TEXAS A&M UNIVERSITY

HEALTH SCIENCE CENTER
Clinical Strategy
8441 State Hwy 47 Suite 3115
Bryan, Texas 77807
Crendialing@tamu.edu

Texas A&M University Health Science Center Department of Clinical Strategy

Credentialing Packet Checklist

To process your application entirely, the following documents must be returned with this packet:

- ✓ **A copy of your current state medical license.**
- ✓ **A copy of your current Drug Enforcement Administration** *(DEA)* **Controlled Substance Registration Certificate.**
- ✓ **A copy of your medical malpractice insurance binder.**
- ✓ **Documentation of board(s) and certifications** *(NALS, PALS, ATLS, etc., if applicable).*
- ✓ **Current photocopy of driver license**
- ✓ **A copy of your current CV/Resume**- *Listing Texas A&M Health Science Center as your current employer.*

If you will be applying for hospital privileges you will be asked to furnish:

- ✓ **Insurance face sheets for the past 6 years**
- ✓ **Volumes/case logs for past 24 months or letter from Program Director attesting to her competency and completion of training**

This packet includes the following forms. Each question is vital to the credentialing process. Carefully complete each form as complete as possible. Some fields are prefilled to reflect your current role with the group.

Attached Application List	
☐ TAMUHSC Credentialing Packet Checklist	Pg. 1
☐ Texas A&M Health- New Provider On-boarding Form	Pg.2-3 General Information
☐ Texas Standardized Credentialing Application	Pg.4-23 Required state application, must be complete with current & accurate information
☐ Coverys Professional Liability Application	Pg.24-29 Application for malpractice Insurance coverage
☐ Alliance Health Providers Brazos Valley-Midlevel/ Supervising Physician	Pg. 30 If you have a current DEA please complete section 2 and sign attestation in section 3
☐ Alliance Health Providers Brazos Valley- BCBS Opt-in	Pg. 31 As a group, we opt into all plan types. Please be sure your signature is present.
☐ Alliance Health Providers Brazos Valley- Designated Admitting Practitioner Agreement (DAP)	Pg. 32 The DAP form is essential to the credentialing process until hospital privileges are approved. Once the top section is signed, the application will be forwarded to the program manager for signature.
☐ Aetna Health Plan Agreement Opt-in	Pg. 33 Please ensure signature is present.

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PERSONAL INFORMATION

FIRST NAME: _____ LAST NAME: _____ TITTLE: _____

DATE PROVIDER JOINED PRACTICE: _____ GENDER: _____

DEGREE: _____ INDIVIDUAL NPI: _____

DOB: _____ PLACE OF BIRTH: _____ SS# _____

DL STATE: _____ DL NUMBER: _____ DL EXPIRATION: _____

CAQH ACCOUNT #: _____ USERNAME: _____ PASSWORD: _____

CREDENTIALS

PRIMARY SPECIALTY: _____ PRIMARY TAXONOMY: _____

SUB- SPECIALTY: _____ CONDARY TAXONOMY: _____

MEDICAL LICENSE #: _____ STATE ISSUED: _____

EXP. DATE _____ ISSUE DATE: _____

DEA #: _____ EXP. DATE: _____ REGISTERED STATE: _____

BOARD CERTIFIED: ☐ *Yes* ☐ *NO* ACTIVE BOARD STAUS: ---

CERTIFYING BOARD: _____

BOARD #: _____ ISSUED: _____ EXPIRATION: _____

PEER REFERENCES

Peer Reference Name _____
Peer Reference Address _____
Peer Reference City, State, Zip _____
Peer Reference Phone _____
Peer Reference Email _____
Peer Reference Years known _____

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HEALTH

Peer Reference Name _____
Peer Reference Address _____
Peer Reference City, State, Zip _____
Peer Reference Phone _____
Peer Reference Email _____
Peer Reference Years known _____

Peer Reference Name _____
Peer Reference Address _____
Peer Reference City, State, Zip _____
Peer Reference Phone _____
Peer Reference Email _____
Peer Reference Years known _____

ADDITIONAL INFORAMTION

Does the provider have any felony charges, sanctions or other issues that may be an issue with the credentialing process? ☐ YES ☐ NO

Describe any potential issues that could affect the credentialing process? (as they relate to the above question)

To provide an electronic signature, please sign in the box below.
A picture of your signature on a white/blank piece of paper can be uploaded

Pursuant to Texas Insurance Code § 1452.052, LHL234 Rev. 01/07 is promulgated by the Texas Department of Insurance. Please send this application to the carrier with whom you wish to become credentialed.

Texas Standardized Credentialing Application

(Please type or print

Section I-Individual Information

TYPE OF PROFESSIONAL

LAST NAME | FIRST | MIDDLE | (JR., SR., ETC.)

MAIDEN NAME | YEARS ASSOCIATED (YYYY-YYYY) | OTHER NAME | YEARS ASSOCIATED (YYYY-YYYY)

HOME MAILING ADDRESS

CITY | STATE/COUNTRY | POSTAL CODE

Texas

HOME PHONE NUMBER | SOCIAL SECURITY NUMBER | ■ Female ☐ Male

CORRESPONDENCE ADDRESS

8441 State Hwy 47 Suite 3115

CITY | STATE/COUNTRY | POSTAL CODE

Bryan, | Texas /USA | 77807

PHONE NUMBER | FAX NUMBER | E-MAIL

979-436-0072

DATE OF BIRTH (MM/DD/YYYY) | PLACE OF BIRTH | CITIZENSHIP

IF NOT AMERICAN CITIZEN, VISA NUMBER & STATUS | ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES? ☐ Yes ☐ No

U.S.MILITARY SERVICE/PUBLIC HEALTH ☐Yes ☐ No | DATES OF SERVICE (MM/DD/YYYY) TO (MM/DD/YYYY) | LAST LOCATION

BRANCH OF SERVICE | ARE YOU CURRENTLY ON ACTIVE OR RESERVE MILITARY DUTY? ☐ Yes ☐ No

Education

PROFESSIONAL DEGREE (MEDICAL, DENTAL, CHIROPRACTIC, ETC.)

Issuing Institution:

ADDRESS

CITY | STATE/COUNTRY | POSTAL CODE

DEGREE | ATTENDANCE DATES(MM/YYYY TO MM/YYYY)

☐ *Please check this box and complete and submit Attachment A if you received other professional degrees.*

POST-GRADUATE EDUCATION | SPECIALTY

☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment

INSTITUTION

ADDRESS

CITY | STATE/COUNTRY | POSTAL CODE

☐ Program successfully completed | ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

PROGRAM DIRECTOR | CURRENT PROGRAM DIRECTOR (IF KNOWN)

POST-GRADUATE EDUCATION | SPECIALTY

☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment

INSTITUTION

ADDRESS

CITY | STATE/COUNTRY | POSTAL CODE

Education - *continued*

POST-GRADUATE EDUCATION ☐ Program successfully completed	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)

☐ Please *check this box and complete and submit Attachment B if you received additional postgraduate training.*

OTHER GRADUATE-LEVEL EDUCATION Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)	

Licenses and Certificates - Please include all license(s) and certifications in all States where you are currently or have previously been licensed.

LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
☐ DEA Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
☐ DPS Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
OTHER CDS (PLEASE SPECIFY)	NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No

UPIN	NATIONAL PROVIDER IDENTIFIER (WHEN AVAILABLE)
ARE YOU A PARTICIPATING MEDICARE PROVIDER? ☐ Yes ☐ No Medicare Provider Number:	ARE YOU A PARTICIPATING MEDICAID PROVIDER? ☐ Yes ☐ No Medicaid Provider Number:

EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES (ECFMG) ☐ N/A ☐ Yes ☐ No ECFMG Number:	ECFMG ISSUE DATE (MM/DD/YYYY)

Professional/Specialty Information

PRIMARY SPECIALTY	BOARD CERTIFIED? ☐ Yes ☐ No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ I have taken exam, results pending for Board.

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I am intending to sit for the Boards on (date)

☐ I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO: ☐ Yes ☐ No PPO: ☐ Yes ☐ No POS: ☐ Yes ☐ No

SECONDARY SPECIALTY	BOARD CERTIFIED? ☐ Yes ☐ No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

Professional/Specialty Information *-continued*

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ I have taken exam, results pending for Board.

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I am intending to sit for the Boards on (date)

☐ I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO: ☐ Yes ☐ No PPO: ☐ Yes ☐ No POS: ☐ Yes ☐ No

ADDITIONAL SPECIALTY	BOARD CERTIFIED? ☐Yes ☐ No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ I have taken exam, results pending for Board.

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I am intending to sit for the Boards on (date)

☐ I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO: ☐ Yes ☐ No PPO: ☐ Yes ☐ No POS: ☐ Yes ☐ No

PLEASE LIST OTHER AREAS OF PROFESSIONAL PRACTICE INTEREST OR FOCUS (HIV/AIDS, ETC.)

Work History - ***Please provide a chronological work history. You may submit a Curriculum Vitae as a supplement. Please explain all gaps in employment that lasted more than six months.***

CURRENT PRACTICE/EMPLOYER NAME Texas A&M University System Health Science Center		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS 2900 E 29th Street Suite 200		
CITY Bryan, TX 77802	STATE/COUNTRY	POSTAL CODE
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		

PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS GREATER THAN SIX MONTHS (MM/YYYY TO MM/YYYY) IN WORK HISTORY.

Gap Dates: Explanation:

Gap Dates: Explanation:

Work History – ***continued***

Gap Dates: Explanation:

Gap Dates: Explanation:

☐ ***Please check this box and complete and submit Attachment C if you have additional work history***

Hospital Affiliations-*Please include all hospitals where you currently have or have previously had privileges.*

DO YOU HAVE HOSPITAL PRIVILEGES? ☐ Yes ☐ No	IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHAT ADMITTING ARRANGEMENTS DO YOU HAVE?	
PRIMARY HOSPITAL WHERE YOU HAVE ADMITTING PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO PRIMARY HOSPITAL?		
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?		

