30 Knightsbridge Road
Piscataway, NJ 08854
Phone: (732) 562-0833
Fax: (732) 562-7868

APPLICATION FOR NETWORK PARTICIPATION

HMO/POS NETWORK PPO NETWORK WORKERS COMP GROUP CONTRACT

I do not wish to participate in Workers' Compensation. (Failure to indicate preference will automatically include you in the Workers' Compensation network)

I. GENERAL INFORMATION

PROVIDER NAME:_____
LAST FIRST M.I.

DEGREE _____ DATE OF BIRTH _____ S.S.# _____ TAX ID# _____

NPI #:_____ CAQH ID # _____ GENDER: ☐ MALE ☐ FEMALE

E-MAIL ADDRESS:_____ WEBSITE ADDRESS:_____

You are applying for participation as a:
Primary Care Physician **TYPE:** _____
Specialty Provider **TYPE:** _____
Allied Health Professional **TYPE:** _____

II. PRACTICE INFORMATION

County: _____

Legal Primary Practice Name_____

_____

Office Address

_____

City State Zip+4

_____

Telephone Fax

Remittance Address
If below is not completed, claims will be sent to the Office Address Address

_____

Street Address

_____

City State Zip+4

_____

Telephone Fax

Group NPI # _____

County: _____

Legal Secondary Practice Name_____

_____

Office Address

_____

City State Zip+4

_____

Telephone Fax

Remittance Address
If below is not completed, claims will be sent to the Office

_____

Street Address

_____

City State Zip+4

_____

Telephone Fax

Group NPI # _____

Physical Billing Address

If below is not completed, claims will be sent to the Office Address

Street Address

City State Zip

Telephone Fax

Physical Billing Address

If below is not completed, claims will be sent to the Office

Street Address

City State Zip

Telephone Fax

*If more than two (2) practices, please attach a separate sheet with all information.

Partner(s)/Associate(s) Name(s) (Attach separate sheet if needed)

NOTE: All members of a group must participate with QualCare, Inc.

Please identify all ancillary providers: Physical Therapist(s), Occupational Therapist(s), Audiologist(s), Speech Therapist(s), Acupuncturist(s), Physician Assistant(s), Nurse Practitioner(s), Nurse Midwives, Optometrist(s) who provide service in your office(s) and bill under the same Tax Identification Number. (Attach separate sheet if needed)

Name: _____ Title: _____

_____ _____

_____ _____

*****Primary Care Practices Only:**

Has your practice achieved **Recognition by NCQA as a Physician Practice Connections® Patient-Centered Medical Home™**?

☐ YES ☐ NO

If yes, please attach a copy or your NCQA PPC® -PCMH™ Recognition Certificate.

Do you have the intention to seek this Recognition? ☐ YES ☐ NO

Are you currently accepting new patients: ☐ YES ☐ NO How many can you accommodate monthly ? _____

Do you, or any of your office staff, speak a foreign language? Please indicate which language(s) _____

Are your offices handicapped accessible? _____

How long have you been in practice?_____In this geographic area? _____

Explain what arrangements, if any, you have for 24 hour/day, 7 day/week coverage for your patients: _____

COVERING PHYSICIAN(S) (Please attach additional sheets, if necessary)

Name

Office Address

City State Zip

Telephone No. TIN

Name

Office Address

City State Zip

Telephone No. TIN

III. MEDICAL LICENSE INFORMATION

In what specialties do you currently practice? Primary _____ Secondary _____

Are you Board Certified? Yes_____ No _____ In what specialty?_____

If Yes, Date of Certification: _____ Recertification: _____

Are you Board Eligible? Yes_____ No _____ In what specialty?_____

If yes, do you intend to become Board Certified? Yes____ No_____

Please indicate Board Name, Date of Application and Date of Eligibility Expiration: _____

_____

License Number: _____ State: _____ Expiration: _____

License Number: _____ State: _____ Expiration:_____

DEA Number: _____ Expiration:_____

CDS Number: _____ Expiration:_____

Medicare Number: _____ Medicaid Number: _____

IV. EDUCATION AND TRAINING/PRACTICE HISTORY

Complete Section IV or Submit Curriculum Vitae, which must include education and work history (Please explain any gaps in chronology) of six (6) months or greater).

