

**UNISON HEALTH PLAN
300 OXFORD DRIVE
MONROEVILLE, PA 15146**

**PROVIDER
CREDENTIALING APPLICATION**

Provider Initials: _____ Date: _____

Pennsylvania Standard Application 2006

**UNISON HEALTH PLAN
PROVIDER APPLICATION
CHECKLIST**

This checklist will assist you with the application process. **Any application which does not include the necessary items will cause a delay in the credentialing process until all items have been received.** All information obtained during the credentialing process should be no more than 180 days old at the time of review according to NCQA standards. The following items must be completed by all individuals applying to the network:

- 1. Completion of provider application.
- 2. Enclose a copy of current Medical License.*
- 3. Enclose a copy of current DEA Certificate.*
- 4. Current Face Sheet of Malpractice Insurance Policy showing policy number, coverage limitations, and expiration dates.*
- 5. Signed Attestation Page.*
- 6. Completed W-9 Form.*

*If you already have a completed copy of the Pennsylvania Standard Application on file, you may submit a copy of that application so long as the five additional items mentioned above are also submitted and are current.

If you have any questions or need clarification regarding this application, please call Provider Services at (800) 600-9007.

Please mail your completed application and attachments to:

**UNISON ADMINISTRATIVE SERVICES, LLC
300 OXFORD DRIVE
MONROEVILLE, PA 15146
ATTN: NETWORK DEVELOPMENT**

* After submission you may request information, during normal business hours, on the status of your application by calling (800) 600-9007.

Provider Initials: _____ Date: _____

Pennsylvania Standard Application 2006

Pennsylvania Standard Application

This form should be typed or legibly printed in black or blue ink. Please answer all questions completely and fully. If more space is needed than provided on this application, attach additional sheets and reference the question being answered. If a question is not applicable to you, please respond with N/A. Incomplete applications cannot be processed and this will delay the credentialing process. Refer to instructions from each managed care insurance company for copies of documents that must be submitted with this application. **Please hand initial and date the bottom of each page of the application.**

I. PERSONAL INFORMATION

Last Name: _____ First: _____ Middle: _____

Degree and/or Title: _____ Social Security Number: _____

Any other name under which you have been known: _____

Birth Date: _____ Gender: (Optional) Male: _____ Female: _____ Ethnicity (Optional): _____

If you are not a US Citizen, do you have authorization to work in the US? Yes: _____ No: _____ N/A: _____

Primary Office Address

Name of Practice: _____ Street Address: _____

Suite/Bldg#: _____ City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Federal Tax ID of Group: _____

Are you applying for affiliation as:

Primary Care Physician: _____ Specialist: _____ Both: _____

Non-physician Practitioner: _____ (Please specify: _____)

If you are applying as a **PRIMARY CARE PHYSICIAN**, please mark which specialty:

Family Practice: _____ General Practice: _____ Internal Medicine: _____ Pediatrics: _____ Med Pediatrics: _____ Other: _____

If you have a subspecialty, please identify: _____

If you are applying as a **SPECIALIST**, please indicate which specialty: _____

If you have one or more subspecialties, please identify: _____

Medical Licensure/Registration

Medical License Number:	Issue Date:	Expiration Date:
CDS/BNDD Number (If Applicable):		Expiration Date:
Federal DEA Reg. Number (s):		Expiration Date:
EPSDT Provider Number:		Expiration Date:
Medicare Provider Number:		Expiration Date:
Medicaid Provider Number:		Expiration Date:

Provider Initials: _____ Date: _____

UPIN/NPI Number: _____	Expiration Date: _____
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Additional State Licenses and Numbers

State: _____	License Number: _____	Expiration Date: _____
State: _____	License Number: _____	Expiration Date: _____
State: _____	License Number: _____	Expiration Date: _____

II. EDUCATION / TRAINING / HOSPITAL PRIVILEGES

Undergraduate/Professional Training

Institution: _____ Degree: _____ Graduation Date: _____
 City: _____ State: _____ Country: _____ Dates of Attendance: _____

Medical School

Institution: _____ Degree: _____ Date of Entry: _____
 City: _____ State: _____ Country: _____ Graduation Date: _____

International Medical Graduates

ECFMG Number: _____ Issue Date: _____

Internship/Residency

Institution: _____ Type of Training: _____
 City: _____ State: _____ Country: _____ Date of Entry: _____
 Program Completed: Yes: _____ Date: _____ Specialty: _____
 No: _____ Explain: _____

