Provider Request
Initial and Recredentialing Application

Line of Business:
- ☐ Medicare Advantage (MMM)
- ☐ MMM Multi Health (Vital)

Please complete in print letter. Fill all items on this form. If not applicable, write N/A.

(1) First Name

(2) Middle Name

(3) Last Name

(4) Second Last Name

(5) Social Security Number*

(7) Rendering NPI Number

(9) Tax ID Name

(10) Specialty

(11) E-mail

If this is a Primary Care Physicians (PCP) contract, please include the IPA and/or PMG name and endorsement letter, if applicable.

(12)

IPA Group Name:		PMG Group Name:	
Billing NPI Number:		Billing NPI Number:	
Tax ID Number:		Tax ID Number:	

(13) Primary Location Address

City/State | Zip Code

(14) Telephone Number

(15) Fax Number

(16) Primary Office Hours
Opening Time

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Opening							
Closing							

(17) Accessibilty Questions

(17.1) Accepting New Patients for Medicare	(17.2) Accepting New Patients for Medicaid	(17.3) Gender Limitation	(17.4) Age Limitation		(17.5) Handicap Access
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Lowest Age: _____ months Highest Age: _____ years	☐ Yes ☐ No

(18) Billing Name

(19) Mailing / Billing Address

City/State | Zip Code

☐ Please check this box if N/A for additional location 2

(20) **Additional Location 2**

City/State | Zip Code

(21) **Telephone Number** | (22) **Fax Number**

(23) **Location 2 - Office Hours Opening Time**

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Opening							
Closing							

(24) **Location 2 -Accessibilty Questions**

(17.1) Accepting New Patients for Medicare	(17.2) Accepting New Patients for Medicaid	(17.3) Gender Limitation	(17.4) Age Limitation		(17.5) Handicap Access
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Lowest Age: _____ months Highest Age: _____ years	☐ Yes ☐ No

(25) **Office Staff I**

☐ Administrator ☐ Biller ☐ Secretary ☐ Other Office Staff ☐ _____ ☐ _____

(26) **Last Name** | (27) **First Name**

(28) **Office Staff II**

☐ Administrator ☐ Biller ☐ Secretary ☐ Other Office Staff ☐ _____ ☐ _____

(29) **Last Name** | (30) **First Name**

☐ Please check this box if N/A for additional location 3

(31) **Additional Location 3**

City/State | Zip Code

(32) **Telephone Number** | (33) **Fax Number**

(34) **Location 3 - Office Hours Opening Time**

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Opening							
Closing							

(35) **Location 3 -Accessibilty Questions**

(17.1) Accepting New Patients for Medicare	(17.2) Accepting New Patients for Medicaid	(17.3) Gender Limitation	(17.4) Age Limitation		(17.5) Handicap Access
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Lowest Age: _____ months Highest Age: _____ years	☐ Yes ☐ No

(36) **Office Staff I**

☐ Administrator ☐ Biller ☐ Secretary ☐ Other Office Staff ☐ _____ ☐ _____

(37) **Last Name** | (38) **First Name**

(39) **Office Staff II**

☐ Administrator ☐ Biller ☐ Secretary ☐ Other Office Staff ☐ _____ ☐ _____

(40) **Last Name** | (41) **First Name**

Information for Credentialing Use

* All Required - Please provide current copy with this application
** Required for NPDB

(42) Suffix

(43) Degree*

(44) Date of Birth** (M D Y)

(45) Gender ☐ Male ☐ Female

(46) Languages Spoken
- ☐ Spanish
- ☐ English
- ☐ Other 1._____

(47) Specialty to be Credential

(48) Specialty Board

(50) SAMHSA License*
Substance Abuse and Mental Health Services Administration

(49) Board Certified ☐ Yes ☐ No

(a) Issue Date (M D Y)

(b) Expiration Date (M D Y)

(c)Recert. Date (M D Y)

(51) DEA License Number*

Issue Date (M D Y)

Expiration Date (M D Y)

Medicare Number*

(52) ASSMCA Number*

Issue Date (M D Y)

Expiration Date (M D Y)

(53) Driver's License in Puerto Rico*

Issue Date (M D Y)

Expiration Date (M D Y)

(54) Medical License Number*

(55) Medicaid Number*

(56) Cellphone Number:

