

PREMIER HEALTH NETWORKS OF ALABAMA, LLC
NAMCI / COMPONE
Credentialing Application and Checklist

In order to expedite your participation in NAMCI and/or CompOne PPO Network the attached Provider Application, Confidential Provider Information and Preferred Provider Network forms must be completed, signed, dated and returned to us with the documents requested.

Following is a checklist to help you make sure you have enclosed all of the necessary information to complete the credentialing process.

- _____ Complete Provider Application - If the question does not pertain to you please indicate by inserting N/A in the space provided. Applications with blanks will not be accepted.
- _____ Confidential Provider Information (signed and dated)
- _____ Preferred Provider Network Form (signed and dated)
- _____ Certificate of Professional Liability Coverage issued to NAMCI by your carrier
- _____ Copy of Current State Medical License
- _____ Copy of current State of Alabama Controlled Substance Certificate
- _____ Copy of current DEA Certificate
- _____ Copy of Board Certification **OR** Verification of Residency Completion(if applicable)
- _____ W-9 or 1099 (Request for Taxpayer Identification Number)
- _____ Explanation of any Professional Liability Suits or other information as indicated on the application
- _____ Copy of Curriculum vitae (work history) include last 5 years with month (mmyyyy), explain any breaks of employment lasting longer than 6 months

If you have questions regarding your application please do not hesitate to call the Provider Relations Department at 256-532-2753 or 1-800-636-2624. **Incomplete applications will only delay the credentialing process. Please make sure it is complete before returning to:**

Premier Health Networks of Alabama, LLC
PO Box 18788
Huntsville, Alabama 35804
Attention: Cathy Ontiveros

Note: Please do not separate forms. Provider copies will be returned after review and execution by NAMCI/Premier.

PROVIDER APPLICATION



Preferred Provider Network

PLEASE TYPE OR PRINT USING BALL POINT PEN

NOTE: THIS INFORMATION WILL ALSO BE USED TO DEVELOP THE PROVIDER DIRECTORY

| | | | | |
|---------------------|-------|--------|--|-------------------------------------|
| PHYSICIAN NAME LAST | FIRST | MIDDLE | DEGREE MD DO DDS DMD DPM DC OD CRNP PA LPC LCSW | STATE LICENSE NUMBER (PROVIDE COPY) |
|---------------------|-------|--------|--|-------------------------------------|

| | | |
|----------------|-----------|---------------------------|
| INDIVIDUAL NPI | GROUP NPI | DEA NUMBER (PROVIDE COPY) |
|----------------|-----------|---------------------------|

| | | | |
|--------------------|---------------|-----------------------------|---|
| MEDICAL GROUP NAME | DATE OF BIRTH | PRACTICE HOURS OF OPERATION | DO YOU HAVE A CURRENT DEA NARCOTICS LICENSE? YES NO |
|--------------------|---------------|-----------------------------|---|

| | | | | |
|---------------------------|---|---------------------|---------------------------------------|------|
| TAX IDENTIFICATION NUMBER | WILL YOU BILL UNDER THIS NUMBER? YES NO | SPECIALTY (PRIMARY) | BOARD CERTIFIED (PROVIDE COPY) YES NO | YEAR |
|---------------------------|---|---------------------|---------------------------------------|------|

| | | | | |
|------------------------|---|-----------------------|---------------------------------------|------|
| SOCIAL SECURITY NUMBER | WILL YOU BILL UNDER THIS NUMBER? YES NO | SPECIALTY (SECONDARY) | BOARD CERTIFIED (PROVIDE COPY) YES NO | YEAR |
|------------------------|---|-----------------------|---------------------------------------|------|

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|---|--|
| DOES THE PROVIDER SPEAK MORE THAN ONE LANGUAGE? IF YES, LIST LANGUAGES YES NO | IF YOU ARE NOT BOARD CERTIFIED, ARE YOU ELIGIBLE TO TAKE A BOARD EXAMINATION? YES NO |
|---|--|

| | | | |
|-----------------|-------------------------------------|--|----------------------------|
| BILLING ADDRESS | STREET | BOARD FOR WHICH YOU ARE ELIGIBLE | DATE ADMISSIBILITY EXPIRES |
| | CITY STATE ZIP CODE | | |
| | TELEPHONE NUMBER () FAX NUMBER () | PLEASE COMPLETE BELOW INFORMATION AND ATTACH CV | |

| | | | | |
|------------------------|-------------------------------------|---------------------|-------------|----------------|
| PRIMARY OFFICE ADDRESS | OFFICE MANAGER | EDUCATION (SCHOOL) | CITY, STATE | YEAR GRADUATED |
| | STREET | TYPE OF INTERNSHIP | DATES | |
| | CITY STATE ZIP CODE | NAME OF INSTITUTION | CITY, STATE | |
| | TELEPHONE NUMBER () FAX NUMBER () | TYPE OF RESIDENCY | DATES | |