Residency Fellowship

Institution: _____ Type of Training: _____
 City: _____ State: _____ Country: _____ Date of Entry: _____
 Program Completed: Yes: _____ Date: _____ Specialty: _____
 No: _____ Explain: _____

Residency Fellowship

Institution: _____ Type of Training: _____
 City: _____ State: _____ Country: _____ Date of Entry: _____
 Program Completed: Yes: _____ Date: _____ Specialty: _____
 No: _____ Explain: _____

Provider Initials: _____ Date: _____

Other Experience or Training (i.e., allied health, public service, or military)

Institution: _____ Type of Training Program: _____

City: _____ State: _____ Country: _____ Dates of Attendance: _____

Program Completed: Yes: _____ No: _____ Supervised Clinical Hours: _____

Additional Information: _____

CME REQUIREMENTS

Have you completed 100 CME's in the past two years? Yes _____ No _____

Work History

List all employment since completion of post-graduate training. There should be **no** gaps in the chronology.

Activity	Location	Dates (inclusive)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Hospital Affiliation

Primary Hospital: _____ Street Address: _____

Department: _____ City: _____ State: _____ Zip: _____

Staff Category: _____ % of Admissions: _____ Dates of Affiliation: From: _____ To: _____

Do you currently admit and care for patients on your own hospital service? Yes: _____ No: _____ N/A: _____

If yes: Adult: _____ Child: _____ If no, please explain: _____

Additional Hospital Affiliation

Hospital: _____ Street Address: _____

Department: _____ City: _____ State: _____ Zip: _____

Staff Category: _____ % of Admissions: _____ Dates of Affiliation: From: _____ To: _____

Additional Hospital Affiliation

Hospital: _____ Street Address: _____

Department: _____ City: _____ State: _____ Zip: _____

Staff Category: _____ % of Admissions: _____ Dates of Affiliation: From: _____ To: _____

Provider Initials: _____ Date: _____

Previous Hospital Affiliations (within the last 10 years)

Hospital: _____
City, State: _____
Hospital: _____
City, State: _____
Hospital: _____
City, State: _____

Dates of Affiliation:
From: _____ To: _____
Dates of Affiliation:
From: _____ To: _____
Dates of Affiliation:
From: _____ To: _____

Board Certification

Board Certified: Yes: _____ No: _____
Certificate Number: _____
Most Recent Recertification Date: _____

Certifying Board: _____
Original Certification Date: _____
Certification Expiration Date: _____

Additional Board Certifications / Other Certifications

Board Certified: Yes: _____ No: _____
Certificate Number: _____
Most Recent Recertification Date: _____

Certifying Board: _____
Original Certification Date: _____
Certification Expiration Date: _____

Are you pursuing Board Certification? Yes: _____ No: _____

If yes, give details of plans to take Board exam:

III. OFFICE PRACTICE INFORMATION

Type of Practice

Corporation: _____ Partnership: _____ Solo: _____ Institution: _____ FQHC: _____

Give a narrative description of your practice, including the type of medicine that comprises the majority of your practice, special interests, and procedures performed in your office: _____

Do you receive vaccines purchased by the city/county through public funding? Yes: _____ No: _____ N/A: _____

Individual Tax ID Number of Applicant: _____

Define age restrictions or other practice limitations: _____

Please list HMOs, POs, PHOs and other managed care programs in which you are participating: _____

Provider Initials: _____ Date: _____

Primary Office Site

List Associates (If more space required, attach roster)

Specialties

Office Hours

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday: _____

Office Manager's Name: _____

Handicap Access? Yes: _____ No: _____

List all languages other than English that are spoken fluently.

Provider: _____

Staff: _____

Billing Information for Primary Office

(Check here: if billing address is the same as the Primary Office Address listed on page 1)

Street: _____ City: _____ State: _____ Zip: _____

Suite/Bldg#: _____ Phone: _____ Fax: _____

Billing Manager: _____

Claims payable to: _____

Submit electronic claims? Yes: _____ No: _____

Electronic Mail Code: _____

Preferred Mailing Address

Please indicate which address you would prefer to receive correspondence related to the status of this application:

Primary Office Site: _____

Primary Office Billing Address: _____

Other: _____

If other, please provide complete address:

Provider Initials: _____ Date: _____

Additional Office Sites

Photocopy this page and complete one sheet for each additional office associated with the applicant's practice.

Name of Practice: _____ Street Address: _____

Suite/Bldg#: _____ City: _____ State: _____ Zip: _____

County: _____ Phone: _____ Fax: _____

List Associates (If more space required, attach roster)

Specialties

Office Hours

Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

Saturday:

Sunday:

Office Manager's Name: _____

Handicap Access? Yes: _____ No: _____

List all languages other than English that are spoken fluently.