Issue Date (M D Y)

Expiration Date (M D Y)

Please provide current recertification card or certificate copy

(57) Membership Certificate - College of Physicians and Surgeons of PR*
Please provide current certificate copy with this application

☐ Yes ☐ No

Only for MD's use

Issue Date (M D Y)

Expiration Date (M D Y)

Insurance Information - Enclose a Copy of Certificate

(58) Insurance Carrier

(59) Coverage Type

(60) Unlimited ☐ Yes ☐ No

(61) Coverage

(62) Policy Number

(63) Original Effective Date (M D Y)

(64) From Date (M D Y)

(65) Expiration Date (M D Y)

Practitioner Education

(66) Education / Training
Enclose a Copy of All Diplomas, Certificates, Etc.
Graduate

Specialty:

(67) From Date (M D Y)

(68) To Completion (M D Y)

(69) Hospital Name / Post Graduate - Internship

Specialty:

(70) From Date (M D Y)

(71) To Completion (M D Y)

(72) Residency / Hospital Name

Specialty:

(73) From Date (M D Y)

(74) To Completion (M D Y)

(75) Fellowship / Training Institution

Specialty:

(76) Effective Date (M D Y)

(77) To Completion (M D Y)

Hospital Privileges

(78) Hospital Name:

Type of Privileges: ☐ Admitting ☐ Consulting ☐ Provisional

(79) Hospital Name:

Type of Privileges: ☐ Admitting ☐ Consulting ☐ Provisional

Work History

(80) 1- Employer Name

(81) Start Date M D Y

(82) End Date: PRESENT

(83) Employer Address

(84) City/State

(85) State

(86) ZIP Code –

(87) 2- Employer Name

(88) Start Date M D Y

(89) End Date M D Y

(90) Employer Address

(91) City/State

(92) State

(93) ZIP Code –

(94) 3- Employer Name

(95) Start Date M D Y

(96) End Date M D Y

(97) Employer Address

(98) City/State

(99) State

(100) ZIP Code –

☐ Please check this box if there is no ownership interest

OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION - (INDIVIDUALS)

All practitioners participating in the Platino Network must complete this section

***Please fill out this section completely, following the guidelines established in the Program Integrity Plan established by MSO of Puerto Rico, LLC (MSO) in compliance with the PR Health Insurance Administration (PRHIA-ASES).**

All organizations that have any of the following must report:
1) All persons who have a 5 percent or greater (direct or indirect) ownership interest in the supplier.
2) Applicant or provider, ONLY IF the supplier, applicant or provider is a corporation (whether for-profit or non-profit).
3) All officers and directors of the supplier, applicant or provider.
4) All managing employees of the supplier, applicant or provider (including secretary, reception, among others).
5) Supplier, applicant or provider. All those who have managing control.
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership the partner has; and authorized delegate officials.

* An owner may also be a managing employee

42 CFR § 455.105
42 CFR § 455.106

☐ Please check this box if there is no ownership interest and/or managing control

Individual having ownership interest and/or managing control

I.

First Name	Middle Name

Last Name	Second Last Name

Rendering NPI Number

Check all applicable to person listed in section 3A, having Ownership Interest and/or Managing Control with the applicant or provider:

- ☐ 5% or more direct ownership interest
- ☐ Managing Employee (W-2)
- ☐ Directly exercises operational control over day-to-day operations
- ☐ Indirectly exercises operational control over day-to-day operations
- ☐ Indirectly has managerial control over day-to-day operations
- ☐ 5% or more indirect ownership interest
- ☐ Partner
- ☐ Contracted Managing Employee
- ☐ Director/Officer
- ☐ Directly has managerial control over day-to-day operations
- ☐ Other, specify: _____

☐ Please check this box if there is no ownership interest and/or managing control

Individual having ownership interest and/or managing control

II.

