

Provider Credentialing / Recredentialing Application

Please complete ONE application for each Provider
 (Universal State recognized application also accepted along with the completed Workers' Injury/Illness section below)

PERSONAL INFORMATION					
Last Name		First Name		M.I.	Jr., Sr., as applicable
Gender (M/F)	Birth Date (mm/dd/yy)	Professional Degree	NPI:	Social Security Number (Billing Purposes <input type="checkbox"/> Yes <input type="checkbox"/> No)	
Clinical Name or D.B.A. Name				Tax I.D. Number (Billing Purposes <input type="checkbox"/> Yes <input type="checkbox"/> No)	
Nurse Practitioner, Certified Registered Nurse First Assistant or Physician Assistants Supervising/Authorizing Physician (Last Name, First Name, Prof. Degree)					
Nurse Practitioner, Certified Registered Nurse First Assistant or Physician Assistants Supervising/Authorizing Physician (Address and Phone)					

OFFICE LOCATIONS	
Office Location #1 (Directory Information)	Phone: (____) _____
Address: _____	Fax: (____) _____
City, State, Zip: _____	E-mail: _____
Office Location #2 (Directory Information)	Phone: (____) _____
Address: _____	Fax: (____) _____
City, State, Zip: _____	E-mail: _____
Office Location #3 (Directory Information)	Phone: (____) _____
Address: _____	Fax: (____) _____
City, State, Zip: _____	E-mail: _____

BILLING LOCATION	
Billing Address (if different from above)	Billing Phone: (____) _____
Address: _____	Fax: (____) _____
City, State, Zip: _____	Repricing Statement E-mail: _____

AVAILABILITY/ACCESSIBILITY OF SERVICE/OFFICE HOURS					
Monday	Hours	_____	a.m.	_____	p.m.
Tuesday	Hours	_____	a.m.	_____	p.m.
Wednesday	Hours	_____	a.m.	_____	p.m.
Thursday	Hours	_____	a.m.	_____	p.m.
Friday	Hours	_____	a.m.	_____	p.m.
Saturday	Hours	_____	a.m.	_____	p.m.
Sunday	Hours	_____	a.m.	_____	p.m.

Do you accept walk-in patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please identify secondary language: _____
Do you accept new patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is your office bilingual?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

WORKERS' INJURY/ILLNESS

Does provider agree to participate in USA's Workers Injury Network? (check one) Yes No

Occupational Medicine Training:

If applicable, please indicate if you perform or assist in the assessment of:

Maximum Medical Improvement Determinations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Impairment ratings using AMA Guides to Physical Impairment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Independent/Required Medical Examinations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Second opinions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

For Texas providers, has provider filed financial disclosure in accordance with Texas Labor Code §408.023 and §413.041? Yes No

HOSPITAL/SURGICENTER STAFF PRIVILEGES

Facility _____ Address _____	City _____ State _____ ZIP _____	Telephone _____ (____) _____	Type of Privileges: _____
Facility _____ Address _____	City _____ State _____ ZIP _____	Telephone _____ (____) _____	Type of Privileges: _____

CURRENT LICENSURE

License Number	State	Effective Date	Expiration Date
License Number	State	Effective Date	Expiration Date
Federal DEA Registration Number	State	Date Issued	Expiration Date
State CDS Registration Number	State	Effective Date	Expiration Date
CLIA Certification Number	State	Effective Date	Expiration Date
Medicaid Number		Medicare Number	UPIN

If you answer "Yes" to any of the following questions, please provide a full narrative description of the circumstance. Your application will not be considered complete without this information.

Have your licenses to provide medical services in any state ever been or are they currently restricted, modified, challenged, suspended, or revoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been the defendant in any criminal proceedings other than minor traffic offenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have your DEA licenses ever been or are they currently challenged, restricted, modified, suspended, revoked, or has your application ever been denied?	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	<input type="checkbox"/> No
Have you been a defendant in a medical malpractice action including out of court settlements or dropped/closed cases in the past 5 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have your staff privileges ever been suspended, restricted or otherwise modified in the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	<input type="checkbox"/> No
Have you ever been involved with a voluntary or involuntary termination of professional or medical staff membership or limitation, reduction, or loss of clinical privileges at a hospital or other health care delivery setting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

INSURANCE

Malpractice/Professional Liability Insurance Company Name:	Policy Number:	Expiration Date:
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LIMITS OF LIABILITY

Each Medical Incident:	Annual Aggregate:
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AMERICAN BOARD CERTIFICATION / QUALIFICATION

American Board Certified Yes No (Please refer to the Minimum Standards for Provider Participation for recognized boards.)

Primary/Main Medical Specialty: _____

Subspecialty: _____

American Board Qualified Yes No (Please refer to the Minimum Standards for Provider Participation for recognized boards.)

Primary/Main Medical Specialty: _____

Subspecialty: _____

SERVICES AND SPECIALTIES PROVIDED AND BILLED BY PROVIDER (Please Check All That Apply)

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Hand Surgery | <input type="checkbox"/> Head and Neck Surgery | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Neuro/Spine Surgery | <input type="checkbox"/> Occupational Medicine | <input type="checkbox"/> Occupational Therapy | |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Plastic Surgery | <input type="checkbox"/> Reconstructive Surgery | |

CLINICAL COMPETENCE (Only For Initial Credentialing)

This section applies to non-medical allied health providers, and those medical providers without clinical privileges.