☐ ***Please check this box and complete and submit Attachment D if you have additional current hospital affiliations.***

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE		

☐ ***Please check this box and complete and submit Attachment E if you have additional previous hospital affiliations.***

References-***Please provide three peer references from the same field and/or specialty who are not partners in your own group practice and are not relatives. All peer references should have firsthand knowledge of your abilities.***

1 NAME/TITLE	PHONE NUMBER
ADDRESS	
CITY STATE/COUNTRY	POSTAL CODE

References *continued*

2 NAME/TITLE	PHONE NUMBER
ADDRESS	
CITY / STATE/COUNTRY / POSTAL CODE	
3 NAME/TITLE	PHONE NUMBER
ADDRESS	
CITY / STATE/COUNTRY / POSTAL CODE	

Professional Liability Insurance Coverage

SELF-INSURED? ☑ Yes ☐ No	NAME OF CURRENT MALPRACTICE INSURANCE CARRIER OR SELF-INSURED ENTITY
	ProSelect Insurance Company

ADDRESS: 675 Atlantic Avenue

CITY	STATE/COUNTRY	POSTAL CODE
Boston	MA/USA	02111

PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
800-225-6168	002TX000034016	01/01/2021	01/01/2022
AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE	TYPE OF COVERAGE	LENGTH OF TIME WITH CARRIER
500,000	1,500,000	☐ Individual ☑ Shared	

NAME OF PREVIOUS MALPRACTICE INSURANCE CARRIER IF WITH CURRENT CARRIER LESS THAN 5 YEARS

ADDRESS

CITY / STATE/COUNTRY / POSTAL CODE			
PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE	TYPE OF COVERAGE ☐ Individual ☐ Shared	LENGTH OF TIME WITH CARRIER

Call Coverage

☐ **See attached list of hospital staff within my department I utilize for call coverage**.

PLEASE LIST NAMES OF COLLEAGUE(S) PROVIDING REGULAR COVERAGE AND HIS OR HER SPECIALTIES.

Name:	Specialty:
Name:	Specialty:
Name:	Specialty:
Name:	Specialty:
Name:	Specialty:

PLEASE LIST FULL NAMES OF ALL PARTNERS IN YOUR PRACTICE. ☐ CHECK THIS BOX AND ATTACH LIST FOR LARGE GROUP.

Name:	Name:
Name:	Name:
Name:	Name:
Name:	Name:

Practice Location Information – ***Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.***

PRACTICE LOCATION of 1of 1

TYPE OF SERVICE PROVIDED
☐ Solo Primary Care ☐ Solo Specialty Care ☐ Group Primary Care ☐ Group Single Specialty ■ Group Multi-Specialty

GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY	GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9
Texas A&M Physicians	Texas A&M University System Health Science Center

PRACTICE LOCATION ADDRESS
■ **Primary** 2900 E 29th Street Suite 200

CITY	STATE/COUNTRY	POSTAL CODE
Bryan,	TX	77802-2622

PHONE NUMBER	FAX NUMBER	E-MAIL
979-776-8440	877-601-5854	

BACK OFFICE PHONE NUMBER	SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER
	198523601	74-2907553

GROUP NUMBER CORRESPONDING TO TAX ID NUMBER	GROUP NAME CORRESPONDING TO TAX ID NUMBER
1063699312	Texas A&M University System Health Science Center

ARE YOU CURRENTLY PRACTICING AT THIS LOCATION?	IF NO, EXPECTED START DATE? (MM/DD/YYYY)	DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY?
■ Yes ☐ No		■ Yes ☐ No

OFFICE MANAGER OR STAFF CONTACT	PHONE NUMBER	FAX NUMBER
Robin Fuller	979-776-8440	877-601-5854

CREDENTIALING CONTACT
Sarah Fernandes

ADDRESS
8441 State Hwy 47, Suite 3115

CITY	STATE/COUNTRY	POSTAL CODE
Bryan,	TX/USA	77807-3208

PHONE NUMBER	FAX NUMBER	E-MAIL
979-436-0483	877-601-5854	credentialing@tamu.edu

BILLING COMPANY'S NAME (IF APPLICABLE)	BILLING REPRESENTATIVE

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

DEPARTMENT NAME IF HOSPITAL-BASED	CHECK PAYABLE TO	CAN YOU BILL ELECTRONICALLY?
	Texas A&M University System	■ Yes ☐ No

HOURS PATIENTS ARE SEEN

Monday	☐ No Office Hours	Morning: 8:00 am	Afternoon:	Evening: 5:00 pm
Tuesday	☐ No Office Hours	Morning: 8:00 am	Afternoon:	Evening: 5:00 pm
Wednesday	☐ No Office Hours	Morning: 8:00 am	Afternoon:	Evening: 5:00 pm
Thursday	☐ No Office Hours	Morning: 8:00 am	Afternoon:	Evening: 5:00 pm
Friday	☐ No Office Hours	Morning: 8:00 am	Afternoon:	Evening: 5:00 pm
Saturday	■ No Office Hours	Morning:	Afternoon:	Evening:
Sunday	■ No Office Hours	Morning:	Afternoon:	Evening:

DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?
■ Answering Service ■ Voice mail with instructions to call answering service ☐ Voice mail with other instructions ☐ None

THIS PRACTICE LOCATION ACCEPTS
■ all new patients ☐ existing patients with change of payor ☐ new patients with referral ☐ new Medicare patients ☐ new Medicaid patients

IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.

PRACTICE LIMITATIONS
☐ Male only ☐ Female only Age: ☐ Other:

DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?
■ Yes ☐ No If yes, provide the following information for each staff member:

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.

Practice Location Information - continued

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.

NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL
Spanish

ARE INTERPRETERS AVAILABLE?
☒ Yes ☐ No If yes, please specify languages: Spanish

DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?
☒ Yes ☐ No

WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?
☒ Building ☒ Parking ☒ Restroom ☐ Other:

DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?
☐ Text Telephony-TTY ☐ American Sign Language-ASL ☒ Mental/Physical Impairment Services ☐ Other:

IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?
☒ Bus ☐ Regional Train ☐ Other:

DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?
☐ Yes ☒ No

DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?
☐ Yes ☒ No

WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)

Basic Life Support	☐ Staff	☐ Provider Exp:	Advanced Life Support in OB	☐ Staff	☐ Provider Exp:
Advanced Trauma Life Support	☐ Staff	☐ Provider Exp:	Cardio-Pulmonary Resuscitation	☐ Staff	☐ Provider Exp:
Advanced Cardiac Life Support	☐ Staff	☐ Provider Exp:	Pediatric Advanced Life Support	☐ Staff	☐ Provider Exp:
Neonatal Advanced Life Support	☐ Staff	☐ Provider Exp:	Other (please specify)	☐ Staff	☐ Provider Exp:

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☒ No

☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☒ No

☐ X-ray; please list all certifications:

OTHER SERVICES

☐ Radiology Services	☐ EKG	☐ Care of Minor Lacerations	☐ Pulmonary Function Tests
☐ Allergy Injections	☐ Allergy Skin Tests	☐ Routine Office Gynecology	☐ Drawing Blood
☐ Age Appropriate Immunizations	☐ Flexible Sigmoidoscopy	☐ Tympanometry/Audiometry Tests	☐ Asthma Treatments
☐ Osteopathic Manipulations	☐ IV Hydration /Treatments	☐ Cardiac Stress Tests	☐ Physical Therapies

☐ Other:

PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?
☐ Yes ☒ No Please specify the classes or categories:

WHO ADMINISTERS IT?

☐ **Please *check this box and complete and submit Attachment F if you have other practice locations.***

Section II-Disclosure Questions - Please *provide* an explanation for any question answered yes-except 16-on page 10.

Licensure

1 Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?

☐ Yes ☐ No

2 Have you ever received a reprimand or been fined by any state licensing board?

☐ Yes ☐ No

Hospital Privileges and Other Affiliations

3 Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?

☐ Yes ☐ No

4 Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?

☐ Yes ☐ No

5 Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?

☐ Yes ☐ No

Education, Training and Board Certification

6 Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?

☐ Yes ☐ No

7 Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?

☐ Yes ☐ No

8 Have any of your board certifications or eligibility ever been revoked?

☐ Yes ☐ No

9 Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?

☐ Yes ☐ No

DEA or DPS

10 Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?

☐ Yes ☐ No

Medicare, Medicaid or other Governmental Program Participation

11 Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?

☐ Yes ☐ No

Other Sanctions or Investigations

12 Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?

☐ Yes ☐ No

Section II - Disclosure Questions - ***continued***

Other Sanctions or Investigations

13 To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?

☐ Yes ☐ No

14 Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?

☐ Yes ☐ No

15 Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?

☐ Yes ☐ No

Malpractice Claims History

16 Have you had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated?

☐ Yes ☐ No

☐ *If yes, please check this box and complete and submit Attachment G.*

Criminal

17 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional

☐ Yes ☐ No

18 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense?

☐ Yes ☐ No

19 Have you been court-martialed for actions related to your duties as a medical professional?

☐ Yes ☐ No

Ability to Perform Job

20 Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

☐ Yes ☐ No

21 Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

☐ Yes ☐ No

Ability to Perform Job

22 Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?

☐ Yes ☐ No

23 Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation?

☐ Yes ☐ No

Please use the space on page 10 to explain yes answers to any question except #16.

Section II - Disclosure Questions-*continued*

Please use the space below to explain yes answers to any question except 16.

