

Facility Request Initial and Recredentialing Application

Line of Business:

☐ Medicare Advantage (MMM)

□ MMM Multi Health (Vital)

Fill all items on this form. If not applicable, write N/A.

Ī		vide		entifi																			
(1)					ID Nui								(2)				Rend	ering N	NPI Nu	mber			
													(3)				Bill	ing NP	l Num	ber			
	Prov	vide	r De	emog	rapl	nic D	ata				D	N											
(4)											PIOVI	der Na	ame										
(5)											E	-mail											
(-)																							
										Drino	ary Lo	antion	۸ ما ما ،										
(6)			l							FIIII	ary LC	cation	i Addi	622									
																							Н
	Ci	ity/Sta	ate														Zip (Code					Ш
(7)				1	eleph	one N	lumbe	er					(8)				i	ax Nu	ımbeı	•			
-												acility											
				(9)	D	ay	Mo	nday	Tue	sday	Wedn	penin esday	g Tim Thur		Frie	day	Satu	ırday	Sur	nday			
					Ope	ning																	
					Clo	sing																	
	(17)									Ac	cessib	ilty Q	uestic	ons									1
	(17)			ing New ledicare				ng New edicaid			Gender				nitation					(17.5) Access	Handica	ар	
			Yes No				Yes No				Yes No			Yes No	Lowest			_ mont			Yes No		
			INO				140							INO	91100			,001			INO		ı
11)				ı		ı	ı	ı	ı	l	Billi	ng Na	me							ı			
12)										Mai	ling / l	Billing	Addre	ess									
	C	ity/Sta	ate														Zip (Code					
						-	•	•		-													



*Please fill out this sect			ablished in the Program Integr		ISO of Puerto R
□ Please check this		in compliance with the P does not have a contra	R Health Insurance Administra cted Facility Director.	ation (PRHIA).	
Facility Staff	,		· · · · · · · · · · · · · · · · · · ·		
•					
Staff I					
☐ Administrator	☐ Biller	☐ Secretary	☐ Other Office Staff		
- Administrator	Last Name	Secretary	(15)	Second Last Name	
	(16)	F	irst Name		
Staff II					
☐ Administrator	☐ Biller	☐ Secretary	Other Office Staff	□	
	Last Name		(19)	Second Last Name	
			_		
	(20)	Fi	rst Name		
	(20)		THE		
Staff III					
☐ Administrator	Biller Last Name	☐ Secretary	Other Office Staff	Second Leat Name	
<u> </u>	Last Name		(23)	Second Last Name	T 1
	(24)	F	rst Name		
Staff IV					
☐ Administrator	☐ Biller	☐ Secretary	☐ Other Office Staff		
- Administrator	Last Name	Secretary	(27)	Second Last Name	
	(28)	F	irst Name		
	(20)		TOCHAINO I	 	



