Practitioner Application

For MultiPlan Use Only

Thank you for your interest in participating with MultiPlan, Inc. This application will serve to qualify you for participation in one or more of our networks (PHCS, Beech Street, MultiPlan) as indicated in your MultiPlan contract. Note: If you are based in Wisconsin, the application also covers your participation in HealthEOS by MultiPlan, our primary PPO network in that region. Items marked with an asterisk (*) will be kept confidential to the extent permitted by law. **PLEASE COMPLETE EVERY SECTION OF THIS FORM, PRINT YOUR RESPONSES AND SUBMIT ALL REQUESTED INFORMATION. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.** If you need assistance completing this form, contact Service Operations at https://provider.multiplan.com or call 800-950-7040.

CONTRACT

Please indicate how you are applying to join our networks:
☐ Individual practitioner
☐ Individual practitioner as part of a group practice that has an existing contract with MultiPlan

Group Name:______________________ CAQH ID: __________
Number of practitioners: _______ Beech Street Group Contract ID (if known):__________
MultiPlan Contract ID (if known): __________

INDICATIVE

LAST NAME | FIRST NAME | M.I. | TITLE *(e.g., Jr., Sr., III)*

PREVIOUS LEGAL NAME (IF APPLICABLE) ______________________

NPI (Required in WA)

*SOCIAL SECURITY NUMBER | *BIRTH DATE (mmddyyyy) | GENDER ☐ M ☐ F | E-MAIL__________

DEGREE

Professional Degree (check only one) NOTE: You must be independently licensed at the highest level for your discipline in your state.

☐ M.D. ☐ D.D.S. ☐ O.D. ☐ Th.D. ☐ M.S.W. ☐ M.S.N. ☐ B.S.N. ☐ B.S. ☐ Other (list below)
☐ D.O. ☐ D.P.M. ☐ D.Min. ☐ Ph.D. ☐ Ed.D. ☐ M.S. ☐ M.A. ☐ B.A. ______________
☐ D.M.D. ☐ D.C. ☐ M.Min. ☐ Psy.D. ☐ M.Ed. ☐ M.S.P.T. ☐ M.C.

AFFILIATIONS

List all hospitals where you currently have admitting privileges. List your primary admitting facility first. Please attach an additional sheet if more than three.

Name of Hospital	Street Address, Suite	City, State, Zip Code
Name of Hospital	Street Address, Suite	City, State, Zip Code
Name of Hospital	Street Address, Suite	City, State, Zip Code

If you do not have admitting privileges, please indicate how you admit patients:

☐Hospitalist ☐Practitioner admits on my behalf (Name of hospitalist or practitioner: ______________) ☐ Other, please explain: ______________

CERTIFICATIONS

Specialty (M.D., D.O., D.M.D., D.D.S. or D.P.M. only)

To ensure that appropriate referrals are made to your practice, please provide the following information about the specialties in which you currently practice. If you are not an M.D., D.O., D.M.D., D.D.S. or D.P.M., please skip to the clinical practice section.

Board Specialty	Hospital Based?	Board Certified Date (mmddyyyy)	List Specialty in Directory?
Primary Practicing Specialty	☐ Yes		☐ Yes ☐ No
Other Practicing Specialty	☐ Yes		☐ Yes ☐ No
Other Practicing Specialty	☐ Yes		☐ Yes ☐ No

Clinical Practice If you are not an M.D., D.O., D.M.D., D.D.S. or D.P.M., please choose the field or title that best describes your clinical practice.

List Specialty in Directory? ☐ Yes ☐ No
☐ Acupuncturist
☐ Audiology
☐ Certified Behavior Analyst (Autism)
☐ Certified Registered Nurse Anesthetist
☐ Chiropractor
☐ Clinical Nurse Specialist
☐ Dietician
☐ Midwife
☐ Nurse Practitioner
☐ Occupational Therapist
☐ Optometrist
☐ Physical Therapist
☐ Physicians Assistant
☐ Speech Therapist
☐ Other ______________

If you are a behavioral health provider, please indicate no more than three areas of expertise for which you have additional training and a minimum of two years post graduate experience.

☐ Anxiety / Panic Disorders
☐ ADHD / Learning Disorders
☐ Certified Behavior Analyst (Autism)
☐ Chemical Dependency
☐ Child / Adolescent Disorders
☐ Chronic Pain
☐ Eating Disorders
☐ Geriatrics
☐ Group Therapy
☐ Marriage / Family Counseling
☐ Mood Disorders
☐ Physical / Sexual Abuse
☐ Phobias
☐ Psychological / Neurological Testing
☐ Sexual Dysfunction

PROFESSIONAL HISTORY

Education Name of college, graduate, or medical school that corresponds with the **professional** degree above.

