



WELLCARE OF OHIO, INC.

ALLIED HEALTH PROFESSIONAL CREDENTIALING APPLICATION FORM

Independent Practitioners:

Acupuncturist, Audiologist, Dietitian, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Master Social Worker, Licensed Mental Health Counselor, Massage Therapist, Occupational Therapist, Physical Therapist, Speech Language Pathologist/Therapist

Collaborative Practice Practitioners:

Nurse Practitioner, Nurse Midwife, Physician Assistant

APPLICANT NAME: _____ **SPECIALTY:** _____

In order to expedite the credentialing process, please complete every item on this application. Please enclose copies of the documentation listed below, and sign and date the attestation of accuracy and the consent and release form. Thank you for your assistance!

“X” if enclosed

- Current Professional Liability Insurance Certificate;*
 - Work History;*
 - Additional locations information sheet; enclosed*
 - Signed and dated Consent and Release form.*
-

FOR PLAN USE ONLY - To be completed by Provider Representative:

- Contract Maintenance Form (CMF) attached*
 - Site Inspection Evaluation (SIE) Collaborative Practice specialty of PCP & Ob/Gyn*
 - Letter of need (if required) is attached*
 - Application information and supporting documentation has been reviewed*
 - All information meets Plan criteria and documentation is current and complete*
-

Signature of WellCare Provider Representative

Date

Signature of WellCare In-house Representative

Date



Practitioner
Last Name: _____ **First Name** _____ **Middle Initial** _____ **Degree** _____

Primary Physical Office Address _____ City State Zip Additional Locations *(Please complete next page)* _____ Pr

County _____ Office Phone # _____ Office Fax # _____ Handicap Access (Y/N) Handicap Assistance (Y/N) Bus Rte. (Y/N) _____

Office Manager or Contact Name _____ Telephone and Extension *(If applicable)* _____ Email address *(for receiving email from Plan)* _____ O

Office Hours: Mon Tues Wed Thu Fri Sat Sun

Practice or Group Name _____

Name to whom checks should be made payable *(if different than Practice/Group name)* _____

Billing Address *(Location where payments will be sent)* _____ City State Zip _____

Billing Office Telephone Number _____ Billing Office Fax Number _____ Bi

Correspondence Address *(for credentialing purposes only)* _____ City State Zip _____

Office Phone # _____ Office Fax # _____ Contact Name _____

Patient Age Ranges

00 yrs – 21 yrs Pediatrics 00 yrs - 99+ yrs Family Practice 12yrs – 99+ yrs Internal Medicine
 12yrs – 99+ yrs Geriatric Medicine 2yrs – 99+ yrs General Practice 00yrs – 99+ General Practice for Health Dept Only

Other _____

General Information:

Gender: Male _____ Female _____ Date of Birth _____

Language(s) spoken in addition to English _____

For EEOC Compliance Requirements Only: *Please indicate the following:*

African American Arabic Hispanic American
Asian American Caucasian Native American



Practitioner Name: _____

Information Sheet Required for Additional Locations

(PLEASE PRINT)

Name of Provider/ Group / Practice Name: _____

List any additional Office Locations: Please include all necessary information listed below.

Second Physical Address: _____

Practice/Group Name: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Tax Identification Number: _____

Contact Name: _____

Handicapped Access Yes___ No___ Handicapped Assistance Yes___ No___ Bus Rte. Yes___ No___

Office Hours _____

Second Billing Address: _____

Checks payable to: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Tax Identification Number: _____

Contact Name: _____

Third Physical Address: _____

Practice/Group Name: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Tax Identification Number: _____

Contact Name: _____

Handicapped Access Yes___ No___ Handicapped Assistance Yes___ No___ Bus Rte. Yes___ No___

Office Hours _____

Third Billing Address: _____

Checks payable to: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Tax Identification Number: _____

Contact Name: _____

Please attach additional location information as necessary.



Practitioner Name: _____

REGULATORY ** Please provide copy of document

Tax ID # ** (copy of W-9)		SS #	
State License #		DEA #	CSR# CDS# (as applicable)
National Provider Identification #	Medicaid Provider #	Medicare Provider #	

SPECIALTY/TAXONOMY

<i>Name of Specialty</i>	<i>Taxonomy Code</i>

EDUCATION – Please complete separate sheet if necessary

<i>Name of School/College</i>	<i>Type of Training</i>	<i>Dates attended</i>

BOARD CERTIFICATION STATUS

<i>Name of Specialty Board</i>	<i>Certification Status</i>	<i>Certification Date</i>	<i>Expiration Date</i>

PROFESSIONAL LIABILITY DATA - Please provide full address

<i>Name of Carrier</i>	<i>Policy #</i>	<i>Limits of Coverage</i>	<i>Retro date of coverage</i>

COLLABORATIVE PRACTICE INFORMATION - Please provide name, address and phone number of a Plan practitioner with whom you have a collaborative agreement, if applicable (*this section must be completed by those practitioners whose state license requires a protocol be entered into with a State Licensed Physician or Dentist*).

