Wellmark, Inc.

Iowa Universal Practitioner Application Addendum

To apply for participation in Wellmark networks, please complete this Addendum in addition to the *Iowa Statewide Universal Practitioner Application.* In it's sole discretion, Wellmark reserves the right not to process or accept a provider's application.
You are only required to answer the questions that apply to your specialty.

M.D./D.O., D.P.M., P.A., A.R.N.P. excluding allergy, anesthesiology, dermatology, emergency room, genetics, occupational medicine, pathology, psychiatry and radiology

Hospital Admitting Privileges

☐ I attest that I have hospital admitting privileges at the hospitals identified in Section E.

☐ I do not have hospital privileges but have the following arrangement for my patients to be admitted:

☐ Arrangement for hospital admissions by referral to a Wellmark participating physician or physician group.

_____ _____

Name of physician or physician group City/State

☐ Arrangement for hospital admissions by a Wellmark participating hospitalist or hospitalist group.

_____ _____

Name of physician or physician group City/State

Obstetrical Services (Family Practice, General Practice, Ob-Gyn, P.A., A.R.N.P. practicing in family or general practice or Ob-Gyn)

If a Family or General Practitioner, do you perform Obstetrical services? ☐ Yes ☐ No

If a Family or General Practitioner performing Obstetrical services, do you perform deliveries? ☐ Yes ☐ No

If an Obstetrics/Gynecology Practitioner, do you perform obstetrical services? ☐ Yes ☐ No

M.D./D.O., P.A., and A.R.N.P. and D.P.M.

State or Federal Controlled Substance

Level of drugs you can prescribe: ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 2N ☐ 3N

List the FDEA or CSA for the state in which you are applying for, if you do not have a current FDEA or CDS, please provide the name(s) of the practitioner(s) who will prescribe for your patients

Name	Title	NPI	Address	FDEA/CDS

Psychologists, Ph.D., Ed.D., Psy.D.

Licensing Information

Are you listed in the National Registry of Health Service Providers in Psychology? ☐ Yes ☐ No

If yes, please indicate Registrant Number _____

Original Issue Date _____/_____/_____
Mo Day Yr

Iowa HSP (Health Service Provider) Number _____

Date Issued _____/_____/_____ Exp. Date _____/_____/_____
Mo Day Yr Mo Day Yr

Site Specific Information - If the information is different by practice site, please make a copy of this section and complete by practice site

The following information is for this practice site (address) _____

Group NPI _____

Credentialing Person's Title _____

Credentialing Fax Number _____ TDD Phone Number *(for hearing impaired)* _____

Do you store electronic medical records? ☐ Yes ☐ No

Do you prescribe medication electronically? ☐ Yes ☐ No

Health Status

During the last three years, have you ever been under the influence of alcohol or illegal drugs during working hours, or have you had a chemical dependency and/or substance abuse problem, treated or untreated? ☐ Yes ☐ No

If yes, please explain: _____

_____

Are you unable, with or without reasonable accommodation, to practice to the fullest extent of your license, qualifications , and/or privileges without in any way posing a risk of harm to your patients? ☐ Yes ☐ No

Have you ever been required to register as a sex offender anywhere? ☐ Yes ☐ No

Malpractice

Next Policy Period: _____

Carrier Name _____

Policy Number _____ Aggregate Amount _____ Per Claim Amount _____

Effective Date _____/_____/_____ End Date _____/_____/_____

Directory Information

List this site and specialty in directory? ☐ Yes ☐ No

Reason not listed ☐ No patient appointments made at this site ☐ Hospitalist ☐ Covering/Back up only

☐ Other _____

Back-Up Physician Information (Blue Access®, hawk-i Blue Access, Blue Choice®, Blue Advantage®)

M.D.s/D.O.s, O.B./G.Y.N.s and P.A.s/A.R.N.P.s practicing as PCPs/O.B./G.Y.N.s: If you are applying for the managed care networks, you must designate a back-up.

Please list each individual providing back-up coverage for you, including their name, complete address, specialty, and NPI. Indicate this information for each site identified in the *Iowa Statewide Universal Practitioner Application*. (If you need more space, use the last page of this addendum.)