QUESTION NUMBER	PLEASE EXPLAIN

Section III – Standard Authorization, Attestation and Release (Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as "Participation") at or with

(PLEASE INDICATE MANAGED CARE COMPANY(S) OR HOSPITAL(S) TO WHICH YOU ARE APPLYING) (HEREINAFTER, INDIVIDUALLY REFERRED TO AS THE "ENTITY")

To requesting entity

and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

For Hospital Credentialing. I consent to appear for an interview with the credentials committee, medical staff executive committee, or other representatives of the medical staff, hospital administration or the governing board, if required or requested. As a medical staff member, I pledge to provide continuous care for my patients. I have been informed of existing hospital bylaws, rules and regulations, and policies regarding the application process, and I agree that as a medical staff member, I will be bound by them.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: (I) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third

APPLICANT'S INITIALS AND DATE (MM/DD/YYYY)

Section III – Standard Authorization, Attestation and Release – continued

party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

SIGNATURE

NAME (PLEASE PRINT OR TYPE)

Last 4 digits of SSN or NPI (PLEASE PRINT OR TYPE)

DATE (MM/DD/YYYY)

Required Attachments or Supplemental Information – Please attach hard copy or scanned documents of the following:

- ☐ Copy of DEA or state DPS Controlled Substances Registration Certificate
- ☐ Copy of other Controlled Dangerous Substances Registration Certificate(s)
- ☐ Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and applicant's name
- ☐ Copies of IRS W-9s for verification of each tax identification number used
- ☐ Copy of workers compensation certificate of coverage, if applicable
- ☐ Copy of CLIA certifications, if applicable
- ☐ Copies of radiology certifications, if applicable
- ☐ Copy of DD214, record of military service, if applicable

Notice About Certain Information Laws and Practices Pertaining to State Governmental Bodies (i.e. State Hospitals)

With few exceptions, you are entitled to be informed about the information that a state governmental body collects about you (i.e. a state hospital). Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However the state governmental body may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that the state governmental body correct information that it has about you that is incorrect. For information about the procedure and costs for obtaining information, please contact the appropriate state governmental body to which you have submitted this application.

OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	

OTHER POST-GRADUATE EDUCATION SPECIALTY
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment

INSTITUTION

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

☐ Program successfully completed

ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

PROGRAM DIRECTOR

CURRENT PROGRAM DIRECTOR (IF KNOWN)

OTHER POST-GRADUATE EDUCATION SPECIALTY
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment

INSTITUTION

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

☐ Program successfully completed

ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

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ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

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OTHER POST-GRADUATE EDUCATION SPECIALTY
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment

INSTITUTION

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

☐ Program successfully completed

ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

PROGRAM DIRECTOR

CURRENT PROGRAM DIRECTOR (IF KNOWN)

OTHER POST-GRADUATE EDUCATION SPECIALTY
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment

INSTITUTION

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

☐ Program successfully completed

ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

PROGRAM DIRECTOR

CURRENT PROGRAM DIRECTOR (IF KNOWN)

PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		

OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES			START DATE (MM/YYYY)
ADDRESS			
CITY	STATE/COUNTRY		POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)		ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?			
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES			START DATE (MM/YYYY)
ADDRESS			
CITY	STATE/COUNTRY		POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)		ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?			
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES			START DATE (MM/YYYY)
ADDRESS			
CITY	STATE/COUNTRY		POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)		ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?			
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES			START DATE (MM/YYYY)
ADDRESS			
CITY	STATE/COUNTRY		POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)		ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?			
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES			START DATE (MM/YYYY)
ADDRESS			
CITY	STATE/COUNTRY		POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)		ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?			

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE		

Practice Location Information - ***Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.***

PRACTICE LOCATION of

TYPE OF SERVICE PROVIDED
☐ Solo Primary Care ☐ Solo Specialty Care ☒ Group Primary Care ☐ Group Single Specialty ☐ Group Multi-Specialty

GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY	GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9
Texas A&M Physicians	Texas A&M University System Health Science Center

PRACTICE LOCATION ADDRESS
☐ **Primary** 1905 Dove Crossing Lane Suite A

CITY	STATE/COUNTRY	POSTAL CODE
Navasota	TX/USA	77868-5272

PHONE NUMBER	FAX NUMBER	E-MAIL
936-825-0755	877-601-5854	

BACK OFFICE PHONE NUMBER	SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER
	198523601	742907553

GROUP NUMBER CORRESPONDING TO TAX ID NUMBER	GROUP NAME CORRESPONDING TO TAX ID NUMBER
	Texas A&M University System Health Science Center

ARE YOU CURRENTLY PRACTICING AT THIS LOCATION?	IF NO, EXPECTED START DATE? (MM/DD/YYYY)	DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY?
☒ Yes ☐ No		☐ Yes ☒ No

OFFICE MANAGER OR STAFF CONTACT	PHONE NUMBER	FAX NUMBER
Robin Fuller	979-776-8440	877-601-5854

CREDENTIALING CONTACT
Sarah Fernandes

ADDRESS
8441 State Hwy 47 Suite 3115

CITY	STATE/COUNTRY	POSTAL CODE
Bryan	TX/USA	77807-3208

PHONE NUMBER	FAX NUMBER	E-MAIL
	877-601-5854	

BILLING COMPANY'S NAME (IF APPLICABLE)	BILLING REPRESENTATIVE

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

DEPARTMENT NAME IF HOSPITAL-BASED	CHECK PAYABLE TO	CAN YOU BILL ELECTRONICALLY?
		☐ Yes ☐ No

HOURS PATIENTS ARE SEEN

Monday	☐ No Office Hours	Morning: 8:00 am	Afternoon: 5:00 pm	Evening:
Tuesday	☐ No Office Hours	Morning: 8:00 am	Afternoon: 5:00 pm	Evening:
Wednesday	☐ No Office Hours	Morning: 8:00 am	Afternoon: 5:00 pm	Evening:
Thursday	☐ No Office Hours	Morning: 8:00 am	Afternoon: 5:00 pm	Evening:
Friday	☐ No Office Hours	Morning: 8:00 am	Afternoon: 5:00 pm	Evening:
Saturday	☒ No Office Hours	Morning:	Afternoon:	Evening:
Sunday	☒ No Office Hours	Morning:	Afternoon:	Evening:

DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?
☒ Answering Service ☒ Voice mail with instructions to call answering service ☐ Voice mail with other instructions ☐ None

THIS PRACTICE LOCATION ACCEPTS
☒ all new patients ☐ existing patients with change of payor ☐ new patients with referral ☐ new Medicare patients ☐ new Medicaid patients

IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.

PRACTICE LIMITATIONS
☐ Male only ☐ Female only Age: ☐ Other:

DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?
☐ Yes ☒ No If yes, provide the following information for each staff member:

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.

Practice Location Information - continued

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.

NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL
Spanish

ARE INTERPRETERS AVAILABLE?
■ Yes ☐ No If yes, please specify languages: Spanish

DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?
■ Yes ☐ No

WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?
■ Building ■ Parking ■ Restroom ☐ Other:

DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?
☐ Text Telephony-TTY ☐ American Sign Language-ASL ☐ Mental/Physical Impairment Services ☐ Other:

IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?
☐ Bus ☐ Regional Train ☐ Other:

DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?
☐ Yes ■ No

DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?
☐ Yes ■ No

WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)

Basic Life Support	☐ Staff	☐ Provider Exp:	Advanced Life Support in OB	☐ Staff	☐ Provider Exp:
Advanced Trauma Life Support	☐ Staff	☐ Provider Exp:	Cardio-Pulmonary Resuscitation	☐ Staff	☐ Provider Exp:
Advanced Cardiac Life Support	☐ Staff	☐ Provider Exp:	Pediatric Advanced Life Support	☐ Staff	☐ Provider Exp:
Neonatal Advanced Life Support	☐ Staff	☐ Provider Exp:	Other (please specify)	☐ Staff	☐ Provider Exp:

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ■ No
☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ■ No
☐ X-ray; please list all certifications:

OTHER SERVICES

☐ Radiology Services	☐ EKG	☐ Care of Minor Lacerations	☐ Pulmonary Function Tests
☐ Allergy Injections	☐ Allergy Skin Tests	☐ Routine Office Gynecology	☐ Drawing Blood
☐ Age Appropriate Immunizations	☐ Flexible Sigmoidoscopy	☐ Tympanometry/Audiometry Tests	☐ Asthma Treatments
☐ Osteopathic Manipulations	☐ IV Hydration /Treatments	☐ Cardiac Stress Tests	☐ Physical Therapies
☐ Other:			

PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?
☐ Yes ■ No Please specify the classes or categories:

WHO ADMINISTERS IT?

☐ **Please *check this box and complete and submit Attachment F if you have other practice locations.***

INCIDENT DATE (MM/DD/YYYY)	DATE CLAIM WAS FILED (MM/DD/YYYY)	CLAIM/CASE STATUS
PROFESSIONAL LIABILITY CARRIER INVOLVED		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER	AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID $ $
METHOD OF RESOLUTION ☐ Dismissed	☐ Settled (with prejudice)	☐ Settled (without prejudice)
☐ Judgment for Defendant(s)	☐ Judgment for Plaintiff(s)	☐ Mediation or Arbitration
DESCRIPTION OF ALLEGATIONS		
WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT?	NUMBER OF OTHER CO-DEFENDANTS	YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.)
DESCRIPTION OF ALLEGED INJURY TO THE PATIENT		
TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)? ☐ Yes ☐ No		

INCIDENT DATE (MM/DD/YYYY)	DATE CLAIM WAS FILED (MM/DD/YYYY)	CLAIM/CASE STATUS
PROFESSIONAL LIABILITY CARRIER INVOLVED		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER	AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID $ $
METHOD OF RESOLUTION ☐ Dismissed	☐ Settled (with prejudice)	☐ Settled (without prejudice)
☐ Judgment for Defendant(s)	☐ Judgment for Plaintiff(s)	☐ Mediation or Arbitration
DESCRIPTION OF ALLEGATIONS		
WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT?	NUMBER OF OTHER CO-DEFENDANTS	YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.)
DESCRIPTION OF ALLEGED INJURY TO THE PATIENT		
TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)? ☐ Yes ☐ No		

COVERYS®

Allied Healthcare Professional (AHP)
Professional Liability Application

☑ ProSelect Insurance Company
☐ Medical Professional Mutual Insurance Company

PART I - PRODUCER INFORMATION

Agency Name		Submitted By	
Agency License Number	State	Telephone	Most Recent Coverys Policy Number: *002TX000034016*