Provider: _____

Staff: _____

Billing Information for Additional Office

(Check here: if billing address is the same as the address above)

Street: _____ City: _____ State: _____ Zip: _____

Suite/Bldg#: _____ Phone: _____ Fax: _____

Billing Manager: _____ Claims payable to: _____

Submit electronic claims? Yes: _____ No: _____ Electronic Mail Code: _____

Federal Tax ID of Group: _____

Provider Initials: _____ Date: _____

Cross Coverage Please list covering providers. If additional names and information, please attach.

Provider: _____ Address: _____ _____ Phone: _____ Specialty: _____ Managed Care Affiliations: _____ _____ Hospital Affiliations: _____ _____ Office Patients: _____ Hospital Patients: _____	Provider: _____ Address: _____ _____ Phone: _____ Specialty: _____ Managed Care Affiliations: _____ _____ Hospital Affiliations: _____ _____ Office Patients: _____ Hospital Patients: _____	Provider: _____ Address: _____ _____ Phone: _____ Specialty: _____ Managed Care Affiliations: _____ _____ Hospital Affiliations: _____ _____ Office Patients: _____ Hospital Patients: _____
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If you utilize providers in addition to those listed above for 24 hour, 7 day a week coverage, list them.

Provider (Attach roster, if more space required)	Phone Number with Area Code
_____	_____
_____	_____
_____	_____
_____	_____

Do you use physician extenders? Yes: _____ No: _____ If yes, list names and license numbers.

Name: _____	Title/Degree: _____	License Number: _____
Name: _____	Title/Degree: _____	License Number: _____
Name: _____	Title/Degree: _____	License Number: _____
Name: _____	Title/Degree: _____	License Number: _____

IV. CONFIDENTIAL INFORMATION

IF YOU HAVE ANY YES ANSWERS TO ANY QUESTIONS IN THE SECTIONS BELOW AND THOSE ON PAGE 9, REFERENCE THE QUESTIONS ON A SEPARATE SHEET, GIVE FULL DETAILS AND ATTACH.

Have any of the following at any time been, or are they currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state?

Medical or professional license	Yes:___	No:___
DEA or CDS/BNDD registration	Yes:___	No:___
Hospital medical staff membership	Yes:___	No:___
Clinical privileges or other rights on any hospital medical staff	Yes:___	No:___
Employment by any hospital, institution, or the military	Yes:___	No:___
Professional society memberships	Yes:___	No:___
Participation in any private, federal, or state health insurance program (i.e., Medicare, CHAMPUS, Medicaid)	Yes:___	No:___
Participation in an HMO, PPO, or any other managed care organization	Yes:___	No:___
Board Certification	Yes:___	No:___

At any time, have you ever been:

Convicted of a criminal offense	Yes:___	No:___
Convicted of a felony	Yes:___	No:___
Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of trial, or an accelerated rehabilitation disposition in the disposition of felony changes in any state, territory or country	Yes:___	No:___

Have you ever at any time or are you currently:

Under indictment for any crime	Yes:___	No:___
The subject of an investigation by any private, federal or state health insurance program or state licensing board	Yes:___	No:___
Under investigation by any state licensing board or federal agency	Yes:___	No:___
The subject of any adverse action reports to a state or federal databank	Yes:___	No:___

Provider Initials:_____ Date:_____

Have you ever either voluntarily or involuntarily:

Withdrawn your application for medical staff membership at any facility	Yes:_____	No:_____
Withdrawn your request for any clinical privileges at any facility	Yes:_____	No:_____

Health Status

Are you currently using any chemical substance(s) which in any way may impair or limit your ability to practice medicine with reasonable skill and safety	Yes:_____	No:_____
Are you currently engaged in the illegal use of controlled dangerous substances	Yes:_____	No:_____
Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors or treats you	Yes:_____	No:_____
Do you have a medical or psychiatric condition which in any way may impair or limit your ability to practice medicine with reasonable skill and safety with or without reasonable accommodation	Yes:_____	No:_____

V. PROFESSIONAL LIABILITY CARRIER INFORMATION

Current Insurance Carrier:_____

Street Address:_____ City:_____ State:_____ Zip Code:_____

Suite/Bldg #:_____ Date of Coverage:_____ Coverage expiration:_____

Coverage Amount _____ Policy Number:_____ Type of coverage:_____

Individual:_____ Procedures excluded from coverage:_____

Aggregate:_____

Previous Insurance Carrier(s) (For the last 5 years, if you have not been with your current carrier for 5 years.)

