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)

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 ☐ Yes ☐No)	
Clinical Name or D.B.A. Name				Tax I.D. Number (Billing Purposes ☐ Yes ☐ 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) Address: _____ City, State, Zip: _____	Phone: (_____) _____ Fax: (_____) _____ E-mail : _____
Office Location #2 (Directory Information) Address: _____ City, State, Zip: _____	Phone: (_____) _____ Fax: (_____) _____ E-mail : _____
Office Location #3 (Directory Information) Address: _____ City, State, Zip: _____	Phone: (_____) _____ Fax: (_____) _____ E-mail : _____

BILLING LOCATION

Billing Address (if different from above) Address: _____ City, State, Zip: _____	Billing Phone: (_____) _____ Fax: (_____) _____ 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? ☐Yes ☐ No

Do you accept new patients? ☐Yes ☐ No

Is your office bilingual? ☐Yes ☐ No If yes, please identify secondary language: _____

WORKERS' INJURY/ILLNESS

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

If yes, please answer the following regarding Occupational Medicine Training and/or expertise. Please indicate 'yes' if you perform or assist in the assessment of:

Maximum Medical Improvement Determinations?	☐Yes ☐ No
Impairment ratings using AMA Guides to Physical Impairment?	☐Yes ☐ No
Independent/Required Medical Examinations?	☐Yes ☐ No
Second opinions?	☐Yes ☐ No

Has provider filed financial disclosure in accordance with Texas Labor Code §408.023 and §413.041? ☐Yes ☐ No

Facility _____ Address _____	City _____ State _____ ZIP _____	Telephone (____) _____	Type of 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?	☐ Yes	☐ No
Have you ever been the defendant in any criminal proceedings other than minor traffic offenses?	☐ Yes	☐ No
Have your DEA licenses ever been or are they currently challenged, restricted, modified, suspended, revoked, or has your application ever been denied?	☐ Yes ☐ N/A	☐ 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?	☐ Yes	☐ No
Have your staff privileges ever been suspended, restricted or otherwise modified in the past 5 years?	☐ Yes ☐ N/A	☐ 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?	☐ Yes	☐ No

INSURANCE

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

LIMITS OF LIABILITY

Each Medical Incident:	Annual Aggregate:

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: _____

CLINICAL COMPETENCE

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: _____

Company Name: _____

City: _____ ST.: ____ Zip: _____

Telephone # (____) _____-_____

Name: _____

Company Name: _____

City: _____ ST.: ____ Zip: _____

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.
1250 S. Capital of Texas Hwy, Bldg 3-500, Austin, Texas 78746
Email: AUSPRREC@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 ☐	10-20 min ☐	20-30 min ☐	30+ min. ☐
Average length of waiting time:	5-10 min ☐	10-20 min ☐	20-30 min ☐	30+ min. ☐
Average wait time for appointment:	0-7 days ☐	7-14 days ☐	14+ days ☐	

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
☐ Joint Commission	_____	_____	_____
☐ 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 (_____) _____

Contact Sheet
For

_____

(Provider or Provider Group Name)

The following person(s) will be USA's contact(s) for the above named provider or provider group.

CONTRACTING:

Name: _____ Title: _____

E-mail Address: _____

Telephone Number: ( ) _____ Fax Number: ( ) _____

PROVIDER UPDATES:

Name: _____ Title: _____

E-mail Address: _____

Telephone Number: ( ) _____ Fax Number: ( ) _____

CEO / PRESIDENT / DIRECTOR:

Name: _____ Title: _____

E-mail Address: _____

Telephone Number: ( ) _____ Fax Number: ( ) _____

This information shall remain valid until USA is notified, in writing, by the above mentioned provider group of any changes.