PART II - APPLICANT INFORMATION

First Name	Middle Initial	Last Name ☐ Male ☐ Female	Social Security Number	Date of Birth

Email Address

Website *N/A*

Contact Person/Insured Representative: *Robin Fuller- Director of Operations*

National Provider Identifier

Office Address One
Percentage of practice: _____
Address One *2900 E 29th Street*
Address Two
City *Bryan* State *Texas* Zip *77802*
Phone *979-776-8440* Fax *877-601-5854*

Residence Address
Address One
Address Two
City State Zip
Phone Fax

Office Address Two
Percentage of practice: _____
Address One *1905 Dove Crossing Ln.*
Address Two *Suite A*
City *Navasota* State *Texas* Zip *77868*

Mailing Address
(if different from office address one)
Address One *8441 State Hwy 47*
Address Two *Suite 3115*
City *Bryan* State *Texas* Zip *77807*

Office Address Three
Percentage of practice: _____
Address One
Address Two
City State Zip

Billing Address
(if different from office address one)
Address One *2900 E 29th Street*
Address Two
City *Bryan* State *Texas* Zip *77802*

PART III - PRACTICE LOCATION(S)

License Number	State	% of Activities in each state	Coverage Needed
	Texas	*100%*	☒ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Is there any part of your practice that is covered by any other professional liability? ☐ Yes ☒ No

If yes, please provide details and copy of declaration page of policy: _____

Name and location of all healthcare facilities where you have medical staff or courtesy privileges:

Facility Name	City	State	JCAHO Approved?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

PART IV - COVERAGE INFORMATION

Type of Coverage (choose one)

☐ Occurrence ☒ Claims Made Retroactive date desired*_____

☐ Moonlighting Only *(When selected, please complete and submit **APP 017, Moonlighter Credit Addendum**.)*

Coverage Effective Date

From _____ To ***01/01/2022***

Do you wish to purchase Prior Acts Coverage? ☐ Yes ☐ No *(If yes, please complete and submit **APP 015, Prior Acts Application**.)*

Do you participate in the Indiana Patient Compensation Fund? ☐ Yes ☐ No

*The retroactive date is the date first continuously insured under a claims made policy. If the retroactive date is prior to the coverage effective date, a 'no known loss' letter is required.

Professional Liability

Each Claim $ ***1,000,000.00*** Annual Aggregate $ ***3,000,000.00***

For New Jersey Applicants Only

In accordance with the New Jersey Medical Care Access and Responsibility Patients First Act, you may choose to have a deductible apply to your limit of liability for a premium credit. Deductible amounts range from $5,000 to $1 million per claim with an aggregate of three times the per claim amount. Prior to adding a deductible to your policy the deductible must be fully collateralized. Would you like more information on deductibles? ☐ Yes ☐ No

PART V - EDUCATION

Country	State/Province	School of Graduation	Type of Degree: Graduated: *(month)* *(year)*

List any post-graduate programs completed: _____ Month: _____ Year: _____

Have you participated in any CEU programs within the last five years? If yes, please attach a description or a copy of a certificate of completion. ☐ Yes ☐ No

Which professional organizations are you a member of? ☐ ACNM ☐ National Nursing ☐ State Nursing ☐ Other _____

Are you certified by an approved specialty board? ☐ Yes ☐ No *(month)* *(year)*

If so, list specialty and attach a copy of the certificate(s): _____ Date Certified: _____ / _____

PART VI - CURRENT PRACTICE

Type of practice: ☐ Individual ☐ Partnership ☐ Solo Corporation ☐ Professional Corporation or Association ☐ Locum Tenens ☒ Other

Do you practice as an employee or are you self-employed? ☒ Employee ☐ Self-employed

Separate Limit of Liability for Partnership or Corporation

Not available on solo corporations (except in PA). Current practice must be partnership or corporation.(*If yes, please complete and submit **APP 008, Partnership & Corporation Professional Liability Application**.)* ☐ Yes ☐ No

Partnership or Corporation *(complete this section)*

Name of Partnership or Corporation

Texas A&M University System Health Science Center

Name of partner(s) or other members

Are you covered by the Federal Tort Claims Act? *(If yes, please complete and submit **APP 024, FTCA Restricted Coverage**.)* ☐ Yes ☐ No

Do you practice less than 21 hours per week in direct patient care services? *(If yes, please complete and submit **APP 020, Limited Practice Credit**.)* ☐ Yes ☐ No

Do you hold a full time teaching appointment with regular clinical supervision responsibilities? ☐ Yes ☐ No

Do you use Locum Tenens? ☐ Yes ☒ No

If yes, indicate the number of days per year: _____ days

PART VII - PRACTICE ACTIVITIES

Nurse Practitioners, please indicate your practice activities below:

☐ Specialize in Adult, Adult Oncology, Family Planning, Geriatric, Gynecology or Women's Healthcare

☐ Specialize in Psychiatric Care

☐ Specialize in Acute Critical Care, Family Practice, School Nurse, Pediatric or Neonatal Care

☐ Specialize in Acute Critical Care OB/GYN, Obstetrics/Gynecology or Perinatal Care

If your specialty is OB/GYN, are you responsible for any labor or delivery? ☐ Yes ☐ No ☐ N/A

Do you perform any invasive surgical procedures? ☐ Yes ☐ No

If yes, please list procedures: _____

Do you have a written collaborative agreement with the physician(s) with whom you practice? ☐ Yes ☐ No ☐ N/A

Physician Assistants, please indicate your practice activities below:

☐ PA 1: Carry out duties generally performed by a licensed physician and practice under the direction and supervision of a licensed physician to assist in the diagnosis and treatment of patients. No surgical procedures.

☐ PA 2: Select if your practice includes any of the following:
Assist a licensed physician in surgery, have any practice exposure in an operating room other than for observation; practice 10 hours a week or less in trauma/emergency room; provide obstetrical-prenatal or postnatal care only; assist a physician in anesthesiology.

☐ PA 3: Select if your practice includes any of the following:
Assist in surgery; practice 10 hours or more per week in trauma/emergency room; provide obstetrics including prenatal/postnatal care and delivery room responsibilities; have contact or exposure with cardiac catharization labs; assist in cosmetic/aesthetic procedures.

Does your supervising physician supervise more than four Physician Assistants, Nurse Practitioners or Certified Nurse Midwives? ☐ Yes ☐ No

Do you want employee coverage under separate limits? ☐ Yes ☐ No

*Protects your healthcare employees for their acts while under your employ. All employees automatically share in your professional liability limits. To purchase separate limits for employees under your professional liability coverage for a premium charge, check "Yes" and complete **APP 026, Employee Limit of Liability Application**.*

Nurse Practitioners and Physician Assistants, please answer the following questions:

Have you completed a risk management course in the last 12 months? *(If yes, please attach a copy of the certificate)* ☐ Yes ☐ No

Do you or any of your employees perform cosmetic procedures? ☐ Yes ☐ No

If yes, please provide a list of all the procedures performed and documentation of the training received to perform the procedures.

Do you participate in any medical research, clinical trials or off-label use of drugs or devices? ☐ Yes ☐ No

*(If yes, please complete and submit **APP 040, Clinical Trials Addendum**)*

Do you provide services in a correctional facility? ☐ Yes ☐ No

If yes, please list the name of the facility: _____

Do you participate in any telemedicine activities? ☐ Yes ☐ No

Do you bill Medicare/Medicaid? ☐ Yes ☐ No

If yes, what percentage of your total billing is for Medicare/Medicaid? _____%

PART VIII - EMPLOYEES/ADDITIONAL INSUREDS

Please list the following for any **physicians**, **surgeons** or **certified nurse midwives** you employ. (Use additional space if necessary.) For each employee identified as an independent contractor please complete ***APP 041, Independent Contractor Addendum***.

First Name				
Middle Initial				
Last Name				
Insurer				
Policy #				
Social Security #				
NPI #				
Date of Birth				
Independent Contractor	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Coverys Insured	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Applying for Coverys Coverage	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Specialty				
Surgery	☐ No surgery ☐ Major surgery ☐ Minor surgery	☐ No surgery ☐ Major surgery ☐ Minor surgery	☐ No surgery ☐ Major surgery ☐ Minor surgery	☐ No surgery ☐ Major surgery ☐ Minor surgery
Assisting with Surgery	☐ Own patients ☐ Other's patients	☐ Own patients ☐ Other's patients	☐ Own patients ☐ Other's patients	☐ Own patients ☐ Other's patients
Any claims?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Graduation Date	*month* *year*	*month* *year*	*month* *year*	*month* *year*
Residency Date	*month* *year*	*month* *year*	*month* *year*	*month* *year*
Fellowship Date	*month* *year*	*month* *year*	*month* *year*	*month* *year*

If you employ **non-physician healthcare providers**, please list job category and number of each. If you employ nurses, please specify between RNs, LPNs, Nurse Practitioners, etc.

Job Title/Specialty	Number of Employees

PART IX - HISTORY

(Practice/Claims/Insurance for a minimum of the last 15 years - Start with the most recent, and attach additional sheet if necessary.)

Dates	*From* *To*	*From* *To*	*From* *To*	*From* *To*
Insurer				
Policy #				
Coverage				
Premium				
Tail Purchased	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Retroactive Date				
Limit				
Facility				
State				
Any claims?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If yes, attach an entire loss history which includes: policy number, claim number, report dates, description of loss and settlement amount.

Have you ever been denied a nursing license or been denied certification by a specialty board? ☐ Yes ☐ No

Has your professional license ever been restricted, suspended, voluntarily surrendered or revoked in any state? ☐ Yes ☐ No

Has any hospital ever brought complaints or actions against you such as restriction, suspension, revocation of privileges or probation? ☐ Yes ☐ No

Have you ever been involved in or are you aware of any future involvement in an investigation by a regulatory agency or peer review board? ☐ Yes ☐ No

Have you ever had a complaint or claim brought against you for sexual misconduct? ☐ Yes ☐ No

Do you now or have you ever had any chronic physical limitation or any mental or emotional illness or disorder which impaired or could adversely affect your practice of medicine to any degree? ☐ Yes ☐ No

Have you ever been indicted and/or convicted of a crime other than minor traffic violations? ☐ Yes ☐ No

Have you ever been suspended, restricted, or put on probation by any governmental health program (e.g., Medicare or Medicaid)? ☐ Yes ☐ No

If you answered yes to any of the above questions, you must provide a detailed written narrative.