Administration (PRHIA-ASES).	alth Insur	
Has any employee been convicted of a criminal offense under Medicare/Medicaid Programs?	☐ Yes	□ No
If yes, please explain:	ı	1
Has there been a business transaction involving \$25,000 or more during the 12-month period ending the date of the submitted form? If yes, please explain:	□ Yes	□ No
Has/Have the individual(s) or Organization under current or former name or bussiness 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:		
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
lf yes, please explain:	1	
Has there been any restriction denial of Federal Financial Participation (FFP)?	□ Yes	□ No
If yes, please explain:		
OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION - (ORGANIZATIO	NAL)	
Please check this box if there is no ownership interest and/or managing control *Please fill out this section completely following the guidelines established in the Program Integrity P	lan set by M	180 of
*Please fill out this section completely, following the guidelines established in the Program Integrity P Puerto Rico, LLC (MSO) in compliance with the PR Health Insurance Administration (PRHIA		10 01
5) Supplier, applicant or provider. All of those who have managing control.		
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership Authorized delegate officials.	the partner h	nas; and
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership Authorized delegate officials.	the partner h	nas; and
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership Authorized delegate officials.	the partner h	nas; and
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership Authorized delegate officials.	the partner h	nas; and
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership Authorized delegate officials.	the partner h	nas; and
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership Authorized delegate officials.	the partner h	nas; and
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership Authorized delegate officials.	the partner h	nas; and
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership Authorized delegate officials.	the partner h	nas; and
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership Authorized delegate officials.	the partner in the pa	nas; and
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership Authorized delegate officials. In general, Owning/Managing organizations belong to one of the following categories: 1) Corporations (including non-profit corporations) 2) Limited Liability Companies 4) Charitable and/or Religious organizations 5) Governmental and/or Tribal organizations An owner may also be a managing employee 42 CFR § 455.104, 42 CFR § 455.105, 42 CFR § 455.106 Legal Business Name (As reported toDepartment of State) Doing Business As' - DBA Name (If Applicable) Physical Address Physical Address		nas; and
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership Authorized delegate officials.		nas; and
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership Authorized delegate officials. In general, Owning/Managing organizations belong to one of the following categories: 1) Corporations (including non-profit corporations) 2) Limited Liability Companies 4) Charitable and/or Religious organizations 5) Governmental and/or Tribal organizations An owner may also be a managing employee 42 CFR § 455.104, 42 CFR § 455.105, 42 CFR § 455.106 Legal Business Name (As reported toDepartment of State) Doing Business As' - DBA Name (If Applicable) Physical Address Physical Address		nas; and
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership Authorized delegate officials. In general, Owning/Managing organizations belong to one of the following categories: 1) Corporations (including non-profit corporations) 2) Limited Liability Companies 4) Charitable and/or Religious organizations 5) Governmental and/or Tribal organizations An owner may also be a managing employee 42 CFR § 455.104, 42 CFR § 455.105, 42 CFR § 455.106 Legal Business Name (As reported toDepartment of State) Doing Business As' - DBA Name (If Applicable) Physical Address Physical Address		nas; and



