Provider Credentialing Application

The original application with attachments should be returned to
Sunshine State Health Plan
PO Box 459089
Fort Lauderdale, FL 33345-9089
Phone: 1-866-796-0530

Please type or print in black ink 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.

Copies of:

- Valid, current State of Florida medical license
- Current Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certification
- Current malpractice coverage or bond that complies with the physician's relevant practice act in the Florida Statutes
    - Check here if providing copy of Financial Responsibility Form
- If you do not have current hospital admitting privileges, please have your covering physician complete the *Covering Physician Letter (see page 13 of application)*
- Curriculum Vitae / Work history for the past 5 years
- Current board certification or actively in the process of obtaining board certification
- Education Certificate for Foreign Medical Graduates (ECFMG) – if applicable
- A completed and signed Sunshine Health application and attestation forms
- A completed and signed attestation of total active patient load *(see insert)*
- Copy of a Driver's License
- Completed W-9 Form

If there is information missing, a Sunshine Health Provider Representative notifies the applicant within thirty (30) days of receipt of missing or incomplete application elements.

Physician has thirty (30) days from the date of signed application to provide all missing elements to Sunshine Health. If all elements have not been submitted within the 30-day timeframe, the application will be returned to the applicant.

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.

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I. General Information

Last Name _____ First Name _____ MI ___

Maiden or Other Names Used (AKA) _____

Gender ☐ Male ☐ Female DOB _____ SSN _____

Medicare Provider #: _____ Expiration Date _____

Medicaid Provider #: _____ Expiration Date _____

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

Degree ☐MD ☐DO ☐DPM ☐DC ☐DDS ☐DMD ☐OD ☐PhD ☐PsyD

Email Address _____

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	Culture (continues)	Race
☐ African American	☐ African American	☐ Greek	☐ Black
☐ Hispanic American	☐ Arabic	☐ Haitian	☐ White
☐ Asian American	☐ Asian or Pacific Islander	☐ Hindi	☐ Other (Red/Yellow)
☐ 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 _____

d.b.a. _____

Address_____City _____State _____ZIP _____

County _____Phone (_)_____ Fax (_) _____

Billing Address_____City _____State _____ZIP_____

NPI number for this location_____
Medicaid number for this location _____
Medicare number for this location _____

Is the facility 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
____*to*____	____*to*____	____*to*____	____*to*____	____*to*____	____*to*____	____*to*____

Age Groups Treated ☐0 -12 yrs ☐13-17 yrs ☐18-64 yrs ☐65 + ☐ all ages ☐Other

Are PAs, CNMs and/or Nurse Practitioners used? ☐Yes ☐No

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:

Business Lines	Percent of Practice
1. Medicare FFS	___%
2. Medicare Managed Care	___%
3. Medicaid FFS	___%
4. Medicaid Managed Care	___%
5. Commercial HMO/PPO/POS	___%
6. Self Pay	___%

Are you a PCP at this location? ☐Yes ☐ No

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

_____

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III. Second Office Information

Practice Name_____Contact_____

d.b.a. _____

Address _____City _____State _____ZIP _____

County_____Phone (__) _____ Fax (__) _____

Billing Address _____City _____ State _____ZIP _____

NPI number for this location _____
Medicaid number for this location_____
Medicare number for this location_____

Is the facility 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
____*to*____	____*to*____	____*to*____	____*to*____	____*to*____	____*to*____	____*to*____

Age Groups Treated ☐0 -12 yrs ☐13-17 yrs ☐18-64 yrs ☐65 + ☐ all ages ☐Other

Are PAs, CNMs and/or Nurse Practitioners used? ☐Yes ☐No

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:

Business Lines	Percent of Practice
1. Medicare FFS	___%
2. Medicare Managed Care	___%
3. Medicaid FFS	___%
7. Medicaid Managed Care	___%
8. Commercial HMO/PPO/POS	___%
9. Self Pay	___%

Are you a PCP at this location? ☐Yes ☐ No
Under what specialty do you choose to be listed in the directory at this location?