Do you now or have you ever had a drug or alcohol addiction or dependency or sought treatment for such? ☐ Yes ☐ No

If yes, please accompany this application with a letter outlining dates of treatment, results of treatments, and current status. This letter should be from your treating physician or institution.

Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled your professional liability policy? ☐ Yes ☐ No
(If yes, please list company, date and reason for this action below.)

Company _____ Date _____ Reason _____

Company _____ Date _____ Reason _____

PART X - OPTIONAL COVERAGES

Check Yes if you are interested in any of the following coverages. Unless otherwise indicated, these coverages require both an additional application and an additional charge over and above your professional liability premium. Applications for optional coverages can be obtained from the company.

Professional Contractual Liability (not available in PA or VA) ☐ Yes ☒ No

Protects you against certain hold harmless agreements in managed care contracts. *Purchase of this coverage does not provide a separate limit of insurance*. There is a charge based on a percentage of your professional liability premium.

Commercial General Liability ☐ Yes ☒ No

Do you wish to purchase Commercial General Liability coverage?
*(If yes, please complete and submit **APP 007, Commercial General Liability Application**.)*

For New Jersey Applicants Only - Consent to Settle

This endorsement is automatically attached to all individual and group policies. It requires the Company to obtain your written consent before settling any claims brought against you. In accordance with the New Jersey Medical Care Access and Responsibility and Patients First Act, you may choose to remove this endorsement for 1% premium credit to your policy.
Would you like to remove this endorsement? ☐ Yes ☒ No

PLEASE ATTACH A COPY OF THE FOLLOWING TO THIS APPLICATION:

- ☐ Copy of current Declaration Page
- ☐ Curriculum vitae (C.V.) for applicant and each employed or contracted physician
- ☐ A narrative of all past claims - *a Claim Information Form may be used when necessary*
- ☐ Signed Notice to New Applicants (APP 028 or 029) for claims made policies
- ☐ Signed Anti-Fraud Statement (Maine and New Jersey)
- ☐ Copies of license to practice and board certification

Read Carefully Before Signing

THE STATEMENTS IN THIS APPLICATION, TOGETHER WITH ANY SUPPLEMENTAL APPLICATIONS, ATTACHMENTS AND ANY OTHER INFORMATION SUBMITTED TO THE COMPANY IN CONNECTION WITH THIS APPLICATION WILL BE REFERRED TO AS THE "POLICY APPLICATION."

Representations as to accuracy of application, the authority of person signing, and applicant's obligation to supplement information

BY SIGNING BELOW, I REPRESENT AND CERTIFY: (I) THAT THE INFORMATION CONTAINED IN THE POLICY APPLICATION IS TRUE AND ACCURATE. (II) THAT I HAVE MADE ALL REASONABLE EFFORTS TO INVESTIGATE THE ACCURACY OF THE INFORMATION PROVIDED IN THE POLICY APPLICATION AND TO OBTAIN SUCH INFORMATION FROM ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED POLICY AS IS NECESSARY TO PROVIDE TRUE AND ACCURATE INFORMATION IN THE POLICY APPLICATION; AND (III) THAT I AM DULY AUTHORIZED TO SIGN THIS POLICY APPLICATION ON BEHALF OF ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED INSURANCE AND THAT I HAVE CAREFULLY READ THIS POLICY APPLICATION.

I ACKNOWLEDGE THAT OBTAINING THE REQUESTED INSURANCE, INCLUDING ANY RENEWALS OF THE REQUESTED INSURANCE, IS CONDITIONED UPON PROVIDING TRUE AND ACCURATE INFORMATION IN THIS POLICY APPLICATION, AND ANY SUCH INSURANCE THAT MAY BE ISSUED WILL BE BASED UPON THE COMPANY'S RELIANCE ON THE INFORMATION PROVIDED IN THE POLICY APPLICATION. I ALSO AGREE AND UNDERSTAND THAT THIS POLICY APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THAT THIS POLICY APPLICATION WILL BE DEEMED TO BE ATTACHED TO AND PART OF SUCH POLICY AND ANY RENEWALS OF SUCH POLICY, IF ISSUED. FURTHER, IF ANY INFORMATION IN THE POLICY APPLICATION IS MISLEADING, INCOMPLETE OR FALSE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION.*

ADDITIONALLY, I AGREE THAT IN THE EVENT THERE IS ANY CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION BEFORE THE EFFECTIVE DATE OF THE REQUESTED INSURANCE OR BEFORE ANY RENEWAL OF THE REQUESTED INSURANCE, I WILL IMMEDIATELY NOTIFY THE COMPANY IN WRITING. IF I FAIL TO PROVIDE SUCH NOTICE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION OR ANY RENEWAL OF THE REQUESTED INSURANCE. I UNDERSTAND THAT IF THERE IS A CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION THE COMPANY, IN ITS SOLE DISCRETION, MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.*

No obligation to issue or purchase insurance

I UNDERSTAND THAT THE POLICY APPLICATION IS NOT A BINDER OF INSURANCE. ACCEPTING THE APPLICATION DOES NOT BIND THE COMPANY TO ISSUE, OR ME TO PURCHASE, THE REQUESTED INSURANCE REGARDLESS OF WHETHER OR NOT I HAVE MADE PAYMENT, IN WHOLE OR IN PART, FOR THE REQUESTED INSURANCE OR THE COMPANY HAS DEPOSITED SUCH PAYMENT. I UNDERSTAND THAT THE REQUESTED INSURANCE SHALL NOT BE EFFECTIVE UNTIL I HAVE PAID A DEPOSIT TO THE COMPANY IN THE AMOUNT INVOICED BY THE COMPANY, REGARDLESS OF WHETHER OR NOT A POLICY OR ANY RENEWALS OF SUCH POLICY HAVE BEEN ISSUED.

Authorization to obtain information

THE COMPANY IS HEREBY AUTHORIZED TO OBTAIN FULL INFORMATION FROM ANY LIABILITY INSURER, HEALTHCARE INSURER, HOSPITAL, HEALTHCARE PROVIDER, MEDICAL ASSOCIATION OR SOCIETY, BOARD OF MEDICAL EXAMINERS, GOVERNMENTAL AGENCY, ATTORNEY OR OTHER PERSON OR ENTITY CONCERNING: (I) ANY MEDICAL MALPRACTICE CLAIM, SUIT, LICENSING BOARD PROCEEDING, CREDENTIALING PROCEEDING, DISCIPLINARY ACTION OR ANY OTHER CIVIL OR CRIMINAL ACTION ASSERTED AGAINST OR RELATING TO THE PROFESSIONAL CONDUCT OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE; (II) THE QUALIFICATIONS OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE TO PERFORM PROFESSIONAL HEALTHCARE SERVICES; AND (III) SUCH OTHER INFORMATION WHICH, IN THE SOLE JUDGMENT OF THE COMPANY, MAY HAVE A BEARING ON WHETHER TO ISSUE THE REQUESTED INSURANCE. I AGREE TO HOLD HARMLESS ANY PERSON OR ENTITY PROVIDING SUCH INFORMATION TO THE COMPANY AND THE COMPANY, ITS DIRECTORS, OFFICERS, EMPLOYEES, AND AGENTS FROM ANY LIABILITY ARISING OUT OF THE DISCLOSURE OF SUCH INFORMATION, INCLUDING ANY LIABILITY ARISING OUT OF ERRORS AND OMISSIONS IN THE INFORMATION DISCLOSED.

CALIFORNIA APPLICANTS: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATED AGENCIES.

DISTRICT OF COLUMBIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAINE APPLICANTS: THE COMPANY WILL NOT RESCIND OR VOID ANY POLICY ISSUED IN MAINE DUE TO FRAUD OR A MISREPRESENTATION WITHOUT FIRST OBTAINING A COURT RULING THAT VOIDANCE OR RESCISSION OF THE POLICY IS PERMITTED. HOWEVER, IN THE EVENT OF A MISREPRESENTATION, OMISSION, CONCEALMENT OF FACT OR INCORRECT STATEMENT IN THIS APPLICATION OR INFORMATION PROVIDED TO US TO OBTAIN INSURANCE, THE COMPANY MAY CANCEL THE POLICY AND/OR DENY COVERAGE FOR ANY CLAIM IF SUCH MISREPRESENTATION, OMISSION, CONCEALMENT OF FACT OR INCORRECT STATEMENT WAS FRAUDULENT OR MATERIAL.IN ACCORDANCE WITH 24-A M.R.S.A. 2186(3), IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

MARYLAND APPLICANTS: THE COMPANY WILL NOT VOID ANY POLICY ISSUED IN MARYLAND. HOWEVER, COVERAGE WILL NOT BE PROVIDED IF WE DISCOVER CONCEALMENT, MISREPRESENTATION, OR FRAUD. ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NEW HAMPSHIRE APPLICANTS: THE COMPANY WILL NOT VOID ANY POLICY OR DENY COVERAGE TO ANY INSURED(S) IN NEW HAMPSHIRE IF THE INSURED(S) HAD NO KNOWLEDGE OF CONCEALMENT, MISREPRESENTATION OR FRAUD. HOWEVER, THE COMPANY WILL NOT COVER ANY CLAIMS AGAINST ONE OR MORE INSUREDS WHO HAS INTENTIONALLY CONCEALED OR MISREPRESENTED A MATERIAL FACT, ENGAGED IN FRAUDULENT CONDUCT, OR MADE A FALSE STATEMENT RELATING TO THIS INSURANCE.