				OV	VNER	SHIP	INTER	REST	AND	OR M	ANAG	SING	CONTI	ROLI	NFOR	RMATI	ON - (INDIV	IDUAL	_S)			
	Ple	eas	e che	ck this	box i	f there	e is no	own	ership	intere	st and	d/or m	anagin	ig con	itrol								
*	Plea	ase								ing th												y MS	O of
1) Al 2) Al 3) Al 4) Al 5) Su 6) Al	l persoplica l offi l mai upplia l indi	rsor ant icer inag ier, livid	or prossers and applications of the second s	o have ovider direct mploye ant or	a 5 pe ONLY ors of ees of a provid partne	rcent IF the the su the su er. All ship i	or great suppliar, pplier, pplier, those	ater (c er, ap applic applic who l	direct of plicant cant or cant or have n	ust report indirect or provider provider provider provider provider provider, applier, applie	ect) ov ovider der. der (ind ng con	is a co cluding trol.	rporations secre	on (w tary, r	hether eception	for-pro	ofit or o	hers).		ərship	o the	partne	or has;
* An o	owner	er ma	ay also	be a m	anaging	emplo	yee														42 CF	R § 455 R § 455 R § 455	105
Inc	livio	du	al h	avin	g ov	ner	ship	inte	eres	t and	/or	man	agin	g co	ontro	ol							
	1			ı	Fir	st Na	me	ı	1	1					1		Mic	ldle N	ame	T	1	1	
					La	st Na	me									5	Secon	d Last	Name)			
				Reno	dering	NPI N	umber																
	5% Mai Dire Indi	or anag ectly directivection	more of ing Em y exerce tly exe tly has	direct ov nployee cises op rcises c	wnershi (W-2) erationa peration erial cor	p interent al contro nal con ntrol ov	ol over o trol over er day-t	day-to-day-to	day ope o-day op	peration:			Partne Contra Direct	er acted N or/Offi ly has	Managin cer manage	orovider og Emple erial con	oyee	r day-to	-day opε	eration	ns		
	5% Mai Dire Indi Indi	or anag rectly direct direct or	more of ing En y exerce tly exe tly has more i	direct over aployee sises op rcises o manag ndirect	wnershi (W-2) erationa perationa perial cor owners	p intere al contr nal con ntrol ov hip inte	ol over o trol over er day-t erest	day-to-or day-to o-day c	day ope o-day op operatic	erations perations ons	s		Partne Contra Direct Direct Other	er acted M cor/Offi lly has specif	Managin cer manage y:	g Empl	oyee	r day-to	-day opε	eration	ns		
	5% Mai Dire Indi Indi	or anag rectly direct direct or	more of ing En y exerce tly exe tly has more i	direct over aployee sises op rcises o manag ndirect	wnershi (W-2) erationa peration erial cor owners	p intere al contr nal con ntrol ov hip inte	ol over of over the day-therest	day-to-or day-to o-day c	day ope o-day op operatic	erations perations	s		Partne Contra Direct Direct Other	er acted M cor/Offi lly has specif	Managin cer manage y:	g Empl	oyee trol ove	r day-to		eration	ns		
	5% Mai Dire Indi Indi	or anag rectly direct direct or	more of ing En y exerce tly exe tly has more i	direct over aployee sises op rcises o manag ndirect	wnershi (W-2) erationa peration erial cor owners	p intered all control over this interest of the control over the control o	ol over of over the day-therest	day-to-or day-to o-day c	day ope o-day op operatic	erations perations ons	s		Partne Contra Direct Direct Other	er acted M cor/Offi lly has specif	Managin cer manage y:	g Empl	oyee trol ove			eration	ns		
	5% Mai Dire Indi Indi	or anag rectly direct direct or	more of ing En y exerce tly exe tly has more i	direct over aployee sises op rcises o manag ndirect	wnershi (W-2) erational perational perational erial corrowners	p intered all control over this interest of the control over the control o	ol over of trol over day-terest	day-to-or day-to o-day c	day ope o-day op operatic	erations perations ons	s		Partne Contra Direct Direct Other	er acted M cor/Offi lly has specif	Managin cer manage y:	g Emplorerial con	trol ove	Idle N			ns		
	5% Mai Dire Indi Indi	or anag rectly direct direct or	more of ing En y exerce tly exe tly has more i	direct over aployee sises op rcises o manag ndirect	wnershi (W-2) erational perational perational erial corrowners	p intered all control control over this interest. Na	ol over of trol over day-terest	day-to-or day-to o-day c	day ope o-day op operatic	erations perations ons	s		Partne Contra Direct Direct Other	er acted M cor/Offi lly has specif	Managin cer manage y:	g Emplorerial con	trol ove	Idle N	ame		ns		
	5% Mai Dire Indi Indi	or anag rectly direct direct or	more of ing En y exerce tly exe tly has more i	direct over ployee cises op reises or manag ndirect	wnershi (W-2) erationa peration erial cor owners G OW Fir	p interest la control over hip interest Na	ol over of trol over day-terest	inte	day ope o-day op operatic	erations perations ons	s		Partne Contra Direct Direct Other	er acted M cor/Offi lly has specif	Managin cer manage y:	g Emplorerial con	trol ove	Idle N	ame		I		
	5% Mai Dire Indi Indi	or anag rectly direct direct or	more of ing En y exerce tly exe tly has more i	direct over ployee cises op reises or manag ndirect	wnershi (W-2) erationa peration erial cor owners G OW Fir	p interest la control over hip interest Na	ol over of trol over day-terest	inte	day ope o-day op operatic	erations perations ons	s		Partne Contra Direct Direct Other	er acted M cor/Offi lly has specif	Managin cer manage y:	g Emplorerial con	trol ove	Idle N	ame		I		



