MultiPlan

Arkansas Preferred Physician 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 both the PHCS Network (primary PPO) and The MultiPlan Network (complementary network). **To ensure appropriate referrals and facilitate timely payment of claims, we ask that you complete all items on this form.** Items marked with an asterisk (*) will be kept confidential to the extent permitted by law. If you need assistance completing this form, please call our Service Operations Department at 1-800-950-7040.

INDICATIVE

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

*SOCIAL SECURITY NUMBER ___ – ___ – ____ | *BIRTH DATE (mm/dd/yyyy) __ / __ / ____ | GENDER ☐ M ☐ F | E-MAIL _____

CERTIFICATIONS

Specialty

Please indicate the specialties in which you would like to receive referrals for new patients.

Primary Specialty

Other

Other

PROF HISTORY

Education

Medical School | City, State | Degree Awarded MD ☐ DO ☐

Country | Attended (mm/dd/yyyy) From __ / __ / ____ To __ / __ / ____

LANGUAGES

Please indicate language(s) spoken by provider in addition to English _____

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

INSURANCE

Professional Liability (Malpractice)

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

Comprehensive General Liability

Carrier	Expiration Date (mm/dd/yyyy)	Levels:	Per Occurrence	In Aggregate
	__ / __ / ____		$	$

REGISTRATION

DEA Certification

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

☐ Yes: DEA Certificate # __ – _____

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

Arkansas State Medical Board License Number: _____

ADDRESSES

Address Information I

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

Address 1 (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

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

After hours call coverage _____

* Information will be kept confidential to the extent permitted by law.

ADDRESSES

Average Appointment Scheduling Time

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

Contact Name

First Name M.I. Last Name Title

Phone Ext. Fax

TAX INFORMATION

Tax I.D. Information I – Address I

- Information listed below will assist MultiPlan clients to pay your claims properly.
- All information must correspond to the W-9 Form submitted to the IRS.

Tax Identification Number

Tax ID Name_____

Tax ID Address _____

(Note: This name must match the name associated with the Tax ID number on your W-9 Form.)

ADDRESSES

Address Information II

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

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

Open to new patients? ☐ Yes ☐ No Accessible to handicapped patients? ☐ Yes ☐ No

Office Hours

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

After hours call coverage _____

Average Appointment Scheduling Time

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

Contact Name

First Name M.I. Last Name Title

Phone Ext. Fax

TAX INFORMATION

Tax I.D. Information II – Address II

- Information listed below will assist MultiPlan clients to pay your claims properly.
- All information must correspond to the W-9 Form submitted to the IRS.

Tax Identification Number

Tax ID Name_____

Tax ID Address _____

(Note: This name must match the name associated with the Tax ID number on your W-9 Form.)

ATTESTATION / RELEASE

I hereby submit this application for participation with MultiPlan, Inc. through the PHCS Network and The MultiPlan Network. 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, accurate and true, and that information found to be false could result in denial or subsequent termination of my participation in the PHCS Network and The MultiPlan Network.

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

X _____ _____ _____

Signature of Provider Name (please type or print) Date (mm,dd,yy)

* Information will be kept confidential to the extent permitted by law.

REMEMBER TO ENCLOSE

1. ☐ **Completed and signed Arkansas Preferred Physician Application.**
2. ☐ **One (1) completed and signed copy of the MultiPlan Participating Professional Agreement (with all Exhibits stapled to each Agreement).**
3. ☐ **Copy of W-9 Form.**
4. ☐ **Copy of Curriculum Vitae. (optional)**

Don't Forget To

☐ **Sign** and **date** the Application
☐ **Keep a photocopy** of the Application for your records.

MULTIPLAN USE ONLY

PPO Fee Schedule _____ Agreement ID _____

OA Fee Schedule _____ Agreement ID _____

* Information will be kept confidential to the extent permitted by law.
PRVP077-AR (12/07)

Questions? Call 1-800-950-7040
1100 Winter St. Waltham, MA 02451-9370

AUTHORIZATION AND RELEASE

I hereby authorize the Arkansas State Medical Board to provide my credentialing information gathered by the Board to _____ (a Credentialing Organization) with whom I am affiliating and seek privileges.

This Authorization shall remain in effect for a period not to exceed two (2) years or until revoked by me in writing.