NEW JERSEY APPLICANTS: IN ACCORDANCE WITH N.J. STAT § 17:33A-6 (C), ANY PERSON WHO INCLUDES FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

OKLAHOMA APPLICANTS: WARNING: ANY PERSON, WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO MAY HAVE COMMITED A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

VIRGINIA APPLICANTS: IN ACCORDANCE WITH VIRGINIA CODE 52-40, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

WASHINGTON APPLICANTS: THE COMPANY WILL NOT VOID ANY POLICY ISSUED IN WASHINGTON UNLESS THE INSURED(S) OR SOMEONE ACTING ON BEHALF OF THE INSURED(S) INTENTIONALLY CONCEALS OR MISREPRESENTS A MATERIAL FACT OR CIRCUMSTANCE RELATING TO THIS INSURANCE. IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

ALABAMA, ALASKA, ARIZONA, ARKANSAS, DELAWARE, FLORIDA, IDAHO, INDIANA, KENTUCKY, LOUISIANA, MINNESOTA, NEW MEXICO, NEW YORK, OHIO, RHODE ISLAND, TENNESSEE, TEXAS, WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS MATERIALLY FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIME AND MAY BE SUBJECT TO CRIMINAL AND CIVIL PENALTIES WHICH MAY INCLUDE VOIDING OF THE POLICY IF ALLOWED BY STATE LAW.

SIGNATURE OF APPLICANT

TITLE

PRINTED NAME

DATE

SIGNATURE OF PRODUCER *(signature is required for N.H. producers only)*

DATE

PRINTED NAME OF PRODUCER

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PO Box 10861
College Station, TX 77842

P 979.846.2489
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Supervising/Collaborating/Monitoring Physician Protocols/Duties/Scope of Practice Supplemental Attestation

Mid-level providers (physician assistants and nurse practitioners) are statutorily required to collaborate with or be supervised and/or monitored (the "Supervision") by a physician licensed to practice in the state where the Mid-level provider currently practices and who is designated as the primary Supervising Physician (or the "Supervisor"). The Mid-level provider may have an alternate Supervisor.

Section 1 – Collaborating/Supervising/Monitoring Physician

In my current position with a Collaborating/Supervising/Monitoring Physician, I have reviewed, understand, agreed upon and signed along with my Supervising Physician, protocols or other written authorization which defines my professional duties, protocols and scope of duties as a Mid-level provider in a manner that promotes professional judgment commensurate with my education, certification, and experience. A copy of the protocols/duties/scope of practice is maintained onsite at my primary practice location.

Supervisor Name *_____ Degree _____

Medical License Number_____State _____

Alternate Supervisor Name *_____ Degree _____

Medical License Number_____State _____

Section 2 – DEA and CDS Credentials

☐ Applicant does have a current, valid DEA and Texas CDS credentials ("Credentials") within the State of Texas.

☐ Applicant does not have current, valid Credentials within the State of Texas because I have moved from out-of-state or because I am starting a new practice, or because I will not be prescribing medications. The Supervising Physician listed below will write all prescriptions on my behalf until such time that I obtain and provide current and valid Credentials to the network. I acknowledge it is my responsibility to immediately notify the network at the address above upon my receipt of the Credentials.

Section 3 – Attestation By Applicant

I certify the information provided herein is true, correct, and complete to the best of my knowledge and belief. I understand and agree that any misstatement or omission concerning my collaborating/supervising physician and the established protocols/duties/scope of practice may constitute grounds for withdrawal of my application for consideration.

Applicant Signature_____Date _____

Applicant's Name_____ Specialty _____

Section 4 – Supervising Physician Certification

I consent to serving as the Supervising Physician for the Applicant named above.

Supervising Physician Name and Degree* _____ TIN ***74-2907553***

Physician Signature_____Date_____DEA Nbr_____CDS Nbr _____

** Supervisors MUST be physicians licensed in the same state of the Mid-level providers practice and MUST participate in the same network(s) as the applicant. Information provided here may be subject to verification.*

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Alliance Health Providers of Brazos Valley
BCBS Opt-In

The following managed care organization has contracted with AHPBV. **All reimbursement is the lesser of billed charges or the payor's scheduled reimbursement**. Please indicate your acceptance or rejection of the payor offer below.

Managed Care Organization	Accept	Reject
Blue Choice PPO	☑	☐
Blue Essentials	☑	☐
Blue Advantage HMO	☑	☐
Medicare Advantage PPO	☑	☐
Medicare Advantage HMO	☑	☐
CHIP	☑	☐
STAR	☑	☐
STAR Kids	☑	☐
STAR Plus	☑	☐

BlueCross BlueShield Provider Record* pending
**Required for participation*

Accepting participation in the payor agreement above does not guarantee acceptance by the payor nor does it mean that you or your practice is immediately accepted by the payor as a participating provider. We strongly recommend that you confirm participation status with the payor directly prior to providing any services to patients enrolled in the payor plan.

By signing below, I/we agree to the terms and provisions indicated above on this BCBS messenger notice.

Authorized Signature _____ Date _____

Print Name _____ Specialty _____ Tax ID ***74-2907553***

Aetna Health Plan

Agreement Opt-in/Opt-out

Election Form

The undersigned provider:

☒ **DOES wish** to opt-in to the AHPBV Aetna Health Plan Agreement

☐ **DOES <u>NOT</u> wish** to opt-in to the AHPBV Aetna Health Plan Agreement

If the provider does wish to opt-in, the provider agrees to participate and hereby authorizes AHPBV to execute such agreements on behalf of the provider as their agent and attorney-in-fact; and

Requests that AHPBV be considered the primary panel over any current agreement(s) and understands that it is the provider's responsibility to compare other panels this may involve.

Signature	*Date*
Printed Provider Name	***Texas A&M Physicians*** *Organization*

Please Note:

- *Each provider in an organization MUST complete this form to be considered "in-network"*
- *Aetna will send each provider a notification of their in-network effective date*
- Please email or fax to:

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Admitting Practitioner Designation Agreement

I, _____ ("Practitioner"), currently do NOT have admitting privileges at an Alliance Health Providers of Brazos Valley ("AHPBV") participating hospital as of the date this agreement was signed. Therefore, I have arranged to have the Designated Admitting Practitioner ("DAP") named below cover inpatient admissions.

_____	_____	***74-2907553***	_____
Practitioner Signature	Date	Tax ID	TMB License

Designated Admitting Practitioner

Name: _____

Practice Name:_____

Address:_____

City: _____ State: _____ Zip: _____

Daytime Phone: _____

After Hours Phone: _____

AHPBV Participating Hospital(s) where DAP has Active or Medical Associate privileges:

- [x] CHI St. Joseph Health Regional Hospital
- [x] CHI St. Joseph Health Grimes Hospital
- [ ] CHI St. Joseph Health Burleson Hospital
- [ ] CHI St. Joseph Health Madison Hospital

As the DAP, I agree to admit and assume responsibility from the Practitioner listed above for inpatient care on those occasions when the patient requires hospitalization. I agree to the following conditions:

1. I will admit patients to the AHPBV participating hospital(s) identified above,
2. I will accept payor's allowable fee as full payment for covered services, and
3. I will obtain authorization, as required, by the patient's insurance plan.

_____	_____	***74-2907553***	_____
DAP Signature	Date	Tax ID	TMB License

BlueCross BlueShield of Texas

HOSPITAL COVERAGE LETTER

To: Blue Cross and Blue Shield of Texas (BCBSTX)

Date: _____

Please accept this correspondence as confirmation that since I do not have active admitting privileges at a participating network hospital (in applicable BCBSTX provider network(s) in which I participate), with the exception of medical emergencies, my practice will be confined to outpatient care.

I hereby agree and attest, that if non-emergency hospitalization is necessary, I will refer BCBSTX subscriber/member care to a participating physician or hospitalist (in the applicable BCBSTX provider network) who has active admitting privileges at a participating network hospital (in the applicable BCBSTX provider network).

(Please print legibly)

Provider's Name: _____

Provider's NPI #: _____

Provider's Signature: _____

Please Note:

- *The only providers permitted to submit a signed "Hospital Coverage Letter" for hospital privileges' requirement, are the following provider specialties/types: Adolescent Medicine, Child & Adolescent Psychiatry, Developmental-Behavioral Pediatrics, Family Practice, General Practice, Geriatric Medicine, Internal Medicine, Pediatrics, Physical Medicine & Rehabilitation, Preventive Medicine, and Psychiatry.*
- *If you are unsure of the participation status in a specific BCBSTX provider network, for yourself, another physician, hospitalist, or hospital, please contact your BCBSTX Network Management office by fax or phone.*

BCBSTX Network Management Office	FAX Number	Telephone Number
Austin	512-349-4853	512-349-4847
Corpus Christi	361-852-0624	361-878-1623
Dallas	972-766-2231	972-766-8900 / 800-749-0966
El Paso	915-496-6614	915-496-6600
Houston, Beaumont, East Texas	713-663-1227	713-663-1149 / 800-637-0171
Lubbock, Amarillo	806-783-4666	806-783-4610
Midland, Abilene, San Angelo	432-620-1428	432-620-1406
San Antonio	361-852-0624	361-878-1623

Physician provider file application

Request date: _____

Name: _____ Phone #: 979-776-8440

National Provider Identifier (NPI) #: _____ Federal tax ID #: 74-2907553

Medicare #: _____ Fax #: 877-601-5854

Are you joining an established group practice? ☒ Yes ☐ No Solo practice: ☐ Yes ☒ No ☐ Both

If Yes, group name: Texas A&M University System Health Science Center

Address: 2900 E 29th Street Bryan, Tx 77802

You must complete the Special Authorization form if the group will bill on your behalf.

Date you began filing with group #: _____

You must complete an Authorized Signer form if a representative will be signing claim forms on your behalf.

If you are filing you taxes under a Federal Tax Identification number because you are incorporated or belong to an incorporated group/ professional association, you must also complete a Group Application form.