First Name	Middle Name

Last Name	Second Last Name

Rendering NPI Number

Check all applicable to person listed in section 3A, having Ownership Interest and/or Managing Control with the applicant or provider:

- ☐ 5% or more direct ownership interest
- ☐ Managing Employee (W-2)
- ☐ Directly exercises operational control over day-to-day operations
- ☐ Indirectly exercises operational control over day-to-day operations
- ☐ Indirectly has managerial control over day-to-day operations
- ☐ 5% or more indirect ownership interest
- ☐ Partner
- ☐ Contracted Managing Employee
- ☐ Director/Officer
- ☐ Directly has managerial control over day-to-day operations
- ☐ Other, specify: _____

☐ Please check this box if there is no ownership interest

OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION - (ORGANIZATIONAL)

All practitioners participating in the Platino Network must complete this section

***Please fill out this section completely, following the guidelines established in the Program Integrity Plan set by MSO of Puerto Rico, LLC (MSO) in compliance with the PR Health Insurance Administration (PRHIA-ASES).**

All organizations that have any of the following must report:
1) All persons who have a 5 percent or greater (direct or indirect) ownership interest in the supplier.
2) Applicant or provider ONLY IF the supplier, applicant or provider is a corporation (whether for-profit or non-profit).
3) All officers and directors of the supplier, applicant or provider.
4) All managing employees of the supplier, applicant or provider (including secretary, reception, among others).
5) Supplier, applicant or provider. All those who have managing control.
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership the partner has; and authorized delegate officials.

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In general, Owning/Managing organizations belong to one of the following categories:
1) Corporations (including non-profit corporations)
2) Partnerships and Limited Partnerships (as indicated above)
3) Limited Liability Companies
4) Charitable and/or Religious organizations

Legal Business Name (As reported to Internal Revenue-Hacienda)

"Doing Business As" - DBA Name (If Applicable)

Tax ID Number

NPI Number

Physical Address

City/State

State

ZIP Code

Telephone Number

Fax Number

What is the above organization's relationship with the applicant or provider in section 1?

☐ 5% or more direct ownership interest
☐ 5% or more indirect ownership interest
☐ Partner
☐ Managing con
☐ Other Specify: _____

☐ Please check this box if N/A to the office staff

This section collects the administrative staff information in compliance with the PR Health Insurance Administration (PRHIA-ASES).

Office Staff I

☐ Administrator ☐ Biller ☐ Secretary ☐ Other Office Staff ☐ _____ ☐ _____

Last Name	Second Last Name

First Name

Office Staff II

☐ Administrator ☐ Biller ☐ Secretary ☐ Other Office Staff ☐ _____ ☐ _____

Last Name	Second Last Name

First Name

Office Staff III

☐ Administrator ☐ Biller ☐ Administrative ☐ Other Office Staff ☐ Secretary ☐ _____

Last Name	Second Last Name

First Name

Ownership and Conflict of Interest Disclosure Questions in compliance with the PR Health Insurance Administration (PRHIA-ASES)

(1)	Has any employee been convicted for a criminal offense under Medicare/Medicaid Programs, or other reason?	☐ Yes	☐ No
	If yes, please explain:		
(2)	Has there been a business transaction involving $25,000 or more during the 12-month period ending the date of the submitted form?	☐ Yes	☐ No
	If yes, please explain:		
(3)	Has/Have the individual(s) or Organization under current or former name or business identity, within the last ten years from the date of this statement, ever had a final adverse action/exclusion, revocation, suspension, conviction by any federal, state or local government program or agency (Ex. Medicare, Medicaid, Tittle V or XX)	☐ Yes	☐ No
	If yes, please explain:		
(4)	Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request?	☐ Yes	☐ No
	If yes, please explain:		
	Is there any restriction denial of Federal Financial Participation (FFP)?	☐ Yes	☐ No
	If yes, please explain:		