				Fir	st Na	me										Mid	dle Na	ame				
				La	st Na	me									S	econo	Last	Name)			
_			Per	dedee	NIDI NI										<u> </u>		<u> </u>					<u> </u>
	T	T	Ten	dering	NPI N	umber	l	ı	T													
																						_
	k all app 5% or						Interes	t and/o	r Mana	ing Cor		th the		nt or pi	ovider:							
	Manag				pintere	ısı					_	Contra		anaging	Emplo	vee						
	`	, ,	cises op		al contro	ol over o	day-to-d	day ope	rations			Directo			, ,	,						
	Indire	tly exe	ercises o	peratio	nal cont	rol over	r day-to	-day op	erations			Directl	y has m	nanager	ial cont	rol ove	day-to	-day ope	erations	S		
		,	manag				o-day o	peratio	ns			Other	specify:									
]	5% or	more i	ndirect (ownersh	ip intere	est																
ı	Pleas	se che	eck this	s box o	of ther	e is no	own	ership	intere	st and	l/or m	anagir	g con	trol								
ė	lividu	ıal h	avin	g ov	ner	ship	inte	erest	t and	/or n	nana	aging	g co	ntro								
				Fir	st Na	me										Mid	dle Na	ame				
				La	st Na	me									S	econo	Last	Name	,			
	Τ																					
			Ren	dering	NPI Ni	umber																
			Ren	dering	NPI N	umber																
	k all app		to thos	se havin	g Owne	ership l		t and/o	r Mana	ing Cor				nt or pr	ovider:							
	5% or	more	to thos	se havin	g Owne	ership l		t and/o	r Manag	ing Cor		Partne	r									
	5% or Manag	more ging Er	to thos direct or nployee	se havin wnershi (W-2)	g Owne	ership l	nteres			jing Cor			r cted M	anaging								
	5% or Manaç Direct	more ging Er ly exer	to thos direct or nployee	se havin wnershi (W-2) perationa	g Owner p intere	est	nteres	day ope	rations			Partne Contra Directo	r cted M or/Office	anaging er	j Emplo	yee		-day ope		S		
	5% or Manaç Direct	more ging Er ly exer ctly exe	direct or	se havin wnershi (W-2) perationa	g Owner p intere	ership I est ol over o	Interes	day ope -day op	rations perations			Partne Contra Directo	r cted M or/Office y has m	anaging er nanager	Emplo	yee rol over	· day-to			S		
	5% or Manag Direct Indirect	more ging Er ly exer ctly exe	direct or mployee cises opercises of	se havin wnershi (W-2) perational operational	g Owner printered all control continutrol over	ership I est ol over o rol over	Interes	day ope -day op	rations perations			Partne Contra Director	r cted M or/Office y has m	anaging er nanager	Emplo	yee rol over	· day-to			S		
	5% or Manage Direct Indirect Indirect 5% or	more ging Er ly exer ctly exe ctly has more i	direct of the total direct	ee havin wnershi (W-2) perationa pperation erial cor pownersh	g Owner printered all control	est ol over or over or over day-to- est	day-to-c r day-to o-day o	day ope day op	rations perations ns			Partne Contra Director Director Other	r cted M or/Office y has m specify:	anaging er nanager :	g Emplo	yee rol over	· day-to			6		
	5% or Manag Direct Indirect	more ging Er ly exer ctly exe ctly has more i	direct of the total direct	ee havin wnershi (W-2) perationa pperation erial cor pownersh	g Owner printered all control	est ol over or over or over day-to- est	day-to-c r day-to o-day o	day ope day op	rations perations ns			Partne Contra Directo Directo Other	cted M. or/Office y has m specify:	anaging er nanager :	g Emplo	yee rol over	· day-to			S		
	5% or Manag Direct Indirect Indirect 5% or	more ging Error extry exercitly exercitly has more in	direct of the total direct	se havin wnershi (W-2) perationa operation erial cor ownersh	g Owner printered all control	ership I est ol over o rol over er day-to est	day-to-c r day-to o-day o	day ope day op peration	rations perations ns	se a (Cop	Partne Contra Directo Directl Other	cted Mor/Office y has my specify:	anaging er nanager :	Emploial cont	yee rol over	· day-to	-day ope				
	5% or Manaç Direct Indirect Indirect 5% or	more ging Error extry exercitly exercitly has more in	direct of those direct of the properties of the	se havin wnershi (W-2) perationa operation erial cor ownersh	g Owner printered all control	est ol over or over or over day-to- est	day-to-c r day-to o-day o	day ope day op peration	rations perations ns	se a (Partne Contra Directo Directl Other	cted M. or/Office y has m specify:	anaging er nanager :	g Emplo	yee rol over	· day-to	-day ope	erations			
	5% or Manag Direct Indirect Indirect 5% or	more ging Error extry exercitly exercitly has more in	direct of those direct of the properties of the	se havin wnershi (W-2) perationa operation erial cor ownersh	g Owner printered all control	ership I est ol over o rol over er day-to est	day-to-c r day-to o-day o	day ope day op peration	rations perations ns	se a (Cop	Partne Contra Directo Directl Other:	cted Mor/Office y has m specify:	anaging er nanager :	Emploial cont	yee rol over	· day-to	-day ope	erations			
	5% or Manag Direct Indirect Indirect 5% or	more ging Error extry exercitly exercitly has more in	direct of those direct of the properties of the	ee havin wnershi (W-2) perationa pperation erial cor pownersh	g Owner p intered all control over the c	ership I est ol over o rrol over er day-te	day-to-c r day-to o-day o	day ope day op peration	rations perations ns	se a (Cop	Partne Contra Director Director Other:	cted Mor/Office y has mospecify:	anaging er nanager : tifica ed e?	Emplo ial cont te (32)	rol over	c day-to	-day ope	overag	ge	rotion	Date
	5% or Manag Direct Indirect Indirect 5% or	more ging Error extry exercitly exercitly has more in	direct of those direct of the properties of the	ee havin wnershi (W-2) perationa pperation erial cor pownersh	g Owner printered all control	ership I est ol over o rrol over er day-te	day-to-c r day-to o-day o	day ope day op peration	rations perations ns	se a (Cop	Partne Contra Director Other:	cted Mor/Office or/Office y has m specify: Ceri nlimite overag Yes No	anaging er nanager :- tiffica ed e?	Emploial cont	rol over	· day-to	-day ope	erations	ge	ration	Date