_____

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IV. **Third Office Information** *If you have more than three locations, attach additional sheets with the following information*

Practice Name_____Contact_____

d.b.a. _____
Address _____ City_____ State_____ZIP_____
County _____Phone (____) _____ Fax (_____) _____
Billing Address _____City _____State _____ZIP ___
NPI number for this location _____
Medicaid number for this location_____
Medicare number for this location_____

Is the facility 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
____*to*____	____*to*____	____*to*____	____*to*____	____*to*____	____*to*____	____*to*____

Age Groups Treated ☐0 -12 yrs ☐13-17 yrs ☐18-64 yrs ☐65 + ☐ all ages ☐Other

Are PAs, CNMs and/or Nurse Practitioners used? ☐Yes ☐No

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:

Business Lines	Percent of Practice
1. Medicare FFS	___%
2. Medicare Managed Care	___%
3. Medicaid FFS	___%
10. Medicaid Managed Care	___%
11. Commercial HMO/PPO/POS	___%
12. Self Pay	___%

Are you a PCP at this location? ☐Yes ☐ No
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 Medical License

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 _____

CDS # _____ Expiration Date _____

Malpractice Insurance - *attach copy of declaration pages*

Current Professional Carrier: _____
Address and phone number of carrier: _____
$ Amount per Occurrence: _____ $ Amount per Aggregate: _____
Dates of Coverage: From _____ To _____

In the space provided below, list the name and address of the malpractice carrier who has provided coverage for you for the most recent five (5) year period. **If there has been more than one carrier, please indicate the dates of coverage with each carrier, and the reason for changing carriers.**

Carrier	Policy Number	Dates of Coverage	Reason for Changing Carriers
Name		From	
Address		To	
Name		From	
Address		To	
Name		From	
Address		To	
Name		From	
Address		To	
Name		From	
Address		To	

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VII. Education & Board Certifications

Educational Institution (include name and complete address)	Degree	From (mm/yy)	To (mm/yy)
Name: Address: Undergraduate			
Name: Address: Graduate/Medical School			
Name: Address: Internship			
Name: Address: Residency			
Name: Address: Fellowship			

If you are a foreign medical school graduate, are you certified by the Education Commission for Foreign Medical Graduates (ECFMG)? ☐Yes ☐No If Yes - ECFMG number: _____

VIII. <u>Continuing Education</u> - seminars/workshops you have attended in the past 24 months. Please attach copy of CEU certificate(s) of completion or you may attach a copy of your Accredited Continuing Education Agency's Report, if applicable.

Course Subject	(Name and Address) Sponsoring Organization	Date Started (mm/dd/yy)	Date Completed	# of CEUs

List current board certifications. (You may **not** refer to you CV for this section.

Board Name *(as recognized by American Board of Medical Specialties)*	Certificate #	Cert. Date	Exp. Date

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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	Description of Activities

Please provide an explanation of any gaps in employment:

X. Hospital Privileges

List your current hospital privileges. If you do not have hospital admitting privileges, please supply the name, Medicaid number and primary admitting facility of the practitioner with whom you have entered into an agreement for hospital admissions in this section. The covering provider must sign the release found at the back of this packet. Please return the signed release letter with your application.

Hospital Name	Address	Please Indicate Type of Privilege
		☐ Primary ☐ Non-Primary
		☐ Primary ☐ Non-Primary
		☐ Primary ☐ Non-Primary

☐ **No:** I do not have admitting privileges but have made a formal arrangement with another Plan affiliated provider

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XI. **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		
11	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	
12	Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or Yes No training program, Medicare or Medicaid program, or any other private, federal or state health program?	☐ Yes ☐ No
	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	☐ Yes ☐ No
21	Do you have a history of chemical dependency/substance abuse?	☐ Yes ☐ No

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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
26	Have you attested to Meaningful Use of EHRs?	☐ 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	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

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 ACTIONS/ MALPRACTICE HISTORY

INCLUDE ALL MALPRACTICE CLAIMS IN WHICH YOU HAVE EVER BEEN NAMED INCLUDING DROPPED CASES, WITHDRAWN CASES, SETTLED CASES OR PENDING CASES

For each claim, the Credentials Committee requires a **very comprehensive description** of the medical facts (must include, but not be limited to, the type of treatment and/or surgery rendered, result of treatment and current status of patient's injury; your involvement, i.e., consultant, primary physician, assistant in surgery, etc.)

1. Date of Incident _____

Description:

Current Status: ☐ Dropped ☐ Name withdrawn ☐ Pending ☐ Settled
Total amount settled $_____ Amount paid on your behalf $_____

2. Date of Incident _____

Description:

Current Status: ☐ Dropped ☐ Name withdrawn ☐ Pending ☐ Settled
Total amount settled $_____ Amount paid on your behalf $_____

3. Date of Incident _____

Description:

Current Status: ☐ Dropped ☐ Name withdrawn ☐ Pending ☐ Settled
Total amount settled $_____ Amount paid on your behalf $_____

If additional space is necessary, please provide a full explanation of details on a separate sheet