



PROVIDER APPLICATION

Please attach the following documentation with a completed application:

- Completed and signed Provider Application including confidential information (original signature required)
 - Completed Provider HIV Specialist Verification form for those providers who wish to be listed as an HIV Specialist Primary Care Provider, or Physician Extenders who wish to be assigned to Amida Care patients
 - A copy of current resume/Curriculum Vitae
 - A copy of current signed New York State License and registration
 - A copy of current DEA certificate (if applicable)
 - A copy of current Professional Liability (malpractice) policy Face sheet (must indicate Provider's name as the insured, policy period and coverage amount)
 - Documentation of Residency/Fellowship Completion Certificate (Board Eligible)
 - Documentation of Board Certification (if applicable)
 - Collaborative Agreement (for Nurse Practitioners and Licensed Nurse Midwives)
 - Verification from Amida Care's participating hospital(s) where you have privileges
 - Details of any pending professional misconduct proceedings or malpractice actions and the substance of the allegations.
 - Information from other HMOs or hospitals with which you have been associated regarding professional misconduct or medical malpractice, and associated judgments/settlements and any reports of professional misconduct by a hospital pursuant to NY State Public Health Law Section 2803-E. (you must obtain and submit this information)
 - Signed Agreement/Contract (Required for private office physicians)
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- Any information entered into this application which subsequently is found to be false could result in termination from Amida Care.
 - Please remember to sign the application and the consent for release of information and return with attachments to the Amida Care Offices:

Amida Care, Inc.
248 W. 35th Street
7th Floor
New York, NY 10001

PLEASE SUBMIT ALL DOCUMENTS AND ANSWER ALL QUESTIONS

I. PERSONAL INFORMATION

Last Name _____ First _____ Middle _____ Suffix (Jr., etc.) _____
Home Address _____ City _____ State _____ Zip _____
Social Security Number _____ Date of Birth _____ Male Female
NYS License/Registration # _____ Exp. Date _____ DEA # _____ Exp. Date _____
Medicaid / MEDs # _____ National Provider Identifier (NPI) _____
Malpractice Insurance Carrier _____ Exp. Date _____
Limits of Liability _____ / _____

Check appropriate box:

- Primary Care Provider – HIV Specialist, list specialty: _____
 Primary Care Provider – Non-HIV Specialist, list specialty: _____
 Specialist, list specialty: _____

Provider Type, check appropriate box: MD / DO NP PA Other, specify: _____

Is your practice: Open to new members? Open to pre-existing patients only? Closed?

II. OFFICE INFORMATION

PRIMARY LOCATION

PRACTICE NAME

OFFICE ADDRESS

CITY STATE ZIP

APPOINTMENT TELEPHONE #

OFFICE CONTACT

OFFICE EMAIL ADDRESS

ADA COMPLIANT: YES NO

Please list any age limitations for your primary practice, or any other practice limitations: _____

Number of patients seen in an average day: _____

What is your current patient panel size? (PCP only) _____

List languages provider speaks: _____

List languages staff members speak: _____

SECOND LOCATION

PRACTICE NAME

OFFICE ADDRESS

CITY STATE ZIP

APPOINTMENT TELEPHONE #

OFFICE CONTACT

OFFICE EMAIL ADDRESS

ADA COMPLIANT: YES NO

III. BILLING INFORMATION

Primary Location

TIN (Tax Identification No.)

Address

City State Zip

Telephone #

Billing Contact

Second Location

TIN (Tax Identification No.)

Address

City State Zip

Telephone #

Billing Contact

IV. EDUCATION, TRAINING AND CERTIFICATION

- Medical School Other Professional School for Non-Physicians

Institution Name _____

Mailing Address _____

Degree _____

Year of graduation _____

Are you an international medical school graduate? Yes No

Are you certified by the Education Council for Foreign Medical Graduates? Yes No

ECFMG Number: _____

Internship, Residency, Fellowship Training (List in chronological order)

Did you successfully complete an accredited residency program? Yes No

Institution Name	Type of Training	Dates

Board Certification

Board Certification(s) _____ Expiration Date(s) _____

Board Eligibility _____

If Board Eligible, include a copy of Residency and/or Fellowship Completion Certificate in the applying specialty.

If you are board certified or board eligible in any additional specialties or subspecialties, please indicate below.

V. OFFICE PROCEDURES

What is the waiting time to obtain an appointment for:

- Elective visits or routine follow-ups _____
- Physical exams _____
- Urgent problems _____

Is it your office's policy to see non-life threatening emergency problems on a same-day basis? Yes No

Once a patient arrives for a scheduled appointment, what is their average waiting time in your office? _____

Do you provide any special services or have a particular area of expertise? Yes No

If yes, please explain. _____

Do you have experience and expertise in the treatment of HIV+ and AIDS patients? Yes No

If yes, please explain. _____

Would you be willing to participate in a Amida Care quality improvement committee in the future? Yes No

VI. HOSPITAL AFFILIATION

Please list all hospitals where you **CURRENTLY** have privileges.