List two names of peers or physicians in same or similar specialty, not associated in the same group, preferably from an in-network provider, personally acquainted with the applicant's professional and clinical performance either in a teaching facility or in other healthcare settings.

Name: _____

Name: _____

Company Name: _____

Company Name: _____

City: _____ ST.: _____ Zip: _____

City: _____ ST.: _____ Zip: _____

Telephone # (____) ____-_____

Telephone # (____) ____-_____

Submit, along with your completed application, one letter from each person listed above, describing their opinions of your scope and level of clinical performance, satisfactory fulfillment of professional obligations, clinical judgement, technical skills, and ethical performance, etc. Each letter must be signed. Primary source verification will be performed during the credentialing process.

EDUCATION / TRAINING / CERTIFICATION (curricular vital accepted)

Medical School Name (Please print school's full name) Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (____) _____	Year Completed _____ Specialty _____
Place of Internship/1st Year Residency Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (____) _____	Year Completed _____ Specialty _____
Place of Residency Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (____) _____	Year Completed _____ Specialty _____
Place of Fellowship Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (____) _____	Year Completed _____ Specialty _____
Undergraduate Program (School Name) Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (____) _____	Year Graduated _____ Specialty _____
Graduate Program (School Name) Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (____) _____	Year Graduated _____ Specialty _____

Chiropractic Graduate Program (School Name) Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (____) _____	Year Graduated _____ Specialty _____
NCCPA Examination (required for Physician Assistants) Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (____) _____	Year Certified _____ Specialty _____
Accreditation/State Certifications Name _____ Address _____	City _____ State _____ ZIP _____	Telephone (____) _____	Year Certified _____ Specialty _____

WORK HISTORY
(At a minimum, past 5 years must be included)

Employer Name _____ Contact name _____ Address _____ City, State, Zip _____	Telephone (____) _____ From _____ To _____ Position _____
Employer Name _____ Contact name _____ Address _____ City, State, Zip _____	Telephone (____) _____ From _____ To _____ Position _____
Employer Name _____ Contact name _____ Address _____ City, State, Zip _____	Telephone (____) _____ From _____ To _____ Position _____
Employer Name _____ Contact name _____ Address _____ City, State, Zip _____	Telephone (____) _____ From _____ To _____ Position _____

REQUIRED SUPPORTING DOCUMENTATION

Please include the following supporting documentation with your application.

Current Malpractice/Professional Liability Insurance Face Sheet

MMI/Impairment Rating Training Certificate (if applicable)

Valid DEA or DPS Controlled Substances Registration Certificate

Current State License

Blinded Medical Record (Minimum information include author identification, patient identification – properly blinded, date of visit, reason for visit, examination notes, diagnosis notes, plan treatment)

Blinded HCFA 1500 Claim Form (Box #31 representing provider’s name as appearing on actual claim)

CONSENT/REPRESENTATIONS AND WARRANTIES

I consent to the inspection of my records and documents pertinent to the consideration of my application and continued participation as a provider in the USA Managed Care Organization. In addition, I consent to the performance of site evaluations performed by USA and/or its affiliates and/or agents.

I am able to perform all of my professional activities without impediment or constraint and meet the minimum standards for provider participation. In the past five years, I have had no physical, mental or chemical dependency condition(s), loss or limitation of licenses and/or felony convictions, loss or limitation of privileges or disciplinary activity that affect, or have affected my ability to perform all of my professional activities. I agree to practice within the scope of my licensure.

The undersigned represents, warrants and certifies that the information provided herein is true, correct and complete. The undersigned agrees to notify USA immediately and in writing of any change in name, address or ownership possession and of any material adverse change in any of the information contained in this statement or in the ability of the undersigned to perform its (or their) obligations. In the absence of such notice, the information provided herein should be considered as a continuing statement and substantially correct. If the undersigned fails to notify USA as required above, or if any of the information herein should prove to be inaccurate or incomplete in any material respect, USA shall immediately decline the application for participation or immediately terminate the provider's participation.

I authorize USA to consult with hospital administrators, members of medical staffs, malpractice carriers and other persons to obtain and verify my credentials and qualifications as a provider. I release USA and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I acknowledge I have the right to:

- review information submitted to support the credentialing application;
- correct erroneous information;
- be informed of the status of the credentialing or re-credentialing application; and
- be notified of these rights.

IF YOU DO NOT COMPLETE THIS APPLICATION IN ITS ENTIRETY INCLUDING ANSWERING ALL APPLICABLE QUESTIONS, THE ENTIRE PACKET WILL BE RETURNED FOR COMPLETION.

