California Participating Physician Application

Addendum A

Health Plans and IPA's/Medical Groups

This Addendum is submitted to:_____ herein, this Healthcare Organization. [1]

I. IDENTIFYING INFORMATION		
Last Name:	First:	Middle:
Medical Group (s) /IPA(s) Affiliation:		
Do you intend to serve as a primary care provider? ☐ Yes ☐ No Do you intend to serve as a specialist? ☐ Yes ☐ No (If yes, please list specialty(s))		
Please check all that apply: ☐ Solo Practice ☐ Single Specialty ☐ Group Practice ☐ Multi specialty		

II. BILLING INFORMATION		
Billing Company:		
Street Address:	City:	
	State:	ZIP:
Contact:	Telephone Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

III. PRACTICE INFORMATION

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? ☐ Yes ☐ No

If so, please list:

Name: Type of Provider: License Number:

____

____

____

____

____

If you are a Physician Assistant Supervisor, please include State License Number:_____

Do you personally employ any physicians (do not include physicians that are employed by the medical group)? ☐ Yes ☐ No

If so, please list:

Name: California Medical License Number:

_____ _____

_____ _____

1 The term "this Healthcare Organization" shall refer to the entity to which this Addendum is submitted as identified above.

Please list any clinical services you perform that are not typically associated with your specialty: _______

Please list any clinical services you **do not** perform that are typically associated with your specialty: ______

Is your practice limited to certain ages? ☐Yes ☐No
If yes, specify limitations: _____

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? ☐Yes ☐No

Do you participate in EDI (electronic data interchange)? ☐Yes ☐No
If so, which Network? _______
Do you use a practice management system/software: ☐Yes ☐No

If so, which one? _______

What type of anesthesia do you provide in your group/office?
☐ Local ☐Regional ☐Conscious Sedation ☐General ☐None ☐Other (please specify) _____

Has your office received any of the following accreditations, certifications or licensures?
☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
☐ California Department of Health Services Licensure
☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
☐ Medicare Certification
☐ The Medical Quality Commission (TMQC)
☐ Other _

IV. OFFICE HOURS - Please indicate the hours your office is open:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holidays

V. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary)

Answering Service Company:	Phone Number: ( )	Fax Number: ( )

Mailing Address:	City:	
	State:	ZIP:

Covering Physician's Name:	Telephone Number: ( )
Covering Physician's Name:	Telephone Number: ( )
Covering Physician's Name:	Telephone Number: ( )
Covering Physician's Name:	Telephone Number: ( )

If you do not have hospital privileges, please provide written plan for continuity of care:

Physician Name:

Physician Name:

VI. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:	Fluently by Staff:

VII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

Tax ID #:	Billing Name:	Type of Service Provided:
Do you have a CLIA certificate?	☐Yes	☐No
Do you have a CLIA waiver?	☐Yes	☐No
Certificate Number:		Certificate Expiration Date:

VIII. PROFESSIONAL ORGANIZATIONS

Please list country, state or national medical societies, or other professional organizations or societies of which you are a member or applicant.

Organization Name	Applicant	Member
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

I certify that the information in this document and any attached documents is true and correct.

Print Name Here: ____

Physician Signature: ____Date: _____
(Stamped Signature Is Not Acceptable)