	Disclosure Questions		
(1)	Have you been denied membership in any medically related organization?	☐ Yes	☐ No
	If yes, please explain:		
(2)	Have you ever been denied or otherwise lost hospital/institution privileges?	☐ Yes	☐ No
	If yes, please explain:		
(3)	Do you have any physical or mental conditions that could impair or limit your ability to practice?	☐ Yes	☐ No
	If yes, please explain:		
(4)	Have you ever been convicted of a felony or misdemeanor involving theft, deceit, dishonesty, or criminal sexual conduct?	☐ Yes	☐ No
	If yes, please explain:		
(5)	Have your hospital/institutional privileges ever been restricted?	☐ Yes	☐ No
	If yes, please explain:		
(6)	Is it currently, or has your malpractice coverage ever been restricted or limited?	☐ Yes	☐ No
	If yes, please explain:		
(7)	Are you currently using any drug or alcohol in an abusive manner?	☐ Yes	☐ No
	If yes, please explain:		
(8)	Have you ever been named in a malpractice suit?	☐ Yes	☐ No
	If yes, please explain:		
(9)	Has your license/certificate to practice medicine in any state ever been revoked, or have any restrictions or modifications ever been assessed against it?	☐ Yes	☐ No
	If yes, please explain:		
(10)	Have you ever been or are you now being treated for alcohol or substance abuse?	☐ Yes	☐ No
	If yes, please explain:		
(11)	Have you ever had your DEA (or a state narcotics) certificate revoked, suspended or limited?	☐ Yes	☐ No
	If yes, please explain:		
(12)	Have you ever been the subject of an investigation or have you ever been suspended, sanctioned or otherwise restricted from participating in any private, state or federal health insurance program, such as Medicare or Medicaid?	☐ Yes	☐ No
	If yes, please explain:		

Other Information

(1)	Have provisions been made for after hours coverage?	☐ Yes	☐ No
(2)	Approximately, how many active patients make up your total practice?		
(3)	Are you enrolled and active with State Medicaid Program?	☐ Yes	☐ No
(4)	Are you enrolled and active with Medicare Program?	☐ Yes	☐ No
(5)	Approximately, how many Government Health Plan enrollees do you currently have as patients?		
(6)	Do you serve as a PCP in the Government Health Plan Program?	☐ Yes	☐ No
(7)	How many Medicare beneficiaries do you currently have as patients?		
(8)	How many additional patients will you accept?		
(9)	Do you perform Home Visits?	☐ Yes (indicate town)	☐ No

Town list

(10) What is the expected waiting time for an appointment to see patients who have:

a. An emergency situation: _____

b. An urgent situation: _____

c. A routine situation: _____

Check the following procedures performed in your office (attach any required certifications)

- ☐ Therapy Service
  - ☐ Physical
  - ☐ Occupational
  - ☐ Speech
- ☐ Chest X rays
- ☐ Pap Smears
- ☐ Endoscopic Procedures
- ☐ Non-invasive cardiology test
- ☐ Extremity X rays
- ☐ Mammograms
- ☐ EKGs
- ☐ Immunizations
  - ☐ Influenza (Flu)
  - ☐ Hepatitis B
  - ☐ Pneumonia
  - ☐ H1N1

☐ Other Procedures (Specify): _____

Provider Attestation & Information Release

I hereby certify that all information provided on this application and its attachments are correct and current to the best of my knowledge. I acknowledge that I have been informed of my right to review primary source verification information obtained by MSO of Puerto Rico, LLC (MSO) in compliance with regulatory requirements, and to correct erroneous information submitted in support of this credentialing application. I understand that MSO will notify me of any information obtained during the credentialing process that varies substantially from the information provided herein. I understand that falsification of information from this application may result in rejection of my request for initial/continued participation in the Provider Network (the "Network") administered by MSO, and Payers that contract with the Network.

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between MSO of Puerto Rico, LLC (MSO), and other Healthcare Organizations. These organizations include: hospitals, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies, and licensing authorities. This information shall be used for the sole purpose of evaluating my credentialing information. In this regard, MSO will take the utmost care to safeguard the privacy and confidentiality of my credentialing information and will protect it from further disclosure. I am aware and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all people and entities providing credentialing information to MSO from any liability they might incur for their acts and/or communications in connection with my credentialing information. I understand and agree that I have the obligation of producing adequate information for proper evaluation of my credentialing information and for resolving any uncertainty regarding said information. I am also aware, that I can receive the status of my credentialing or recredentialing application, upon request by contacting the Provider Contact Center Department at 1-866-787-6060. I recognize that the MSO will not consider my application complete unless it is submitted with at least the following documents: medical license, DEA license, malpractice insurance and ASSMCA license, as applicable.

_____
Print Name

_____ _____
Applicant Signature* Date*

*Form will be returned if section is not filled out

If you need to verify the documents in your file, or you wish to check on the status of your application, feel free to contact our Credentialing Department at credentialinghelpdesk@mso-pr.com
MSO Call Center Number: 1-866-676-6060

Credentialing Department
PO Box 71500
San Juan, PR 00936
Fax: 787-625-3374