Typed or Printed Name of Physician:_____

Licensure Number:_____

Signature of Physician:_____Date:_____
(Stamped signature is not acceptable)

**This document does not authorize the Arkansas State Medical Board to release information collected to third parties except as later authorized by the above physician and Arkansas law.*

A&R.doc
Revised: 6/30/03 LJM; Rev. 3/14/05 ANM

Arkansas State Medical Board
Centralized Credentials Verification Service

Phone: (501) 296-1951
Fax: (501) 296-1806
www.armedicalboard.org

PLEASE fax back to CCVS AT YOUR EARLIEST OPPORTUNITY!

DO NOT MAIL

DO NOT ALTER THE OUESTIONS ON THIS ATTESTATION FORM!!!

Yes ____ No ____ Do you currently maintain individual or group malpractice insurance coverage? *If NO, list reason*: _____

Policy number (s): _____ Coverage amounts: _____ Expiration date: _____

Insurance Carrier(s)Name: _____If Group (List Group Name Policy is under):_____

_____

If you answer YES to any of the following questions, provide an explanation of the circumstances on an attached page.

1. Yes ____ No ____ *Since your last attestation*, have your privileges or medical staff membership at any hospital or other healthcare organization been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending?* *If YES, briefly explain on attached page.*

2. Yes ____ No ____ *Since your last attestation*, have you been charged or convicted of (including a plea of guilty or *nolo contendere*) a felony? (NOTE: Applicants must answer affirmatively if records, charges, or convictions have been pardoned, expunged, plead down, released or sealed.)* *If YES, briefly explain on attached page or attach copies of your documents.*

3. Yes ____ No ____ *Since your last attestation,* has your license or certificate to practice medicine or Drug Enforcement Administration registration in any jurisdiction (state or country) been challenged, denied, reduced, limited, suspended, revoked, placed on probation, not renewed, voluntarily or involuntarily relinquished, or is any such action pending?* *If YES, briefly explain on attached page.*

4. Yes ____ No ____ *Since your last attestation*, have you been or are you presently being treated for alcoholism or substance abuse? If Yes, was this voluntary or the result of a Medical Board action?* *If YES, briefly explain on attached page.*

5. Yes ____ No ____ *Since your last attestation*, have you been advised or required by the Arkansas State Medical Board or any other licensing board to seek treatment for a physical or mental health condition?* *If YES, briefly explain on attached page.*

6. Yes ____ No ____ *Since your last attestation,* do you currently, or have you had since your last renewal, any physical or mental health condition, including alcohol or drug dependency, which, with accommodation, affects or is reasonably likely to affect your ability to practice medicine or to perform professional or medical staff duties appropriately?* *If YES, briefly explain on attached page.*

7. Yes ____ No ____ *Since your last attestation*, are you presently involved in the use of any illegal substance?* *If YES, briefly explain on attached page.*

8. Yes ____ No ____ *Since your last attestation*, have any malpractice claims or professional liability lawsuits been filed against you?* *If YES, briefly explain on attached page.* **CLAIM DATE** ____/____/____ **CLAIMANT'S INITIALS** _____. **ASMB Requirement (Medical Practices Act 17-95-103)**

9. Yes ____ No ____ *Since your last attestation,* have any malpractice judgments been entered against you, or settlements been agreed to, in professional liability lawsuits or malpractice claims?* *If YES, briefly explain on attached page or attach documents.*

   CLAIM DATE _____/_____/_____ **CLAIMANT'S INITIALS** _____.

10. Yes ____ No ____ Have you participated in continuing medical education related to your area of practice **since your last AR license renewal**?*

    If NO, list reason:_____

11. How many CME credits have you acquired since your last AR license renewal? _____How many relate to your practice specialty? _____.

ATTESTATION – ALL QUESTIONS MUST BE ANSWERED (if not applicable, put N/A in blank)

I affirm that all information contained in the original application or most recent update is true, correct, current, and complete in all respects to the best of my ability. I accept the responsibility to keep the Arkansas State Medical Board advised of any change or appropriate addition to any information contained in this form between now and the time such information is updated by subsequent renewals or updates.

_____

Licensee's Signature (Required) ***(No Rubber Stamps)*** **Date Signed (Month/Day/Year - Required)**

_____ _____

Licensee's Printed/Typed Name (Required) **AR License Number (Required)**