Name	Address	Specialty	NPI	Effective Date
				/ /
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Site Specific Information (cont) - If the information is different by practice site, please make a copy of this section and complete by practice site

Restrictions - mark the groups you want to see

Age? ☐ No age restrictions ☐ 0-5 ☐ 6-12 ☐ 13-17 ☐ 18-65 ☐ 65+

Gender? ☐ No gender restrictions ☐ Female only ☐ Male only _____

Imaging Services Performed at your site

☐ CT	☐ MRI	☐ PET
☐ CTA	☐ Mammography	☐ PET/CT
☐ Echocardiography	☐ Nuclear Cardiology	☐ X-Ray
☐ MRA		

Clinic Authorization and Agreement

For clinics with two or more providers - Please sign the following authorization for payment if you are billing as a clinic and want payment to come to you in the name of the clinic.

I authorize Wellmark Blue Cross and Blue Shield of Iowa to make payment to :

Clinic Name _____

Clinic Address _____

_____

for services that I perform. I agree that charges for my services will be uniform with all other physicians or health care providers that practice in the clinic named above.

Practitioner's Signature _____ Date _____/_____/_____

Hospital-Based Practitioners

If you practice exclusively in a hospital setting, you are considered hospital-based. However, if you practice at other sites(s) outside the hospital and would like your name to appear in Wellmark's provider directory, you will need to be credentialed.

Do you see patients outside of the hospital? ☐ Yes ☐ No

Do you want to be listed at the other site(s) identified in the *Iowa Statewide Practitioner Universal Application*, in the Wellmark provider directory? ☐ Yes ☐ No

Ownership - If you have multiple affiliations please copy page and complete for each affiliation.

Document current affiliations with other health care or health related organizations.

Organization Name _____

Address _____ City _____ State _____ Zip _____

Start Date _____/_____/_____ End Date _____/_____/_____

Position Held _____ Compensated ☐ Yes ☐ No

Do you own or a family member own or have ownership interest in a healthcare facility or organization that provides health or medical services (lab, nursing home, pharmacy, radiology/imaging center, rehab, HMO, medical equipment supplier, etc.)?

☐ Yes ☐ No

If yes, then provide the following:

Name of Facility _____

Address _____

Percent of Ownership _____ Owned By _____

Name of Organization _____

All Practitioners (cont.)

Med/Surg & Behavioral Health Practice Focus

Please check those capabilities in which you focus your practice. These may or may not be a covered benefit. The information provided may be used to direct members to providers that practice in the areas indicated below.

Medical/Surgical

MD/DO's Only

Surgery:

- ☐ Bariatric
- ☐ Gastric
- ☐ Mastectomy
- ☐ Gynecological Oncology

Dental Surgery:

- ☐ TMJ Surgery

Dermatology:

- ☐ MOHS Surgery

Medical Services:

- ☐ Epilepsy

Orthopedics:

- ☐ Back Surgery
- ☐ Hip Surgery
- ☐ Joint Replacement
- ☐ Knee Surgery
- ☐ Shoulder Surgery
- ☐ Wrist

Ophthalmology:

- ☐ Cataract Laser Surgery
- ☐ Cornea Specialist
- ☐ Glaucoma Specialist
- ☐ Oculoplastics
- ☐ Orbit Specialist
- ☐ Retinal Specialist
- ☐ Strabismus Specialist

Behavioral Health Practitioners Only

- ☐ ADD/ADHD
- ☐ Addictions
- ☐ Adjustment Disorder
- ☐ Adoption Issues
- ☐ Anger Management
- ☐ Anxiety Disorder
- ☐ Asperger's Syndrome
- ☐ Autism Spectrum Disorders
- ☐ Bariatric Assessment
- ☐ Behavior Modification
- ☐ Bi-Polar Disorder
- ☐ Biofeedback
- ☐ Child Abuse
- ☐ Christian Counseling
- ☐ Chronic Mental Illness
- ☐ Chronic Physical Illness
- ☐ Co-Dependency
- ☐ Cognitive Behavioral Therapy
- ☐ Compulsive Gambling
- ☐ Conduct/Disruptive Disorders
- ☐ Couples/Marriage Therapy
- ☐ Crisis Intervention Services
- ☐ Critical Incident Debriefing
- ☐ Depressive Disorder
- ☐ Developmental Disabilities
- ☐ Dialectical Behavior Therapy
- ☐ Disability Evaluation
- ☐ Dissociative Disorder
- ☐ Divorce
- ☐ Domestic Violence
- ☐ Dual Diagnosis
- ☐ Eating Disorders
- ☐ Faith-based Counseling
- ☐ Family Therapy
- ☐ Forensic/Sex Offenders
- ☐ Gay/Lesbian
- ☐ Geriatric Mental Health
- ☐ Grief Counseling
- ☐ Gender Identity
- ☐ Group Therapy
- ☐ Head Injury Patients
- ☐ Hearing Impaired Issues
- ☐ HIV Positive/AIDS Patients
- ☐ Home Based Services
- ☐ Home Care/Home Visits
- ☐ Hypnosis
- ☐ Infertility
- ☐ Learning Disabilities
- ☐ Medical Stress/Behavioral Med
- ☐ Medication Management
- ☐ Men's Issues
- ☐ Mood Disorders
- ☐ Multicultural Issues
- ☐ Neuropsych Assessment
- ☐ Nursing Home Services
- ☐ Obesity Assessment & Counseling
- ☐ Organic Brain Syndrome
- ☐ Pain Management
- ☐ Palliative Care
- ☐ Panic Disorder
- ☐ Parenting Skills
- ☐ Pastoral Counseling
- ☐ Pervasive Development Disorders
- ☐ Personality Disorder
- ☐ Phobias
- ☐ Physical Abuse/Violence