Applicant's Signature: _____ Date: _____

Applicant's Printed Name: _____

Supervising Physician Signature: _____ Date: _____

Supervising Physician Printed Name: _____

**USA MANAGED CARE ORGANIZATION, INC.
NARRATIVE OF MALPRACTICE SUIT**

Provider Name: _____

Date: _____

Please provide detailed information regarding any and all malpractice suits. Your narrative should include at a minimum:

Gender: _____ **Age:** _____

Insurance Carrier at the time of suit:

Description of allegations:

Dates of treatment and/or surgery and narrative defense of your activity:

If filed, specify disposition or current status of claim or suit:

Date and dollar amount of settlement (if applicable):

Please return this form to:

USA MANAGED CARE ORGANIZATION, INC.
USA WORKERS INJURY NETWORK, INC.
5301 Southwest Parkway, Suite 425, Austin, Texas 78735
New Providers Email: ProviderMarketingInfo@usamco.com Fax: (512) 306-1369
Recredentialing Email: AUSPREEC@usamco.com Fax: (512) 306-1921

PRACTITIONER SITE QUESTIONNAIRE

1. Check all that apply to this site

Setting/Type

- Ambulatory
 - Free Standing Building
 - Mobile Unit
- Home Care
- Hospice
- Hospital
- Long Term Care
- Mental Health
 - Inpatient Outpatient Residential
 - Supervised Living Partial Hosp
- Network
 - POS HMO IPA PPO
- Practitioner Office
- Laboratory

High Risk Services

- Anesthesia
- Average LOS greater than 24 hours
- Birthing Center
- Chronic Dialysis
- Contrast Imaging
- Infusion Therapy
- Radiation Oncology
- Ventilator Care
- 23-hour Recovery Center
- Emergency/Urgent Care Center

Other Services

- Acute Inpatient
- Alcohol/Drug Rehab Services
- Chemical Dependency
 - Adult Child/Adolescent
- Dementia/Alzheimer's
- General Long Term _____
- Imaging Services _____
- Mental Health Services _____
 - Adult Child/Adolescent
- MR/DD Services
- Physical Rehab Services
- Radiation Services
- Other _____

- Acquired Brain Injury
- Durable Medical Equip
- Home Healthcare
- Laboratory Services
- Pharmaceutical Services
- Primary Care Services
- Subacute Services

2. Please list the education and training of all management, clinical personnel and equipment technicians including title of position and degree(s) and/or certification held.

Title	Degree/Training/Certification

3. Availability of Services (check those that apply):

- | | | | | |
|------------------------------------|-----------------------------------|------------------------------------|------------------------------------|-----------------------------------|
| Average length of office visit: | 5-10 min <input type="checkbox"/> | 10-20 min <input type="checkbox"/> | 20-30 min <input type="checkbox"/> | 30+ min. <input type="checkbox"/> |
| Average length of waiting time: | 5-10 min <input type="checkbox"/> | 10-20 min <input type="checkbox"/> | 20-30 min <input type="checkbox"/> | 30+ min. <input type="checkbox"/> |
| Average wait time for appointment: | 0-7 days <input type="checkbox"/> | 7-14 days <input type="checkbox"/> | 14+ days <input type="checkbox"/> | |

- 4. Does the practitioner site have specific policies regarding patient record security and confidentiality including appropriate access by staff? YES NO
- 5. Does the practitioner site use a standard Patient Assessment form for all patients seen? YES NO
- 6. Does the practitioner site have specific policies for scheduling appointments based on the needs of the patient? YES NO
- 7. Does the practitioner site office environment provide patients with safety, privacy and access to rest rooms? YES NO
- 8. Does the practitioner site provide sufficient patient access and availability including extended hours, parking, proximity to public transportation and accommodations for the handicapped? YES NO
- 9. Does the practitioner site provide appropriate maintenance and training in the use of clinical equipment with provisions for emergency power? YES NO
- 10. Does the practitioner site have procedures in place to assist patients that need referrals to other facilities or for additional treatments? YES NO
- 11. Is the practitioner site accredited? YES NO

If yes, provide the following:	ID #	Award Date	Expiration Date
<input type="checkbox"/> Joint Commission			
<input type="checkbox"/> Other, (Identify)			

12. How do you communicate self-care, health promotion and disease prevention to your patients?

- Newsletter Brochures Pamphlets Other

13. General Comments: Please provide comments on how USA could serve you and your patients more effectively.

Provider acknowledges USA may schedule a site visit in accordance with its Policies and Procedures as appropriate for Provider Participation.

Name: _____

Date of Completion: _____

Signature: _____

Phone Number: _____

PROVIDER REFERRALS

In an effort to assist USA in developing a comprehensive network, providing for a full continuum of care, please provide the following information for each entity you commonly refer patients to:

Name _____
Address _____
City, State, Zip _____
Services Provided _____
Contact Name _____ Telephone (_____) _____

Name _____
Address _____
City, State, Zip _____
Services Provided _____
Contact Name _____ Telephone (_____) _____

Name _____
Address _____
City, State, Zip _____
Services Provided _____
Contact Name _____ Telephone (_____) _____

Name _____
Address _____
City, State, Zip _____
Services Provided _____
Contact Name _____ Telephone (_____) _____

Name _____
Address _____
City, State, Zip _____
Services Provided _____
Contact Name _____ Telephone (_____) _____