VII. CONFIDENTIAL INFORMATION

Please provide an explanation for any questions to which you answered "YES". Use a separate sheet if necessary.

1. Are your hospital staff privileges presently reduced, withheld, suspended, voluntarily surrendered, revoked, or subject to any special provision? Yes No
2. In the past five years, have your hospital privileges been reduced, withheld, suspended, voluntarily surrendered, revoked, or subject to any special provision? Yes No
3. Do you have any physical, mental, or emotional condition, including but not limited to any history of drug or alcohol abuse, which currently impairs your ability to render the professional services which are the subject of this application? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to safely and competently render the professional services which are the subject of this application. Yes No

4. Have you ever had a complaint lodged against you as a member of any professional society or association or any health maintenance organization which resulted in or will result in a hearing before a review mechanism of that organization? Yes No
5. Have you been investigated or are you presently under investigation by any state licensing board? Yes No
6. Have you ever been convicted of a criminal offense? Yes No
7. Has your license ever been revoked or otherwise limited in any states? Yes No
8. Has your DEA number ever been revoked or otherwise limited? Yes No
9. Are there any malpractice suits pending against you? Yes No
10. Have any judgments ever been entered against you in a legal proceeding? Yes No
11. Has your malpractice insurance ever been terminated or revoked? Yes No
12. Have you ever been expelled or suspended from receiving payment under the Medicare or Medicaid program? Yes No
13. Have you ever been sanctioned or disciplined by the NYSDOH Office of Professional Medical Conduct? Yes No
14. Have you ever been a defendant or are you presently a defendant in a malpractice, discrimination or professional liability lawsuit or proceeding or have you been placed on notice or have reason to believe of such a potential lawsuit or proceeding yet to be filed? Yes No
15. List all individuals with an ownership interest in your practice. If none, please indicate as none.
- _____
16. Does any hospital or health care facility have an ownership interest in your practice? Yes No
If yes, please list. _____
17. Do you, any other member of your practice, or any member of your immediate family or the immediate family of any other member of your practice have any ownership or financial interest in any other health care facility, treatment center, laboratory, or diagnostic facility? Yes No
If yes, please list. _____
18. List any other HMOs, PHSPs with which you are currently associated. (use a separate sheet if needed)
- _____
- _____
19. List any hospitals, HMOs, PHSPs and/or medical groups with which you were previously associated. Please explain any reason for discontinuance of such associations. (use a separate sheet if needed)
- | Name of Hospital, HMO, PHSP, medical group | Reason for Discontinuance |
|--|---------------------------|
| _____ | _____ |
| _____ | _____ |
20. Have you ever been denied privileges at a hospital or HMO to which you applied? Yes No
If yes, explain _____

I certify that my answers to the foregoing questions are complete and true and correct to the best of my knowledge. I certify that all information provided in my application is accurate and true. I authorize the release to Amida Care of information related to the subject matter of this questionnaire from governmental units and agencies, insurance carriers, and hospitals and medical facilities with which I am or have been affiliated.

I hereby release from any liability any person, agency, or institution as referenced in the above paragraph that is approached for or provides information concerning my credentials, qualifications or any information related to the subject matter of this questionnaire.

A photocopy of this permission will serve as the original. I understand that Amida Care will use this information solely for the purposes of evaluating participation in Amida Care.

Signature: _____

Date: ____/____/____

Print Name: _____



CONSENT FOR RELEASE OF INFORMATION

By applying for appointment or re-appointment as a participating primary care or specialty provider in Amida Care, I hereby signify my willingness to supply information, appear for an interview and permit an inspection of my practice office(s) and medical record keeping practices in regard to my application for appointment. I authorize Amida Care, its staff and its agents to consult with members of the administrative and medical staffs of other hospitals, health-related facilities, insurance companies and managed care plans with which I have been associated and with others who may have information bearing on my professional competence, character and ethical qualifications.

I hereby release from liability to me all representatives of Amida Care, its staff and its agents for their acts performed in good faith, in connection with evaluating my application, credentials and qualifications, and I hereby release from liability to me any and all individuals and organizations who provide information to Amida Care or its staff in good faith concerning my professional competence, ethics, character and other qualifications for appointment and clinical privileges, and I hereby consent to the release of such information. I understand and agree that, except in the case of queries made to the National Practitioner Data Bank by Amida Care that any documents related to my professional competence, ethics, character and other qualifications for appointment and clinical privileges shall be obtained by Amida Care only upon my express written consent following receipt by me of a description of such documents.

I understand that Amida Care shall keep confidential the information obtained pursuant to this written consent except as other wise required by law, and shall use such information only to determine my qualifications to participate in Amida Care's managed care programs.

Signature

____/____/____
Date

Print Name