| | | | | |
|-----------------------|-------------------------------------|--|-------------|--|
| SECOND OFFICE ADDRESS | OFFICE MANAGER | NAME OF INSTITUTION | CITY, STATE | |
| | STREET | TYPE OF FELLOWSHIP | DATES | |
| | CITY STATE ZIP CODE | NAME OF INSTITUTION | CITY, STATE | |
| | TELEPHONE NUMBER () FAX NUMBER () | LIST ALL HOSPITALS AT WHICH YOU CURRENTLY HAVE ADMITTING PRIVILEGES | | |

| | | | | |
|----------------------|-------------------------------------|---|--|--|
| THIRD OFFICE ADDRESS | OFFICE MANAGER | IF YOU ARE NOT BOARD CERTIFIED IN YOUR PRIMARY OR SECONDARY SPECIALTY (LISTED ABOVE) AND NOT ELIGIBLE TO TAKE EITHER EXAMINATION, PLEASE ATTACH AN EXPLANATION OF ANY RELEVANT TRAINING AND EXPERIENCE. | | |
| | STREET | | | |
| | CITY STATE ZIP CODE | | | |
| | TELEPHONE NUMBER () FAX NUMBER () | | | |

| | | |
|---|------------------|----------------|
| NAME OF PROFESSIONAL LIABILITY INSURANCE CARRIER (PROVIDE A COPY OF COVERAGE) | PRACTICE WEBSITE | PRACTICE EMAIL |
|---|------------------|----------------|

| | |
|---|------------------------|
| DO YOU HAVE FULL TIME COVERAGE FOR YOUR PATIENTS YES NO | IF YES, PHYSICIAN NAME |
|---|------------------------|

| | | | |
|---------|------|-------|----------|
| ADDRESS | CITY | STATE | ZIP CODE |
|---------|------|-------|----------|

| | | |
|------------------|---------|-----------|
| TELEPHONE NUMBER | TIN/SSN | SPECIALTY |
|------------------|---------|-----------|

| | |
|--|-----------------------|
| ARE YOU ACCEPTING NEW PATIENTS? YES NO | AGE RANGE OF PATIENTS |
|--|-----------------------|

PLEASE DO NOT SEPARATE

| | | YES | NO |
|--|--|-----|----|
| 1. A. ARE YOU NOW OR HAVE YOU EVER BEEN INVOLVED IN ANY MALPRACTICE SUIT, INCLUDING ARBITRATION? | | | |
| B. HAS ANY MALPRACTICE CLAIM SETTLEMENT, NOT INVOLVING LITIGATION OR ARBITRATION, EVER BEEN PAID BY YOU OR PAID ON YOUR BEHALF? | | | |
| IF THE ANSWER TO EITHER OF THE ABOVE QUESTIONS IS YES, PLEASE ATTACH THE FOLLOWING INFORMATION FOR EACH SUIT OR SETTLEMENT: DATE AND DETAILS OF THE INCIDENT(S) LEADING TO THE SUIT OF SETTLEMENT DATE OF SUIT OR SETTLEMENT PROFESSIONAL LIABILITY INSURER INVOLVED YOUR ROLE IN THE INCIDENT(S) YOUR STATUS IN ANY SUIT OR OTHER LEGAL ACTION (PRIMARY DEFENDANT, CODEFENDANT, OTHER) CURRENT STATUS OF SUIT OR OTHER LEGAL ACTION AMOUNT RESERVED BY CARRIER FOR EACH CLAIM, OR AMOUNT PAID AS AN OUT-OF-COURT SETTLEMENT, OR AMOUNT OF JURY AWARD OR COURT AWARD (PLEASE OBTAIN THIS INFORMATION FROM YOUR INSURER IF NECESSARY) | | | |
| 2. HAS YOUR PROFESSIONAL LIABILITY INSURANCE EVER BEEN DENIED, SUSPENDED, CANCELLED, OR NOT RENEWED? IF THE ANSWER IS YES, PLEASE EXPLAIN IN AN ATTACHMENT. | | | |
| 3. A. DO YOU NOW HAVE OR WITHIN THE LAST FIVE YEARS HAVE YOU HAD ANY PHYSICAL CONDITION, MENTAL CONDITION OR CHEMICAL DEPENDENCY CONDITION (ALCOHOL OR OTHER SUBSTANCE DEPENDENCY) THAT DOES OR HAS INTERFERED WITH YOUR ABILITY TO PRACTICE MEDICINE? | | | |
| B. HAVE YOU EVER RECEIVED TREATMENT OR BEEN ADVISED TO RECEIVE TREATMENT FOR ALCOHOL OR OTHER SUBSTANCE DEPENDENCY? | | | |
| IF THE ANSWER TO EITHER OF THE ABOVE QUESTIONS IS YES, PLEASE EXPLAIN IN AN ATTACHMENT. | | | |
| 4. HAVE YOU EVER HAD ANY OF THE FOLLOWING ITEMS DENIED, REVOKED, SUSPENDED, NOT RENEWED, PLACED UNDER PROBATION, SUBJECTED TO DISCIPLINARY ACTION, OR OTHERWISE LIMITED OR CURTAILED; OR HAVE YOU VOLUNTARILY RELINQUISHED ANY ITEM IN ANTICIPATION OF ANY OF THESE ACTIONS; OR ARE ANY OF THESE ACTIONS PENDING WITH RESPECT TO ANY OF THE FOLLOWING ITEMS? | | | |
| STATE LICENSE | | | |
| DEA REGISTRATION OR OTHER NARCOTIC LICENSE | | | |
| HOSPITAL OR OTHER HEALTH CARE FACILITY STAFF MEMBERSHIP OR PRIVILEGES | | | |
| PROFESSIONAL ORGANIZATION MEMBERSHIP | | | |
| MEDICARE, MEDICAID, OR OTHER GOVERNMENT PROGRAM PARTICIPATION | | | |
| HMO, PPO, OR OTHER PREPAID HEALTH PLAN PARTICIPATION | | | |
| IF THE ANSWER TO ANY OF THE ABOVE ITEMS IS YES, PLEASE EXPLAIN IN AN ATTACHMENT | | | |
| 5. IF YOU HAVE EVER BEEN EMPLOYED AS A PHYSICIAN BY A MILITARY SERVICE, A HOSPITAL, AN HMO OR ANY OTHER HEALTH CARE ORGANIZATION, WAS YOUR EMPLOYMENT EVER TERMINATED BY THE EMPLOYER? <input type="checkbox"/> N/A (NOT APPLICABLE) | | | |
| 6. HAVE YOU EVER BEEN CONVICTED OF A CRIME (OTHER THAN A TRAFFIC OFFENSE), OR ARE YOU CURRENTLY UNDER INDICTMENT FOR AN ALLEGED CRIME? IF THE ANSWER IS YES, PLEASE EXPLAIN IN AN ATTACHMENT. | | | |