College or University | City, State | Degree Awarded

Country | Attended (mmddyyyy) From ______ To ______

Post Graduate Training

Internship	Specialty	Hospital / Facility	City, State	Attended From To
Residency or Post-Doctoral Internship	Specialty	Hospital / Facility	City, State	Attended From To
Fellowship	Specialty	Hospital / Facility	City, State	Attended From To

LANGUAGES

Please indicate language(s) spoken in addition to English ____________________

Please indicate if you communicate in Sign Language ☐ Yes ☐ No

INSURANCE

Professional Liability (Malpractice) Please enclose a copy of your malpractice insurance face sheet. Your application may not be processed without it.

Carrier	Policy Number: ______ Expiration Date (mmddyyyy)	Coverage Levels Per Occurrence $ / In Aggregate $

Do you intend to maintain your current professional liability insurance limits? If no, please enclose a detailed explanation. ☐ Yes ☐ No

Do you have any supplemental professional insurance? If yes, please enclose a detailed explanation. ☐ Yes ☐ No

Comprehensive General Liability If you do not carry this insurance, please enclose a detailed explanation. ☐ Yes ☐ No

Carrier	Policy Number: ______ Expiration Date (mmddyyyy)	Coverage Levels Per Occurrence $ / In Aggregate $

REGISTRATION

Licenses You must be independently licensed at the highest level for your specialty in your state. List all current and historical licenses.

State	Currently practicing in state of license?	Number	License Type	Expiration Date (mmddyyyy)
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

Current Federal DEA Certification*

Do you administer or prescribe controlled substances (Schedule II, III, V medications)?

☐ Yes: DEA Certificate # Expiration Date (mmddyyyy)

☐ No: I do not administer or prescribe controlled substances; I do not have a DEA number.

ADDRESSES I

Address Information Please provide practice, billing and mailing information for each office in which you see patients under this contract. Attach additional sheets as necessary.

Address Information I (Please provide your payment address first. Note: If this is also a practice address, it cannot be a P.O. Box

☐ Payment Address ☐ Practice Address ☐ Mailing Address

Street Suite

City State Zip

Phone Numbers

Appointments Ext. Billing Ext. Fax

Is This Office

Your primary practice location? ☐ Yes ☐ No

Open to new patients? ☐ Yes ☐ No

An address you wish to appear in the directory? ☐ Yes ☐ No

Accessible to handicapped patients? ☐ Yes ☐ No

Office Hours (Required for certain states)

MONDAY From - To	TUESDAY From - To	WEDNESDAY From - To	THURSDAY From - To	FRIDAY From - To	SATURDAY From - To	SUNDAY From - To

Average Appointment Scheduling Time (Required for certain states)

New patient _________Hours / Days / Weeks Routine Visit _________Hours / Days / Weeks Urgent Visit _________Hours / Days / Weeks

Services

Please list only the specialties practiced at this location:

Contact Name

First Name M.I. Last Name Title

Phone Ext. Fax

Tax ID Information I – Address I All information must match the W-9 Form submitted to the IRS.

Tax Identification Number

Tax ID Name____________________

Tax ID Address ____________________

ADDRESSES II

Address Information II Please provide practice, billing and mailing information for each office in which you see patients under this contract.

☐ Payment Address ☐ Practice Address ☐ Mailing Address

Street | Suite

City | State | Zip

Phone Numbers

Appointments | Ext. | Billing | Ext.

Fax

Is This Office

Your primary practice location? ☐ Yes ☐ No
Open to new patients? ☐ Yes ☐ No
An address you wish to appear in the directory? ☐ Yes ☐ No
Accessible to handicapped patients? ☐ Yes ☐ No

Office Hours (Required for certain states)

MONDAY From - To	TUESDAY From - To	WEDNESDAY From - To	THURSDAY From - To	FRIDAY From - To	SATURDAY From - To	SUNDAY From - To

Average Appointment Scheduling Time (Required for certain states)

New patient __________Hours / Days / Weeks Routine Visit __________Hours / Days / Weeks Urgent Visit __________Hours / Days / Weeks

Services

Please list only the specialties practiced at this location:

Contact Name

First Name | M.I. | Last Name | Title

Phone | Ext. | Fax

Tax ID Information II – Address II All information must match the W-9 Form submitted to the IRS.

Tax Identification Number

Tax ID Name______________________________

Tax ID Address ______________________________

HISTORY

Employment History

Please describe the last five (5) years (month specific) of your employment/professional history. Please include with your application a brief explanation of any gap of six (6) months or greater.* Please note that your application cannot be processed if **month** and **year** specific detail is not provided.

