

Outpatient Rehabilitation Providers (Medicare) Practitioner Credentialing Application

Submit completed application to:

ConnectiCare, Inc. & Affiliates
Network Operations Department
 175 Scott Swamp Road
 Farmington, CT 06032
 Tel.: (860) 674-2835
 Fax: (860) 674-2849

Applicants have the right to review the information submitted in support of their application and to correct erroneous information. ConnectiCare, Inc. & Affiliates will notify the applicant of any information obtained during the credentialing process that varies substantially from the information submitted.

SECTION I	INDIVIDUAL PRACTITIONER INFORMATION
Practitioner Name _____ <i>Last First Middle Maiden Name</i>	
Degree <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Speech Therapist <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Other _____	
Date of Birth _____ Social Security Number _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Languages Spoken _____	

SECTION II	LICENSE & CERTIFICATION INFORMATION
License Number _____ State _____ Date of Expiration _____	
License Number _____ State _____ Date of Expiration _____	
Federal DEA Number _____ Date of Expiration _____	
NPI# _____	

SECTION III	LIABILITY INSURANCE
By signing this application, I attest that I maintain Professional Liability coverage as follows:	
Coverage Amounts _____ / _____ Policy Period _____ - _____ <i>Incident Aggregate From (mm/dd/yy) To (mm/dd/yy)</i>	

SECTION IV PRACTICE INFORMATION	
Primary Office Practice Name _____	
Type of Practice <input type="checkbox"/> Solo <input type="checkbox"/> Group <input type="checkbox"/> Clinic <input type="checkbox"/> Other _____	
Office Address _____	
City _____ State _____ Zip Code _____ County _____	
Telephone (_____) _____ Fax (_____) _____ E-mail Address _____	
Tax ID Number _____ Handicap-Accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you offer extended hours? <input type="checkbox"/> Before 9 a.m. <input type="checkbox"/> After 5 p.m. <input type="checkbox"/> Weekends <input type="checkbox"/> No extended hours	

SECTION V EDUCATION & TRAINING			
Name of Institution	Address	From - To	Specialty/Degree
_____	_____	_____ - _____	_____
<i>Graduate/Medical School</i>	<i>City/State or City/Country (outside USA)</i>	<i>(mm/yy) (mm/yy)</i>	
_____	_____	_____ - _____	_____
<i>Residency</i>	<i>City/State or City/Country (outside USA)</i>	<i>(mm/yy) (mm/yy)</i>	
_____	_____	_____ - _____	_____
<i>Residency</i>	<i>City/State or City/Country (outside USA)</i>	<i>(mm/yy) (mm/yy)</i>	

SECTION VI PROFESSIONAL EMPLOYMENT HISTORY	
<i>From - To (mm/yy - mm/yy)</i>	<i>List all employment history/professional practice for <u>the past five years</u>. Explain any gaps of six months or more.</i>

SECTION VII	QUESTIONS	
1. Have you ever voluntarily surrendered or had your license revoked, restricted, suspended or placed on probation in any state?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you been subject to any disciplinary action(s) by a licensing board of any state?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you ever had your DEA (or CDS) number to prescribe controlled substances voluntarily or involuntarily limited, suspended or revoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you ever had your privileges at any hospital voluntarily or involuntarily suspended, restricted, revoked or not renewed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you ever been named as a party in a malpractice action?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you ever been reprimanded by or had your membership refused, suspended or revoked by any professional organization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have you ever been indicted or convicted of fraud?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have you ever been treated in any manner for substance abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Is your ability to practice impaired due to chemical dependence or substance abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Does your mental or physical health status affect or interfere with your ability to practice your profession?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Have you ever been refused participation in, been disenrolled, or voluntarily resigned from any IPA, HMO, PPO, and/or any other managed care organization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Have you ever been terminated or suspended, either voluntarily or involuntarily, from receiving payments under the Medicare/Medicaid or Federal Employee Benefits programs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Have you ever been the subject of investigation by any peer review committee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

A response of "Yes" to any of the above questions requires a detailed explanation on a separate sheet to be attached to this application.

SECTION VIII**RELEASE OF INFORMATION**

By applying to be a participating provider with ConnectiCare, either directly or through my IPA and/or my PHO which has entered into an agreement with ConnectiCare, I certify that the information I have provided and responses I have given are true, correct and complete to the best of my knowledge and belief. I understand and agree that if this form contains either (i) any material omissions or misrepresentations, or (ii) false or misleading information, my application to participate may be denied and/or my participation with ConnectiCare may be terminated. I agree to notify ConnectiCare immediately in the event there are any changes to any of the information I have provided on this application.

I understand that in accordance with applicable laws and the requirements of accreditation organizations, ConnectiCare will credential practitioners and every three (3) years will recredential practitioners. To facilitate compliance with those requirements, as well as the credentialing standards of other regulatory and accrediting agencies or organizations, I hereby authorize ConnectiCare or its designee to receive and to inspect all records and documents and to verify with individuals, organizations, and other health practitioners all information, including information described in this form, that may be appropriate to an evaluation of my personal and professional qualifications, and my ability to perform my professional and medical duties. I agree to cooperate with scheduled on-site visits including reviews of record documentation and agree, when requested, to submit copies of medical records for audit purposes to the extent permitted by applicable laws.

I hereby authorize and request all individuals and institutions to promptly reply to all requests from ConnectiCare for information or verification of information as described above. I agree to hold harmless and release from any and all liability all individuals and institutions furnishing such information to ConnectiCare, their respective agents, employees, and representatives, provided the information is given in good faith and without malice.

I hereby authorize ConnectiCare to use the information provided in their selection, credentialing and recredentialing process and to verify such information as appropriate. Notwithstanding, I understand and agree that I have the responsibility of producing all information required or requested by ConnectiCare in accordance with this application. ConnectiCare is under no obligation to complete the processing of this application until such information is provided by me.

I understand and agree that the authorizations and other provisions contained herein shall remain in force for so long as this application is pending or for a period not greater than three (3) years.

I agree that a photocopy of my signature below may be relied upon by any person or entity receiving a copy of this authorization.

Provider _____
(Please print clearly)

Signature _____ Date _____

THIS DOCUMENT CANNOT BE MODIFIED