

## Provider Request Initial and Recredentialing Application

Line of Business:

☐ Medicare Advantage (MMM)

□ MMM Multi Health (Vital)

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	Information for Credentialing Use									* All Required - Please provide current copy with this application  ** Required for NPD										
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	Work History
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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 § 455.106  Please check this box if there is no ownership interest and/or managing control
Individual having ownership interest and/or managing control
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
☐ Please check this box if there is no ownership interest and/or managing control
Individual having ownership interest and/or managing control
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:
S% or more direct ownership interest  ☐ Managing Employee (W-2) ☐ Directly exercises operational control over day-to-day operations ☐ Indirectly has managerial control over day-to-day operations ☐ Indirectly has managerial control over day-to-day operations ☐ Other, specify:
5% or more indirect ownership interest



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).

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  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.

- 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

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	Vhat is the above organization's relationship with the applicant or provider in section 1?																				
	5% or more direct ownership interest																				
_																					
	□ Partner																				



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
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
PR Health Insurance Administration (PRHIA-ASES)  Has any employee been convicted for a criminal offense under Medicare/Medicaid Programs, or other reason?  Tyes  Tyes  Tyes
Tyes, piedse explain.
Has there been a business transaction involving \$25,000 or more during the 12-month period ending the date of the submitted form?
f yes, please explain:
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)
f yes, please explain:
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?
f yes, please explain:
s there any restriction denial of Federal Financial Participation (FFP)?
f 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?		<u> </u>	
(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?	□ Y (indicat	e town)	□ No
	Town list	,		•
(10)				
(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:			
	☐ Therapy Service ☐ Chest X rays ☐ Extremity X	(rays 🗖 Immu	unizations	
	□ Physical □ Pap Smears □ Mammogra		Influenza (F	lu)
	□ Occupational □ Endoscopic Procedure: □ EKGs □ Speech □ Non-invasive cardiology test		Hepatitis B Pneumonia	
	Other Presedures (Speciful)		H1N1	
	Other Procedures (Specify): Provider Attestation & Information F	Release		
	acknowledge that I have been informed of my right to review primary source verification info (MSO) in compliance with regulatory requirements, and to correct erroneous information sub application. I understand that MSO will notify me of any information obtained during the credithe information provided herein. I understand that falsification of information from this application initial/continued participation in the Provider Network (the "Network") administered by MSO, and I hereby consent to the disclosure, inspection and copying of information and documents relaperformance ("credentialing information") by and between MSO of Puerto Rico, LLC (MSO), organizations include: hospitals, medical societies, professional associations, medical school	omitted in support of this lentialing process that va ation may result in rejecti and Payers that contract ating to my credentials, q and other Healthcare Or	credentialing ries substant on of my req with the Net ualifications aganizations.	ially from uest for work. and These
	liability insurance companies, and licensing authorities. This information shall be used for the information. In this regard, MSO will take the utmost care to safeguard the privacy and confiprotect it from further disclosure. I am aware and acknowledge that federal and state laws p and entities for their acts and/or communications in connection with evaluating the qualification people and entities providing credentialing information to MSO from any liability they might in connection with my credentialing information. I understand and agree that I have the obligation evaluation of my credentialing information and for resolving any uncertainty regarding said interest status of my credentialing or recredentialing application, upon request by contacting the Prov 6060. I recognize that the MSO will not consider my application complete unless it is submit medical license, DEA license, malpractice insurance and ASSMCA license, as applicable.	dentiality of my credential rovide immunity protections of healthcare providencer for their acts and/or on of producing adequate formation. I am also awarder Contact Center Dep	ling informations to certain ers. I hereby a communication information er, that I can artment at 1-	ion and will individuals release all ons in for proper receive the 866-787-
	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 Creden	tialing Department		
		O Box 71500		
	• •	Juan, PR 00936		
	at credentialinghelpdesk@mso-pr.com  MSO Call Center Number: 1-866-676-6060	: 787-625-3374		