	Institution/Location	**Dates Attended (Month/Year)**	**Degree/Specialty**
Undergraduate		Beg:	
		End:	
Medical School		Beg:	
		End:	
Internship		Beg:	
		End::	
Residency		Beg:	
		End:	
Fellowship		Beg:	
		End:	
Post Graduate		Beg:	
		End:	
Academic Appointments		Beg:	
		End:	

Practice History: (Attach additional sheets if necessary)

From: / (Month/Year)	**To: / (Month/Year)**
Facility /Group Name:	
Address:	
Primary Responsibility:	
Name/Title Supervisor:	

From: / (Month/Year)	**To: / (Month/Year)**
Facility /Group Name:	
Address:	
Primary Responsibility:	
Name/Title Supervisor:	

From: / (Month/Year)	**To: / (Month/Year)**
Facility /Group Name:	
Address:	
Primary Responsibility:	
Name/Title Supervisor:	

V. HOSPITAL AFFILIATION

Please list all hospital staff appointments including the type of privileges at each hospital, **if applicable.**

	HOSPITAL	**DEPARTMENT(S)**	**TYPE OF PRIVILEGE (Active, Courtesy, Etc.)**
Primary			
Secondary			
Third			

Are there any restrictions on admitting privileges at these or any other hospitals? ☐ Yes ☐ No

If yes, please explain: _____

VI. PROFESSIONAL AFFILIATIONS (MEMBERSHIPS, SOCIETIES, ETC.)

ORGANIZATIONS	LOCATION	DATES	OFFICE HELD

VII. PROFESSIONAL LIABILITY

Current Insurance Carrier: **(Include Copy of Policy Face Sheet**) _____

Policy Number:_____ Policy Period: From:_____To: _____

Amount of Coverage per Occurrence: $ _____ Aggregate: $_____

Has your professional liability insurance ever been denied, suspended, canceled or not renewed? **If yes, please attach an explanation.** ☐ Yes ☐ No

Previous Insurance Carrier (past five years):_____

Policy Number: _____ Policy Period: From _____To: _____

Do you have any litigation pending or completed within the last five years? ☐ Yes ☐ No

If yes, please provide the following written information for each pending litigation or settlement and attach to this application:

- Date and details of the incident(s)
- Current status of the claim(s)
- If settled, amount paid
- If pending, amount being sought
- Professional liability insurer involved
- Your role in incident(s) e.g., primary defendant, co-defendant, other

VIII. CONFIDENTIAL RECORD

If any of the questions in this section are answered **"YES,"** please provide a complete explanation on a separate sheet of paper.

		YES	NO
1.	Has your medical license to practice in any jurisdiction ever been limited, suspended or revoked?	_____	_____
2.	Has your DEA registration or other narcotic license ever been suspended or revoked?	_____	_____
3.	Has your request for specific clinical privileges ever been denied or granted with stated limitations or have your hospital privileges ever been suspended, revoked or not renewed?	_____	_____
4.	Have you ever been denied membership on a hospital medical staff?	_____	_____
5.	Are you currently having any medical, psychiatric or substance abuse problem(s) which would adversely affect your ability to practice medicine and/or surgery?	_____	_____
6.	Are you currently under indictment for any crime or have you ever been convicted of a criminal offense?	_____	_____
7.	Are there currently any actions pending against your medical license to practice in any jurisdiction?	_____	_____
8.	Have you ever been expelled or suspended from service reimbursement from Medicaid or Medicare?	_____	_____
9.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization?	_____	_____

IX. CREDENTIALS VERIFICATION/ RELEASE FORM

I will acknowledge and agree that QualCare, Inc., has a valid interest in obtaining and verifying information concerning my professional competence, in determining whether to enter into an agreement with me for the provision of medical services to members of its prepaid health care plan. Accordingly,

I. I represent and warrant to QualCare, Inc. that **the information contained in the foregoing application is true and complete to the best of my knowledge and belief**, and I agree to inform QualCare, Inc. promptly if any material change in such information occurs, whether before or after my entering into an agreement with QualCare, Inc. for the provision of medical services.

II. I authorize QualCare, Inc. and/or its agent to consult with administrators, members of medical staffs of hospitals (if applicable), malpractice carriers and other persons to obtain and verify information concerning my professional competence, character and moral and ethical qualifications, and I release QualCare, Inc. and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

III. I consent to the release by any person to QualCare, Inc. of all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualifications, including any information relating to any disciplinary action; suspension or curtailment of hospital privileges; malpractice allegations; and hereby release any such person providing such information from any and all liability for doing so.

IV. I acknowledge that I am a member in good standing of a Medical Staff and that my delineation of privileges in QualCare, Inc. is the same as the hospital's delineation, except where otherwise indicated (if applicable).

V. I understand that this application does not entitle me to participate in QualCare, Inc. I also understand that any falsification, misrepresentation, misstatement or intentional omission in this application may constitute grounds for denial of this application or for summary dismissal as a participating physician.

VI. I further understand and agree that if this application is accepted by QualCare, Inc., I will be bound by the terms of the Network Physician Service Agreement, of which this application is a part.

VII. A photostatic copy of this original statement constitutes my written authorization and request to release any and all documentation relevant to this application. Said photostatic copy shall have the same force and effect as the signed original.

Print Name: _____

Signature: _____

Date: _____

Tax ID Number: _____