Office location (street address): 2900 E 29th Street

City: Bryan State: Texas ZIP: 77802

Billing address (if different): _____

City: _____ State: _____ ZIP: _____

License #: _____ ☐ Temporary/Limited ☐ Permanent

Issuing state: _____ Date license was first issued: _____ Expiration date: _____

Are you transferring from another state where you had an established practice? ☐ Yes ☐ No If Yes, state: _____

Primary specialty: _____

Humana Military | TRICARE®

Physician provider file application

Request date: _____

Name: _____ Phone #: 936-825-0755

National Provider Identifier (NPI) #: _____ Federal tax ID #: 74-2907553

Medicare #: _____ Fax #: 877-601-5854

Are you joining an established group practice? ☒ Yes ☐ No Solo practice: ☐ Yes ☒ No ☐ Both

If Yes, group name: Texas A&M University System Health Science Center

Address: 2900 E 29th Street Bryan, TX 77802

You must complete the Special Authorization form if the group will bill on your behalf.

Date you began filing with group #: _____

You must complete an Authorized Signer form if a representative will be signing claim forms on your behalf.

If you are filing you taxes under a Federal Tax Identification number because you are incorporated or belong to an incorporated group/ professional association, you must also complete a Group Application form.

Office location (street address): 1905 Dove Crossing Ln. Suite A

City: Navasota State: Texas ZIP: 77868

Billing address (if different): 2900 E 29th Street

City: Bryan State: Texas ZIP: 77802

License #: _____ ☐ Temporary/Limited ☐ Permanent

Issuing state: _____ Date license was first issued: _____ Expiration date: _____

Are you transferring from another state where you had an established practice? ☐ Yes ☐ No If Yes, state: _____

Primary specialty: _____

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Are you:

☐ Hospital-salaried/employed physician?	☐ Yes	☐ No	Location: _____
☒ Teaching-setting physician?	☒ Yes	☐ No	Location: Texas A&M University
☐ Employed by the U.S. Government?	☐ Yes	☐ No	Location: _____
☐ National Health Service Corporation (NHSC) physician?	☐ Yes	☐ No	Location: _____
☐ Intern?	☐ Yes	☐ No	Location: _____
☐ Resident?	☐ Yes	☐ No	Location: _____

☐ Are you employed by the U.S. Government?

Dual compensation/conflict of interest. Title 5, United States Code, section 5536 prohibits medical personnel who are active duty Uniformed Service members or civilian employees of the Government from receiving additional Government compensation above their normal pay and allowances tor medical care furnished. In addition, Uniformed service members and civilian employees of the Government are generally prohibited by law and agency regulations and policies from participating in apparent or actual conflict of interest situations in which a potential for personal gain exists or in which there is an appearance of impropriety or incompatibility with the performance of their official duties or responsibilities. The Departments of Defense, Health and Human Services, and Transportation have a responsibility, when disbursing appropriated funds in the payment of TRICARE benefits to ensure that the laws and regulations are not violated. Therefore, active duty Uniformed Service members (including a reserve member while on active duty) and civilian employees of the United States Government shall not be authorized to be TRICARE providers. While individual employees of the Government may be able to demonstrate that the furnishing of care to TRICARE beneficiaries may not be incompatible with their official duties and responsibilities, the processing of millions of TRICARE claims each year does not enable Program administrators to efficiently review the status of the provider on each claim to ensure that no conflict of interest or dual compensation situation exists. The problem is further complicated given the numerous interagency agreements (for example, resource sharing arrangements between the Department of Defense and the Veterans Administration in the provision of health care) and other unique arrangements which exist at individual treatment facilities around the country. While an individual provider may be prevented from being an authorized TRICARE provider even though no conflict of interest or dual compensation situation exists, it is essential tor TRICARE to have an easily administered, uniform rule which will ensure compliance with the existing laws and regulations. Therefore, a provider who is an active duty Uniformed Service member or civilian employee of the Government shall not be an authorized TRICARE provider. In addition, a provider shall certify on each TRICARE claim that he/she is not an active duty Uniformed Service member or civilian employee of the Government.

☐ Are you employed or under a contract which provides for payment to the individual professional provider by an institutional provider? If you are, your application cannot be considered. Hospital employees are not eligible for additional provider numbers outside the realm of the hospital.

Signature of provider: _____ Date: _____

CONFLICT OF INTEREST STATEMENT

For TRICARE providers:

Federal Law (5 U.S.C. 5536) prohibits medical personnel, who are active duty members or civilian employees of the government, compensation above their normal pay and allowances for medical care rendered. This prohibition applies to TRICARE benefits whether the claim for reimbursement is filed by the individual who provided the care, the facility in which the care was rendered, or by the sponsor/beneficiary. Claims for TRICARE benefits will be denied in any situation where either a uniform member or civilian employee of the uniform services has the opportunity to exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries to one or more providers on a selective basis.

Please notify us of any changes related to your provider file information (name, address, specialty, tax number, group affiliations, etc.).

Humana Military | TRICARE®

Please return to:

Fax:

608-221-7535

Mail:

TRICARE East Provider Certification
P.O. Box 7870
Madison, WI 53707-7870

CME Acknowledgement Form

Application Addendum

Scott & White/FirstCare Health Plans Board Certification Requirement:

For Non-boarded physicians (Non-applicable for board eligible physicians)

Scott and White Health Plan (SWHP) and FirstCare Health Plan (FCHP) require physicians to have current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) board certification (or be in the active process of obtaining such) in the specialty you are practicing in.

If you are NOT board certified or let your certification lapse, SWHP & FCHP require that **each year** you obtain **at least 50 AMA Physician Recognition Awards (PRA)** or equivalent CME credits, of which 25 are Category I. Twenty-five of those 50 credits (either Category I, II or combination) must be in the field in which you are practicing medicine. Failure to complete the 50 CME credits per year, will result in your failure to be an eligible practitioner within SWHP & FCHP network.

I will submit evidence of ongoing Continuing Medical Education as a demonstration of competency to the SWHP and FCHP Credentialing Committee. By signing below, I agree to complete 50 CME credits per year and will submit written proof at re-credentialing.

Signature: _____

Printed Name: _____

Date: _____

Please email the addendum to:
BSWHPExpedites@BSWHealth.org

Provider Profile

Group Practice Name: Texas A&M University Health Science Center Date:

Billing Tax ID: 742907553 Group NPI: 1063699312

PRACTITIONER INFORMATION

Professional Category: MD ☐ DO ☐ DPM ☐ DC ☐ NP ☐ PA ☑ Other: Psychologist

Applying As: PCP ◯ Specialist (non-PCP) ◯ PCP/Specialist ☐

Practitioner First Name: Practitioner Last Name:

Date of Birth: Social Security Number:

Specialty: Subspecialty:

CAQH Number: Practitioner NPI Number:

If practitioner is not registered with CAQH, please provide a current TDI Credentialing application with a current date and signature.

Is the practitioner hospital based? Yes ☐ No ◯ Note: A yes response indicates the practitioner only practices in a hospital.

Practice Restrictions: Ages ____ to ____ Male Only ☐ Female Only ☐ Accepting New Patients Yes ☐ No ◯

Credentialing Contact Name: Sarah Fernandes Contact Email: credentialing@tamu.edu

Does the practitioner perform Advanced Imaging Services (CT/CTA, MRI/MRA, PET Scan)? Yes ☐ No ◯

STAR HEALTH (foster care) PRACTITIONERS ONLY

Does the practitioner have experience in treating any of the following:

Children with Post-traumatic Stress Disorder ☐ Children with sexual abuse ☐

Children with developmental disabilities ☐ Children with physical abuse ☐

Members with Special Health Care Needs (MSHCN) ☐

Does the practitioner have experience with:

Evidence-based practices (EBPs) modalities or promising practices such as TIC? ☐

Treatment Expertise/Specialties

Please select the types of services you offer, including the disorders you treat and the modalities you practice (check all that apply).

Note: Please submit evidence of certificates or transcripts that account for the associated trainings in the treatment modalities and/or disorders selected below.

Cultural Competence

- ☐ African American
- ☐ Alaskan Native
- ☐ American Indian
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Pacific Islander

Settings/Populations Treated

- ☐ Adolescents
- ☐ Adults
- ☐ Blind/Visually Impaired
- ☐ Children
- ☐ Community Based
- ☐ Deaf/Hearing Impaired
- ☐ Developmental Disability
- ☐ Emotionally Disturbed
- ☐ Gay/Lesbian
- ☐ Geriatric
- ☐ Home Based
- ☐ Homelessness
- ☐ Men
- ☐ Mobile Crisis
- ☐ Nursing Home
- ☐ Physical Disability
- ☐ School Based
- ☐ Serious Emotional Disturbance School Based
- ☐ Serious Mental Illness
- ☐ Severe Persistent Mentally Ill
- ☐ Telehealth
- ☐ Telemedicine
- ☐ Telemonitoring
- ☐ Women
- ☐ Young Children

Treatment Modalities/Approaches

- ☐ Applied Behavioral Analysis (ABA)
- ☐ Addictive Disorders
- ☐ Adolescent Psychotherapy
- ☐ Adolescent Sex Offender
- ☐ Adolescent Psychiatry
- ☐ Adoption Issues
- ☐ Alcohol/SA Treatment
- ☐ Anger Management
- ☐ Art Therapy
- ☐ Attachment Therapy
- ☐ Behavioral Therapy
- ☐ Brief Therapy
- ☐ Biofeedback
- ☐ Chemical Dependency Assessment
- ☐ Child Parent Psychotherapy (CCP)
- ☐ Child Psychiatry
- ☐ Child Psychological Testing
- ☐ Christian Counseling
- ☐ Client Centered Therapy
- ☐ Cognitive Rehab Therapy
- ☐ Cognitive Therapy
- ☐ Community Support Program
- ☐ Community Support Program for the Homeless
- ☐ Couples Therapy
- ☐ Crisis Intervention/Stabilization
- ☐ Critical Incident Debriefing
- ☐ Dialectical Behavioral Therapy
- ☐ Developmental Evaluation
- ☐ Domestic Violence
- ☐ ECT
- ☐ EMDR
- ☐ Evaluation/Assessment
- ☐ Family Systems
- ☐ Family Therapy
- ☐ Gay/Lesbian/Bisexual
- ☐ Group Therapy
- ☐ Geriatric Psychiatry
- ☐ Gestalt