	Oth	ner Provider Information								
(37)		Hosp	oital Only - Checl	c all t	that apply					
		Anesthesiology			Laboratory (Pathology)					
		Emergency Room			CLIA #	Ex	p. Date	·/		
		Inpatient			Physical Therapy					
		Outpatient			Transportation					
		Inpatient and Outpatient			Radiology					
		tpatient and Inpatient services total, # of Medicare Be	eds	DOH	H Radiology Machine Licens	e Expiration				_/
-		ou serve as a provider in the Medicaid Program?						Yes		No
-		ur office computerized? s your facility have Internet access?					□ Yes □ Yes		l No l No	
(38)	Docs		gical Laboratory	- Ski	illed Nursing Facility		_ 103			
(00)			,		, ,					
		Laboratory (Pathology)	CLIA #			Exp. D	ate	/	/	
						,				No.
		ou serve as a provider in the Medicaid (Vital) Prog ou make appointments? If so, in what manner (da		urs)?	,		_	∃ Yes		No
		ou perform Home Visits?	.,,,	u. 07.	I] Yes		No
(39)			Town lis	st						
(40)		Radiolog	y Facility with N	lamr	nogram Only					
Ī										
		DOH Radiology Machine License			Exp. Date	<i></i>				
(44)			DME & DMI	-P/19						
(41)		DOLLL's area Newsbards discours Madiestics		_, 00		, ,				
		DOH License Number to dispense Medications			Exp. Date					
ŀ			Please include co	ру о	of license, must not be ex					
		DOH License Number to Operate Practice			Exp. Date	J				
ŀ		License #	Please include co	ру о	of license, must not be ex	(pired)				
		Check if DME Manufactures own Products and	•	-		/ including	j produ	cts,		
ŀ		operations, Professional Liability and limits of at	least \$300,000. (Polic	y must not be expired)					
		Surety Bond (\$50,000 or over according with CI	MS rule, must no	t be e	expired) Exp. Date		/_			
		Joint Commission Accreditation - JCAHO (must			Exp. Date		/_			
(42)			Ambulan							
		Vehicle Identification Number (VIN), license plate	number and expi	ratior	1 date for each transport	ation vehic	cle fron	n Depa	ırtment	t of
ŀ	Healt	th (DOH) Certificate				ı				
ļ	VIN#	·	_icense Plate #			Exp. Dat	e			
	VIN#	·	_icense Plate #			Exp. Dat	e	_/		
	VIN#		_icense Plate #			Exp. Dat	e	_/		_
ĺ	VIN#		_icense Plate #			Exp. Dat	e	/	/	
l	VIN#		_icense Plate #			Exp. Dat		/		
ŀ						·		<u> </u>		
ŀ	VIN#		_icense Plate #			Exp. Dat				
ŀ	VIN#		_icense Plate #		_	Exp. Dat	e			
ļ	VIN#	ı l	_icense Plate #		_	Exp. Dat	e	_/		
	VIN#	ı	_icense Plate #			Exp. Dat	e			
	VIN#		_icense Plate #			Exp. Dat	e	_/		
	VIN#		_icense Plate #			Exp. Dat	e	_/_		_
ľ	VIN#		_icense Plate #			Exp. Dat		/	/	
L	•.									



