to continue, if necessary.

Licensure		
1	Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?	☐ Yes ☐ No
2	Have you ever received a reprimand or been fined by any state licensing board?	☐ Yes ☐ No
Hospital Privileges and Other Affiliations		
3	Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?	☐ Yes ☐ No
4	Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?	☐ Yes ☐ No
5	Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?	☐ Yes ☐ No
Education, Training and Board Certification		
6	Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?	☐ Yes ☐ No
7	Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?	☐ Yes ☐ No
8	Have any of your board certifications or eligibility ever been revoked?	☐ Yes ☐ No
9	Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?	☐ Yes ☐ No
DEA or CDS		
10	Have your Federal DEA and/or CDS Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?	☐ Yes ☐ No
Medicare, Medicaid or other Governmental Program Participation		
12	Have you ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?	☐ Yes ☐ No

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	Other Sanctions or Investigations	
13	To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?	☐ Yes ☐ No
14	Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?	☐ Yes ☐ No
15	Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?	☐ Yes ☐ No
	Malpractice Claims History	
16	Have you had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated)?	☐ Yes ☐ No
	Criminal	
17	Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional ?	☐ Yes ☐ No
18	Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense?	☐ Yes ☐ No
19	Have you been court-martialed for actions related to your duties as a medical professional?	☐ Yes ☐ No
	Ability to Perform Job	
20	Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)	☐ Yes ☐ No
21	Do you have a history of chemical dependency/substance abuse?	☐ Yes ☐ No
22	Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?	☐ Yes ☐ No
23	Do you have any physical or mental health problems that may affect your ability to provide health care?	☐ Yes ☐ No
24	Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?	☐ Yes ☐ No
25	Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation?	☐ Yes ☐ No

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Practice/Group Related Information		
26	Have you attested to Meaningful Use of Electronic Health Records?	☐ Yes ☐ No
27	Do you currently use an Electronic Health Record (EHR)?	☐ Yes ☐ No
28	Are you currently participating in Florida's Health Information Exchange (HIE)?	☐ Yes ☐ No
29	I attest adherence to ADA accessibility requirements in accordance to F.S. 553 Part II.	☐ Yes ☐ No
30.	Have you participated in, and/or your office provided fraud, waste and abuse awareness compliance training (FWA Training) to all personnel/FDRs as required by the final rules in 42 CFR Parts 422.503 and 423.504? *(If yes, please submit copy of the signed and dated Attestation of the Training.)*	☐ Yes ☐ No
31.	I attest that staff has received appropriate training in reporting abuse, neglect and exploitation and will report knowledge or reasonable suspicion of these activities via the Florida abuse statewide toll free hotline (1-800-96-Abuse) in accordance with F.S. 415.	☐ Yes ☐ No

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature: _____

Printed Name: _____

Date: _____

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AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for participation status with Sunshine Health I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.
2. I further understand and acknowledge that Sunshine Health or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the health care related organization(s) as a part of the verification and Credentialing process.
3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.
6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.
7. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of Sunshine Health before initiating judicial action.
8. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Signature	Printed Name	Date

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LEGAL ACTION/MALPRACTICE HISTORY

Include all cases in which you have been named including dropped, withdrawn and settled cases.
For each claim, the Credentials Committee requires a **comprehensive description** of the facts. This form must include the type of treatment rendered, result of treatment and status of patient's injury; your involvement as well as the settlement amount paid in full and in your behalf.

Incident date: _____ **Patient Gender:** _____ **Patient Age:** _____

Nature of Allegation/Specific Allegation:

_____

_____

_____

_____

_____

Description of Treatment/Procedure Performed:

_____

_____

_____

_____

_____

Patient Outcome:

_____

_____

_____

Current case status:

☐ Dismissed ☐ Settled ☐ Pending ☐ Other: _____

Settlement Amount: $_____ Amount paid on your behalf: $_____

Signature _____ **Date:** _____