Premier Health Networks of Alabama, LLC

Preferred Provider Network Application

PLEASE NOTE THIS INFORMATION WILL BE USED TO DEVELOP THE PROVIDER DIRECTORY

PROVIDER NAME – LAST	**FIRST**	**MIDDLE**	**DEGREE**	GENDER M F	STATE LICENSE NUMBER (PROVIDE COPY)
INDIVIDUAL NPI	**GROUP NPI**	**PRACTICE HOURS OF OPERATION**		**DO YOU HAVE A DEA LICENSE? Y N**	**DEA NUMBER** (PROVIDE COPY)
PRACTICE NAME		**DATE OF BIRTH**	**PRIMARY SPECIALTY**		**BOARD CERTIFIED? Y N YEAR**
TAX ID NUMBER	**SOCIAL SECURITY NUMBER - WILL YOU BILL UNDER THIS NUMBER? YES NO**		**SECONDARY SPECIALTY**		**BOARD CERTIFIED? Y N YEAR**
DOES THE PROVIDER SPEAK MORE THAN ONE LANGUAGE? IF YES PLEASE LIST	**IF NOT BOARD CERTIFIED ARE YOU ELIGIBLE TO TAKE A BOARD EXAMINATION? YES NO BOARD FOR WHICH YOU ARE ELIGIBLE**				**DATE ADMISSIBILITY EXPIRES**
BILLING ADDRESS – STREET				**PHONE**	**FAX**
CITY	**STATE**	**ZIP**			
PRIMARY OFFICE ADDRESS – STREET				**PHONE**	**FAX**
CITY	**STATE**	**ZIP**			
SECOND OFFICE ADDRESS – STREET				**PHONE**	**FAX**
CITY	**STATE**	**ZIP**			
CITY	**STATE**	**ZIP**			
OFFICE CONTACT NAME	**PHONE**		**EMAIL**		

EDUCATION AND TRAINING – PLEASE COMPLETE INFORMATION BELOW AND ATTACH CV

EDUCATION (NAME OF SCHOOL)	**ADDRESS:**	**YEAR GRADUATED**	**DEGREE**
	CITY STATE ZIP		
INTERNSHIP – NAME OF INSTITUTION	**ADDRESS:**	**DATES**	
TYPE OF INTERNSHIP:	**CITY STATE ZIP**		
RESIDENCY – NAME OF INSTITUTION	**ADDRESS:**	**DATES**	
TYPE OF RESIDENCY:	**CITY STATE ZIP**		
PROGRAM DIRECTOR:	**Phone or Contact Information:**		
FELLOWSHIP – NAME OF INSTITUTION	**ADDRESS:**	**DATES**	
TYPE OF FELLOWSHIP:	**CITY STATE ZIP**		

IF YOU ARE NOT BOARD CERTIFIED IN YOUR PRIMARY OR SECONDARY SPECIALTY AND ARE NOT ELIGIBLE TO TAKE EITHER BOARD EXAMINATION, PLEASE ATTACH AN EXPLANATION OF ANY RELEVANT TRAINING AND EXPERIENCE

NAME OF PROFESSIONAL LIABILITY INSURANCE CARRIER (PROVIDE COPY)	**ARE YOU ACCEPTING NEW PATIENTS YES NO**	**AGE RANGE OF PATIENTS**
DO YOU HAVE FULLTIME COVERAGE FOR YOUR PATIENTS? YES NO	**IF YES, PHYSICIAN NAME**	**ADDRESS**
LIST OF HOSPITALS AT WHICH YOU CURRENTLY HAVE ADMITTING PRIVILEGES		**IF YOU DO NOT HAVE ADMITTING PRIVILEGES WHO WILL BE ADMITTING YOUR PATIENTS ON YOUR BEHALF? PLEASE PROVIDE COPY OF REFERRAL ARRANGEMENT**

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CONFIDENTIAL PROVIDER INFORMATION	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: 1- DATE AND DETAILS OF THE INCIDENT(S) LEADING TO THE SUIT OR SETTLEMENT 2- DATE OF SUIT OR SETTLEMENT 3- PROFESSIONAL LIABILITY INSURER INVOLVED 4- YOUR ROLE IN THE INCIDENT(S) 5- YOUR STATUS IN ANY SUIT OR OTHER LEGAL ACTION (PRIMARY DEFENDANT, CODEFENDANT OR OTHER) CURRENT STATUS OF SUIT OR OTHER LEGAL ACTION 6- AMOUNT RESERVED BY CARRIER FOR EACH CLAIM OR AMOUNT PAID AS AN OUT OF COURT SETTLEMENT OR AMOUNT OF JURY 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, AHOSPITAL, AN HMO OR ANY OTHER HEALTH CARE ORGANIZATION, WAS YOUR EMPLOYMENT EVER TERMINATED BY THE EMPLOYER? **N/A** (CIRCLE IF NOT APPLICABLE)		
6. HAVE YOU EVER BEEN CONVICTED OF A FELONY OR CRIME (OTHER THAN A TRAFFIC OFFENSE), OR ARE YOU CURRENTLY UNDER INDICTMENT FOR AN ALLEGED FELONY OR CRIME? **IF THE ANSWER IS YES, PLEASE EXPLAIN IN AN ATTACHMENT.**		

I authorize Premier Health Networks of Alabama (referred to as PHNA, NAMCI, APN 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 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 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 Provider. If any material changes occur affecting my professional status, it is my obligation to notify Premier Health Networks of Alabama 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 or to medical groups, IPAs, or other similar entities contracting with those plans. I certify that the information provided on this application is true and correct.

NAME (PLEASE PRINT)	SIGNATURE	DATE

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

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R USE PEN	TION	NING LAW F 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 (PRINT)

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