Previous Insurance Carrier:_____ Type of coverage:_____

Street Address:_____ Suite/Bldg#:_____ City:_____ State:_____

Policy Number:_____ Coverage: To:_____ From:_____

Procedures excluded from coverage:_____

Previous Insurance Carrier:_____ Type of coverage:_____

Street Address:_____ Suite/Bldg#:_____ City:_____ State:_____

Policy Number:_____ Coverage: To:_____ From:_____

Procedures excluded from coverage:_____

Provider Initials:_____ Date:_____

Professional Liability History

In the past 10 years, has your liability insurance ever been canceled or denied	Yes:_____	No:_____
Do you have any malpractice judgments against you including arbitration in the last 10 years	Yes:_____	No:_____
Have you had any claim settlements not involving litigation or arbitration paid by you or on your behalf in the last 10 years	Yes:_____	No:_____
Are you now a defendant in a pending malpractice suit	Yes:_____	No:_____

IF YOU ANSWER YES TO ANY OF THE QUESTIONS ABOVE, PROVIDE THE FOLLOWING INFORMATION FOR EACH CASE/SITUATION:

Date of occurrence of alleged malpractice:_____ Plaintiff name:_____

Name of the insurance carrier involved:_____

Status of the case:

Pending:_____

If pending, list carrier:_____

Found for plaintiff:_____

Found for defendant:_____

Dismissed / dropped:_____

Settled:_____

If settled, give the amount:_____

Professional relationship to patient:_____

Alleged harm to patient:_____

Circumstances of patient's illness:_____

Any other pertinent details:_____

REQUIRED COPIES

REFER TO INSTRUCTIONS FROM EACH MANAGED CARE ORGANIZATION FOR DOCUMENTS REQUIRED FOR CREDENTIALS THAT ARE IN ADDITION TO THE INFORMATION YOU ATTACH TO PROPERLY RESPOND TO QUESTIONS ON THIS APPLICATION

Provider Initials:_____ Date:_____

**UNISON HEALTH PLANS
CREDENTIALING APPLICATION ATTESTATION**

PLEASE READ CAREFULLY BEFORE SIGNING:

All information submitted in this application is correct and complete to my best knowledge and belief; any misstatement or omission from this application may lead to the denial of my application. As regards my application for network participation with any or all of the Unison Health Plans, I hereby agree:

1. To appear for interview, upon request;
2. That Unison Administrative Services, LLC, which conducts credentials review for the Unison Health Plans, may consult: (a) administrators and medical staff members at the hospitals or other institutions with which I have been associated, (b) past and present malpractice carriers and (c) any others with information as to my professional competence, character and ethical qualifications;
3. That Unison Administrative Services, LLC or other Unison Health Plan representatives may inspect documents that may be material to my professional qualifications and competence;
4. That Unison Administrative Services, LLC may query the National Practitioner Databank, the Federation of State Medical Boards and other such services or agencies regarding my application;
5. To release from liability all the Unison Health Plans, Unison Administrative Services, LLC and their representatives for acts performed in good faith and without malice in evaluating my application, credentials and qualifications;
6. To release from liability all individuals and organizations that provide information in good faith and without malice concerning my professional competence, ethics, character and qualifications;
7. To the release and exchange of information relating to any disciplinary action, suspension or curtailment of surgical-medical privileges;
8. That, I bear the burden of producing adequate information for: (a) the proper evaluation of my professional competence, character, ethics, and other qualifications; and (b) resolving any doubts about such qualifications;
9. That I may provide information to correct allegedly erroneous information and may review information obtained to evaluate my application, unless disclosure is prohibited by law or the information is protected by peer review or other similar privileges.
10. That I will not be a participating provider in the Unison Health Plan provider network until my credentials are approved;
11. That, I will provide Covered Services to Unison Members during the credentialing process and accept as payment in full the compensation rate specified in the individual or group participation agreement that accompanies this application , except that special "carved out" compensation terms will not take effect until my credentials are approved and I am a network participating provider. In the event I do not become a network participating provider, I agree to continue providing Covered Services to established Unison Member patients and to accept the payment set forth herein until such Unison Members complete the course of treatment or can be transferred to network participation providers.

Print Name

Signature

Date

**UNISON ADMINSTRATIVE SERVICES, LLC
300 OXFORD DRIVE
MONROEVILLE, PA 15146
CREDENTIAL REVIEWS FOR THE UNISON HEALTH PLANS**

Provider Initials: _____ Date: _____