- ☐ Hypnosis
- ☐ Individual Therapy
- ☐ Intake Assessment
- ☐ Intensive Family Intervention
- ☐ Intensive Outpatient
- ☐ Medication Management
- ☐ Methodone/Suboxone
- ☐ Mood Disorders
- ☐ Neuro-Linguistic Programming (NLP)
- ☐ Neuropsychological Testing
- ☐ Outcomes Oriented Therapy
- ☐ Pain Management
- ☐ Parent Child Interaction Therapy (PCIT) Play Therapy
- ☐ Play Therapy
- ☐ Psychoanalytic Therapy
- ☐ Psychodynamic Therapy
- ☐ Psychological Testing
- ☐ Psychopharmacology
- ☐ Rationale Emotive Therapy
- ☐ Relapse Prevention
- ☐ Relationship Disorders
- ☐ Sensory Processing/Integration
- ☐ Sex Therapy
- ☐ Sexual Compulsions/Addictions
- ☐ Solution Empowerment Therapy
- ☐ Stress Management
- ☐ Tobacco
- ☐ Trauma Focused Cognitive Behavioral Therapy
- ☐ (TF-CBT)
- ☐ Trauma Informed Care (TIC)
- ☐ Trust Based Relational Intervention (TBRI)
- ☐ Weight Management
- ☐ Tobacco Cessation

Disorders/Issues

- ☐ Addictive Medicine
- ☐ ADD/ADHD
- ☐ Addictive Disorders
- ☐ Adjustment Disorder
- ☐ Adolescent Behavior Disorders
- ☐ Adoption Issues
- ☐ Adult ADD
- ☐ AIDS/HIV
- ☐ Anger Management
- ☐ Anxiety/Panic Disorder
- ☐ Attachment Disorder
- ☐ Autism/Aspergers
- ☐ Bipolar Disorders
- ☐ Chemical Dependency
- ☐ Child/Parent Bonding
- ☐ Christian/Spiritual
- ☐ Chronic Pain/Pain Management
- ☐ Crisis Stabilization
- ☐ Cultural Issues
- ☐ Cognitive Disorder
- ☐ Concussion
- ☐ Co-occuring Disorders
- ☐ Criminal Offenders
- ☐ Dementia Disorders
- ☐ Depression
- ☐ Disabled
- ☐ Disruptive Behavior
- ☐ Dissociative Disorder
- ☐ Domestic Violence
- ☐ Dual Diagnosis
- ☐ Eating Disorders
- ☐ Equine Assisted Therapies
- ☐ Family Dysfunction
- ☐ Feeding Disorders
- ☐ Gay/Lesbian/Bisexual
- ☐ Gender Identity Issues
- ☐ Grief/Loss/Bereavement
- ☐ Head Trauma
- ☐ Home Visits
- ☐ Impulse Disorders
- ☐ Infertility
- ☐ Inpatient Attending
- ☐ Inpatient Consult MD
- ☐ Intellectual or Developmental Disorders
- ☐ Learning Disability
- ☐ Medical Evaluation
- ☐ Medical Illness/Chronic Illness
- ☐ Men Issues
- ☐ Mood Disorders
- ☐ Marital Issues
- ☐ Mental Retardation
- ☐ Obsessive Compulsive Disorder
- ☐ Oppositional Defiant Disorder
- ☐ Organic Mental Disorder
- ☐ Panic Disorder
- ☐ Parenting Issues
- ☐ Personality Disorders
- ☐ Phobias
- ☐ Physical Abuse
- ☐ Post-Partum Disorder
- ☐ PTSD
- ☐ Reactive Attachment Disorder

- ☐ Relapse Prevention
- ☐ Schizophrenia
- ☐ Self-Injury
- ☐ Separation/Divorce
- ☐ Serious/Persistent Mental Illness
- ☐ Sexual Abuse/Incest
- ☐ Sexual Disorders
- ☐ Sexual Dysfunction
- ☐ Sexual Offender
- ☐ Sexual/Physical Abuse (Adults)
- ☐ Sexual/Physical Abuse (Children)
- ☐ Sleep Disorder
- ☐ Step/Blended Families
- ☐ Stress Management
- ☐ Substance Abuse
- ☐ Suicide
- ☐ Tobacco Cessation
- ☐ Women Issues
- ☐ Work Related Problems

Certifications

- ☐ Art Therapy
- ☐ Center of Excellence
- ☐ Emergency Services Provider
- ☐ Lead Behavior Analysis Therapist
- ☐ Positive Behavior Support
- ☐ SBIRT
- ☐ Trauma Informed Cre
- ☐ TX CANS (Certificate Requierd)

Signature: _____ Date: _____

Conflict of Interest Disclosure Statement

I, _____ , hereby declare that I (or a related party) Do ☐ Do not ☐ have an actual, potential or perceived Conflict of Interest that I wish to disclose to Superior HealthPlan, Inc.

Such disclosure must include, , the legal name of the entity involved, its business address, its federal tax ID number, its principal line(s) of business, and the provider's ownership interest (by percentage) and/or management role (including title) with the entity.

If I checked "do" above, the following is a summary of my disclosure, including all material facts and the above-listed items of information (use additional paper as necessary):

Legal name of the entity involved: _____

Business address: _____

_____

Federal tax ID number: _____

Provider's ownership interest (e.g., type and percentage): _____

_____

Entity's principal line(s) of business: _____

_____

Signed: _____

Name: _____

Title: _____

Date: _____

Financial Interest Disclosure Statement

Name: _____ **Filing Period:**

Title: _____ Annual _____ Interim

FINANCIAL INTEREST

1. Do you or a related party (see definition above) have a direct or indirect ownership orinvestment interest in any entity (see definition below)?

   ☐ Yes ☒ No

2. Do you or a related party have a compensation arrangement with any entity?

   ☐ Yes ☒ No

*an entity is any provider, supplier, or business that provides any form of healthcare services or products.

Disclosure of Interest

If you answered YES to any of the above questions, please explain in detail the financial interest or relationship being reported (use separate sheet as needed). Please include the legal name of entity, business address, Federal tax ID number, ownership interest amount, and entity's line of business:

_____

_____

_____

_____

_____

CERTIFICATION

To the best of my knowledge and belief, I hereby certify that the information provided above accurately and completely describes all financial and other interests, which are required to be reported. If any situation should arise in the future which may involve me in a conflict of interest, I will promptly provide a new Disclosure Statement to Superior Health Plan, Inc.

Signature: _____ Date: _____

Typed/Printed Name: _____

Disclosure of Prior Contracts or Business with Superior HealthPlan

Have You or any Affiliate ever held (prior to now) a provider contract or done other Business with Superior HealthPlan or any of its Affiliates? ☐ Yes ☐ No

If yes, please identify the name of such entity and its relationship to You below. As used above, the capitalized terms are defined as follows:

"You" means the individual, partnership, corporation or other entity that is entering into a provider agreement with Superior HealthPlan, Inc.

"Affiliate" means an entity that is related by ownership (of any amount) or control (by sharing the same officers or directors) to You or to Superior HealthPlan

"Business" means holding a contract for provider services, vendor services or other services with Superior HealthPlan or an Affiliate of Superior HealthPlan.

If You answered "yes" above, please provide the following information (use additional paper as necessary):

Legal name of the entity with a Prior Contract or Other Business: _____

_____

Business address of such entity: _____

_____

Federal tax ID number of such entity: _____

Entity's relationship to You: _____

_____

Signed: _____

Name: _____

Title: _____

Date: _____

Participating Provider Attestation

WHEREAS, Superior HealthPlan, Inc. ("MCO"), has executed an agreement with _____ ("Provider") dated _____ pursuant to which Contracted Provider has agreed to provide Covered Services to Covered Persons through the Participating Provider Agreement (the "Agreement"); and

WHEREAS, Provider has requested that the undersigned Contracted Provider serve as a provider under the Agreement and Contracted Provider so desires to participate; and

WHEREAS, as a condition of such participation and Provider's designation as a "Contracted Provider" under this Agreement, Contracted Provider must satisfy MCO's credentialing criteria and execute this Attestation acknowledging his/her agreement to comply with, and be bound by, the terms and conditions of the Agreement that are applicable to Contracted Providers.

NOW THEREFORE, Contracted Provider hereby agrees as follows:

1. Contracted Provider agrees to provide Covered Services to Covered Persons in accordance with therequirements of the Agreement that are applicable to Contracted Providers so long as ContractedProvider qualifies as a Contracted Provider.
2. Contracted Provider understands and agrees that his/her initial and continued participation as aContracted Provider under the Agreement is contingent upon meeting and complying with MCO'scredentialing standards and otherwise complying with the terms and conditions of the Agreement.
3. Contracted Provider acknowledges that MCO expressly reserves the right to reject, suspend, and/ orterminate his/her participation under the Agreement for breaching or otherwise failing to: (i) comply withthe term of the Agreement or any Attachment thereto; (ii) meet MCO's credentialing requirements; or(iii)comply with the Provider Manual.
4. This Attestation shall be effective as of _____

Contracted Provider: _____

Signature: _____

Print Name: _____

Specialty: _____

Date: _____

NPI: _____

Texas A&M Health
eClinicalWorks Account Request

Name: Credintials:

Email:

Cell: Work:
(If available)

Role:

Primary Location: Choose Facility

TAMU HIPAA training completion date: Course # 2114226
(If available)

Manager Name: Choose Manager Start Date:

Manager Signature:
(eCW Admin can obtain)

Date:

Provider: NPI#

DEA# Active Date: Term Date:

Will the provider prescribe controlled substances? Yes ☐ No ☐

How many clinic days a week: *Providers only*

* Forward HIPAA confirmation email or Train Traq Transcript to EMR ADMIN