Last Name First Middle Degree Specialty

Office Address, City, State, Zip Code Office Phone # Office Fax #

Practitioner Name: _____

QUESTIONNAIRE - If the answer to any of the questions is **yes**, please provide details on a separate sheet.

<i>Please answer the following questions by checking the appropriate box:</i>	YES	NO
Do you have any physical or mental health problems or limitations in ability that may affect your ability to practice medicine and provide health care with reasonable skill and safety?		
Do you have any history of chemical dependency/substance abuse?		
Have you been the subject of an investigation, or have proceedings <i>ever</i> been initiated to have your license to practice limited, suspended, revoked, denied, sanctioned or subject to probationary conditions, or have you voluntarily or involuntarily relinquished your license in this or any other state?		
Has your narcotics registration certificate <i>ever</i> been voluntarily or involuntarily relinquished, limited, suspended, sanctioned or revoked, or are any such actions pending?		
Have you been the subject of an investigation, or have you <i>ever</i> been suspended, sanctioned or otherwise restricted from participating in any private, state, or federal health insurance program, for example Medicare or Medicaid?		
Have you <i>ever</i> been named a defendant in a criminal proceeding?		
Has your medical staff membership, employment, or medical staff status at any health care institution, <i>ever</i> been rejected, limited, suspended, revoked, not renewed or subject to probationary conditions, or have you been the subject of an investigation, or, relinquished clinical privileges while under investigation or disciplinary action, or are any such actions pending?		
In the last five years, have you been a defendant in a malpractice/professional liability suit, or are there currently any pending or potential suits against you, or, have any judgments been made or settlements paid on your behalf?		
Have you <i>ever</i> been denied professional liability insurance coverage or had your professional liability insurance coverage denied, restricted, limited, special rated, not renewed or cancelled by your carrier for reasons other than the carriers termination of operations in your state?		
Have you <i>failed</i> to meet the State Licensure requirements for continuing medical education?		

AFFIRMATION OF ACCURACY AND COMPLETENESS

I understand I have the responsibility for producing adequate information for proper evaluation of my qualifications and for addressing any concerns about such qualifications. I understand that a condition of this application is that any misrepresentation or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and it shall not be processed any further. In the event credentialing information received from other sources substantially varies from that provided by me, I will be notified by the Company, and I understand I will be given the opportunity to correct such information. In the event that my application is rejected for this reason, I may not be entitled to any hearing, appeal or other due process rights as may otherwise be provided in the Policies and Procedures of the Company. I affirm that information provided in or attached to this application is correct and complete.

9-18-2006 – Ohio - AHP

Practitioner Name: _____

APPLICANT’S RELEASE AND HOLD HARMLESS

By applying for participation, I accept the following conditions. These conditions shall remain in effect for the duration of any term of participation I may be granted:

I acknowledge that the Company may at its sole discretion share or disclose the information provided in the credentialing and re-credentialing process to affiliates and subsidiaries or other related entities of WellCare Health Plans, Inc.

- (1) I extend immunity to, and release from liability, the Company, its authorized representatives and any third parties, as defined below, for any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken or received by the Company or its authorized representatives, in good faith, relating, but not limited to matters or inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; or any other matter that might directly or indirectly have an effect on my competence, on patient care or on the orderly operation of this health care organization.
- (2) I authorize the Company and its authorized representatives to consult with any third party who may have information bearing on my professional qualifications (credentials). This authorization includes the right to inspect or obtain clinical privileges, documents, recommendations, reports, statements or disclosures relating to such questions. I also expressly authorize said third parties to release this information to the Company and its authorized representatives upon request.
- (3) The term “Company and its authorized representatives” means any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application:
 - a. members of the Board and its appointed representatives;
 - b. the Chief Executive Officer or his/her designee;
 - c. all appointees to medical staff committees;
 - d. other Company employees;
 - e. consultants to the Company;the Company’s attorney and members of his/her firm, associates or designee;
any delegated or subdelegated agency with which the Company contracts for credentialing purposes.
- (4) The term “third parties” means the following:
 - a. government agencies;
 - b. malpractice insurance carriers;
 - c. peer references;
 - d. hospital affiliations;
 - e. any delegated or sub-delegated agency with which the Company contracts for credentialing purposes.

SIGNATURE OF APPLICANT

DATE

PRINTED NAME



WELLCARE OF OHIO, INC.

**Collaborative Practice Information for
Allied Health Professional Dependent Practitioners**

Name of Allied Health Professional License Type Specialty

Location where member services are to be provided: _____

Type of member services to be provided: _____

Name of Collaborating Physician (please print) Specialty

Signature of Collaborating Physician Date

Collaborating Physician is a Plan participating provider Yes No

A copy of the protocol submitted to the state licensing body may be substituted for this form.

9-18-2006 – Ohio - AHP