I authorize Premier Health Networks of Alabama, LLC (referred to as NAMCI and Comp1One) to consult with members of hospital medical staffs, professional liability carriers and other persons or entities to obtain information concerning my professional qualifications, including competence, ethics, and other qualifications. I release Premier Health Networks of Alabama, LLC and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my application. I consent to the release, by any person to Premier Health Networks of Alabama, LLC of all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions or other confidential or privileged information. I release, from any and all liability, anyone providing this information in good faith and without malice. I understand that any misstatement in this application may constitute grounds for denial of this application or for summary dismissal as a participating Premier Health Networks of Alabama, LLC Provider. If any material changes occur affecting my professional status, it is my obligation to notify Premier Health Networks of Alabama, LLC as soon as possible. I consent to the release of this information, as well as other quality assurance data relating to me, to health plans owned or managed by Premier Health Networks, LLC or to medical groups, IPAs, or other similar entities contracting with those plans.

| | | |
|---------------------|-----------|------|
| NAME (PLEASE PRINT) | SIGNATURE | DATE |
|---------------------|-----------|------|

PLEASE BE SURE TO ENCLOSE WITH THIS APPLICATION
ANY EXPLANATORY STATEMENTS RELATED TO CONFIDENTIAL QUESTIONS 1-6

Premier Health Networks of Alabama, LLC



Preferred Provider Network

PLEASE TYPE
OR USE BALL POINT PEN

TERMS OF PARTICIPAION

GOVERNING LAW STATE OF
ALABAMA

I/We hereby apply for preferred provider status in Premier Health Networks of Alabama, LLC. I/We certify that the information provided on this form and the Premier Health Networks of Alabama, LLC Provider Application is accurate to the best of my/our knowledge and belief. If this application is accepted by Premier Health Networks of Alabama, LLC, I/we acknowledge that I/we have read the Terms of Participation, and agree to abide by such Terms of Participation.

PROVIDER/PHYSICIAN GROUPS

If this application is being submitted on behalf of a legal entity representing two or more physicians, the Physician Application should be completed for **each participating physician** and submitted with this application.

IF PROVIDER/PHYSICIAN GROUP

NAME OF CORPORATION OR OTHER LEGAL ENTITY (PRINT)

NAME OF AUTHORIZED REPRESENTATIVE (PRINT)

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE

IF INDIVIDUAL PROVIDER/PHYSICIAN

NAME

SIGNATURE

DATE

ACCEPTED AND AGREED TO

Premier Health Networks of Alabama, LLC

NAME (PRINT)

TITLE

SIGNATURE

EFFECTIVE DATE OF AGREEMENT

ANNIVERSARY DATE OF AGREEMENT

PROVIDER HAS THE RIGHT TO REVIEW DOCUMENTATION RECEIVED IN SUPPORT OF THIS APPLICATION