authorization Num: authorization Num:	Exp. Date	<u>J</u>	<u>J</u>
authorization Num:		<u>/</u>	<u></u>
	Exp. Date	,	
			<u></u>
authorization Num:	Exp. Date	<u></u>	<u></u>
authorization Num:	Exp. Date	<u>/</u>	<u></u>
authorization Num:	Exp. Date	<u></u>	<u></u>
authorization Num:	Exp. Date	<u></u>	<u></u>
authorization Num:	Exp. Date	<u></u>	<u></u>
authorization Num:	Exp. Date	<u></u>	<u></u>
authorization Num:	Exp. Date	J	J
authorization Num:	Exp. Date	<u>/</u>	<u></u>
Opes your company provide Non emergency transportation services? SPACE AVAILABLE FOR ANY ADDITIONAL INFO	☐ Yes DRMATION		No



	Disclosure Questions		
(1)	Has your license and/or certifications ever been revoked or have any restrictions or modifications ever been assessed against it/them?	□ Yes	□ No
	If yes, please explain:		
(2)	Has your facility ever had a malpractice suit?	□ Yes	□ No
	If yes, please explain:		
(3)	Has your malpractice coverage ever been restricted or limited?	□ Yes	□ No
	If yes, please explain:		
(4)	Has your facility ever been found to have quality measure deficiencies?	□ Yes	□ No
	If yes, please explain:		
(5)	Has your facility ever been found to have healthcare deficiencies?	□ Yes	□ No
	If yes, please explain:		
(6)	Does the company currently have a malpractice suit filed against it?	□ Yes	□ No
	If yes, please explain:		
(7)	Have you ever been the subject of an investigation or have you ever been suspended 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:		
	Provider Attestation & Information Release		
	I hereby certify that all information provided on this application and its attachments is correct and current to the behavior of puerto Rico, LLC (MSO) in compliance with regulatory requirements, and to correct erroneous information subtracted that MSO will notify me of any information obtained during the creder varies substantially from the information provided herein. I understand that falsification of information from this a in rejection of my request for initial/continued participation in the Provider Network (the "Network") administered that contract with the Network.	on obtained bomitted in suntialing processipplication m	upport of ess that nay result
	I hereby consent to the disclosure, inspection and copying of information and documents relating to my credenti performance ("credentialing information") by and between MSO of Puerto Rico, LLC (MSO), and other Healthcai These organizations include: hospitals, medical associations, professional associations, medical school faculty porgrams, professional liability insurance companies, and licensing authorities. This information shall be used for evaluating my credentialing information. In this regard, MSO will take the utmost care to safeguard the privacy and my credentialing information and will protect it from further disclosure. I am aware and acknowledge that federal provide immunity protections to certain individuals and entities for their acts and/or communications in connection qualifications of healthcare providers. I hereby release all people and entities providing credentialing information liability they might incur for their acts and/or communications in connection with my credentialing information. I that I have the obligation of producing adequate information for proper evaluation of my credentialing information uncertainty regarding said information. I am also aware, that I can receive the status of my credentialing or recreupon 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 follows:	re Organizat ositions, train the sole pur nd confident I and state la on with evalu to MSO fron understand a n and for res dentialing ap	ions. ning rpose of tiality of aws uating the n any and agree olving any oplication,
	medical license, DEA license, malpractice insurance and ASSMCA license, as applicable.		
	Authorized Name Date*		
	Authorized Signature* Title (Print)		
	*Form will be returned if section is not filled out Please mail application to the following a Credentialing Department	iddress:	
	If you need to verify the documents in your file, or PO Box 71500		
	you wish to check on the status of your application, feel free to contact our Credentialing Department at credentialinghelpdesk@mso-pr.com		