All Practitioners (cont.)

Behavioral Health Practitioners Only (cont.)

- ☐ Physically Impaired Patients
- ☐ Play Therapy
- ☐ Police Personnel
- ☐ Post Partum Issues
- ☐ Post Traumatic Stress Disorder
- ☐ Psych. Disability Eval/Mgmt
- ☐ Psychological Testing
- ☐ Psychosomatic
- ☐ Psychotic Disorders
- ☐ Rape Victims
- ☐ Schizophrenic Disorders
- ☐ Sex Offender
- ☐ Sexual Abuse/Violence
- ☐ Sexual Dysfunction
- ☐ Sexual Harassment
- ☐ Sleep Disorders
- ☐ Somatoform Disorders
- ☐ Substance Abuse
- ☐ Terminally Ill Patients
- ☐ Visually Impaired Patients
- ☐ Women's Issues
- ☐ Wound Care

Confirmation of Practitioner Enrollment *(Print Legibly)*

For an electronic summary of the practitioner's network participation status resulting from this application, complete the following fields. If you would like others to receive this information, such as billing staff, include e-mail addresses on the lines provided.

Primary Contact _____

Primary Contact Phone Number _____

Primary Contact E-mail Address _____

Other E-mail Address(es) _____

_____

Note: If a contract is being signed as part of this application process, this option is not available. Contract(s) and participation status will be sent by mail.

Certification and Release

Applicants have the following rights:
- You may request to review the information submitted in support of your credentialing application
- You may correct any erroneous information found in your credentialing files
- You will be notified if any information collected during the credentialing process varies substantially from the information you submitted

You must sign and date this section for all Wellmark networks. Please do not back date it. It will be returned if signature date is older than 60 days.

All Practitioners (cont.)

WELLMARK CERTIFICATION AND RELEASE

I understand that any information entered on this application and any Wellmark, Inc. addenda appropriate to my specialty identified on pages 1 and 3 of the last Statewide Universal Practioners Application, which subsequently is found to be false could result in immediate dismissal from any Wellmark Blue Cross and Blue Shield of Iowa program.

I hereby certify that the information contained in this application is accurate, true and complete. I authorize release of information as may be required by Wellmark Blue Cross and Blue Shield of Iowa to process this application and understand and agree Wellmark Blue Cross and Blue Shield of Iowa may communicate with me through various means, including but not limited to telephone, mail, and/or e-mail over the internet, regarding my application.

My signature on this application does not constitute a contract with Wellmark Blue Cross and Blue Shield of Iowa. By signing this application, I authorize Wellmark Blue Cross and Blues Shield of Iowa to release this information to Wellmark subsidiaries and affiliates.

Practitioner's Signature _____ Date _____/_____/_____

Practitioner's Name (Please type or print) _____

Complete this section if this application has been prepared by someone other than the applicant.

I, _____, hereby attest that the information included on this application is correct and complete and can be retrieved from the files located at:

Clinic Name _____

Clinic Address_____

_____

Preparer's Signature _____ Date _____/_____/_____

Instructions: Once you have completed the application, go to www.wellmark.com (Provider>Credentialing & Enrollment>Apply for Participation>Step 3: Obtaining Your Participation Agreements) to access contracts. Please send the completed contract(s) *with* this application to the address given on the application instruction sheet.

Additional Information