Activity / Position	Facility / Program	City, State	From (mmyy)	To
				– Present
Activity / Position	Facility / Program	City, State	From (mmyy)	To (mmyy)
Activity / Position	Facility / Program	City, State	From (mmyy)	To (mmyy)
Activity / Position	Facility / Program	City, State	From (mmyy)	To (mmyy)
Activity / Position	Facility / Program	City, State	From (mmyy)	To (mmyy)

Explanation:

PROFESSIONAL QUESTIONS *

Please provide a detailed description of all positive responses.	
A. Have you ever had any negative action taken in connection with your license, including, but not limited, to refusal, suspension, revocation, probation reprimand, censure or restriction in any way by any state or jurisdictional board?	☐ Yes ☐ No
B. Have you ever been censured by a medical society or other professional society or other professional board or association?	☐ Yes ☐ No
C. Have you ever had your Drug Enforcement Administration number (DEA #) restricted, suspended, revoked or otherwise limited or DEA license application refused?	☐ Yes ☐ No ☐ NA
D. Have you ever had an agreement with Medicare or Medicaid that was restricted, probational, suspended, excluded or terminated?	☐ Yes ☐ No
E. Have you ever been required or agreed to pay civil monetary penalties under Medicare or Medicaid?	☐ Yes ☐ No
F. Have you ever been convicted of a criminal offense other than a minor traffic violation?	☐ Yes ☐ No
G. Has any hospital or facility ever taken any action regarding your privileges, including, but not limited, to suspension, restriction, denial or revocation?	☐ Yes ☐ No
H. Have you ever voluntarily resigned privileges in lieu of disciplinary action?	☐ Yes ☐ No
I. Has there been, within the last five years, more than one malpractice judgment found against you or malpractice settlement made, with or without prejudice, in excess of five hundred thousand ($500,000) dollars?	☐ Yes ☐ No
J. Do you have an impairment, which even with reasonable accommodation would interfere with your ability to provide care according to accepted standards of professional performance, or would pose a threat to patient health and safety?	☐ Yes ☐ No
K. Are you now or have you ever been an active or habitual user of any mind or mood altering substance, including, but not limited, to alcohol, narcotics, barbiturates, hypnotics, amphetamines, cocaine, benzodiazepines, or other controlled or illegal substances?	☐ Yes ☐ No
L. Has your participation in any insurance carrier sponsored program been suspended or revoked?	☐ Yes ☐ No

ATTESTATION / RELEASE

I hereby submit this application for participation in MultiPlan, Inc.'s networks as indicated in my MultiPlan contract. I understand that this application will be reviewed based on the information I have provided herein.

I hereby certify that the information contained and enclosed with this form is complete and accurate, and that information found to be false could result in denial or subsequent termination of my participation in any or all of the MultiPlan networks. I understand that I have an obligation to alert MultiPlan of any material changes to the items attested to above.

To assist MultiPlan and/or its Credentials Verification Organization (CVO) in evaluating my application, I authorize any hospital, group practice, other clinical employer, professional society, malpractice carrier or other agency or organization with information regarding my professional credentials to release, furnish copies, or give details of my professional credentials, qualifications and hospital records related to my privileges, qualifications, type of clinical practice and competence, including my moral and ethical qualifications. I hereby release from liability any and all individuals and organizations who, in good faith and without malice, provide information to MultiPlan for the purposes of evaluating this application, and release MultiPlan from liability for its use of the information it gathers in the application process.

A photocopy of this permission will be as valid as the original.

X ____________________________ ____________________________ ______________

Signature of Provider (Must be participating provider's signature) | Name (please type or print) | Date (mm/dd/yyyy)

NOTE: Signature and date on this application MUST be within 30 days of submission to MultiPlan.

APPLICATION CHECKLIST

1. ☐ Completed and signed Application.
2. ☐ If applying as an individually contracted practitioner, submit completed and signed copy of the MultiPlan Participating Professional Agreement (with all Exhibits stapled to the Agreement).
3. ☐ Copy of current DEA and license certificate(s).
4. ☐ Copy of current insurance certificate which includes Professional and Comprehensive General Liability.
5. ☐ Please note that TIN Name must match the name on your W-9. If you or your practitioner is not the owner of the TIN, a letter from the TIN owner giving you permission to use the TIN must accompany this application.
6. ☐ Copy of Curriculum Vitae.
7. ☐ A signed and dated detailed explanation and documentation for any affirmative responses to Professional Questions or Employment History Gaps six (6) months or greater.

☐ Keep a photocopy of this Application for your records.

9. ☐ Send your completed application and all supporting materials to MultiPlan:
Online via the Provider Service Portal: http://provider.multiplan.com.
E-mail: registrar@multiplan.com. Include case number.
Fax: 781-487-8273. Include case number.
Mail: MultiPlan, ATTN: Registrar, 16 Crosby Drive, Bedford, MA 01730. Include case number.