Gila Multi-specialty Independent Practice Association

Sandra Hicks, Credentialing Specialist
Rebekka VanNess, Administrator
P.O. Box 2158
Silver City NM 88061
575-538-2355

GMIPA Application for Managed Plan Care Credentialing

Only original documents signed in black or blue ink will be accepted

Please Email a JPEG photo or include a jpeg photo on a jump drive with this application

This application must be submitted to Gila Multi-specialty Independent Practice Association (GMIPA) by mail or in person.

Revised November 2016

DATE RECEIVED IN GMIPA OFFICE_____

Please complete the attached Managed Care Plan Credentialing Application Packet.
Please return within **14 days** from your receipt of this packet.

Please return this application to the address listed above or hand deliver to the GMIPA office.
As requested on the application, please include the following documents and information:

- ☐ Completed and signed application (and any supplemental documents required by the healthcare organization, if applicable). The application attestation page must have been signed within sixty (60) days. Signature stamps and date stamps are not acceptable.
- ☐ Completed and signed release. The release must have been signed within sixty (60) days. Signature stamps and date stamps are not acceptable.
- ☐ Copy of Current New Mexico License
- ☐ Copy of all Other State Licenses
- ☐ Copy of New Mexico Board of Pharmacy Controlled Substance Certificate (if applicable)
- ☐ Copy of DEA Certificate
- ☐ Copy of Current Liability Insurance Cover Sheet
- ☐ List and phone numbers of Previous Liability Insurance Companies (for past 10 years, with dates)
- ☐ Copy of Board Certification (if applicable)
- ☐ Copy of Medical Degree
- ☐ Copy of Residency/Internship/Fellowship Certificates
- ☐ Copy of Curriculum Vitae (CV) including months and years for all places of employment during the past ten (10) years. Explain any gaps of thirty (30) days or more during the past five (5) years.
- ☐ Copy of ECFMG Certification (if applicable)
- ☐ Copy of IRS W-9 Form
- ☐ Signed Attestation Form (attached)
- ☐ Copy of ID (current driver's license or valid passport)
- ☐ JPEG portrait image sent via email or included on a jump drive with this application
- ☐ 1-3 paragraph biography

It is very important that the application is signed and dated in black or blue ink only. Failure to do so will result in the return of the application to the applicant and will delay processing. If any documents listed above are missing this application will be returned to you. No areas may be left blank. Please place N/A in cells that do not apply.

If you have any questions, concerning this process, please contact the GMIPA Credentialing Department at 575-538-2355.

APPLICATION FOR MANAGED CARE PLAN CREDENTIALING

INSTRUCTIONS: Applicant must fill out the application in its entirety (Any section not applicable mark N/A, *DO NOT LEAVE ANY BLANKS*) and include all required documentation in accordance with the instructions given above.

Clinical Specialty	☐ Anesthesiology	☐ Nephrology	☐ Orthopedic	☐ Pulmonology
	☐ Cardiology	☐ Neurology	☐ Otolaryngology	☐ Radiology
	☐ Dermatology	☐ OB/Gyn	☐ Pathology	☐ Surgery
	☐ Emergency Medicine	☐ Ophthalmology	☐ Pediatrics	☐ Urology
	☐ Family Practice	☐ Oncology	☐ Psychiatry	
	☐ Other:			

PERSONAL IDENTIFICATION DATA		
Last Name	First Name	Middle Name or Middle Initial
Other Names By Which You Have Been Known	Degree	Social Security Number

Professionally		
Preferred E-Mail Address for professional correspondence	Citizenship	If not a US Citizen, specify status & Visa #:
Date of Birth	Gender ☐ Male ☐ Female	Birth Country
Birth State	City of Birth	Ethnic Origin (optional)
Spouse's Name (optional)	Marital Status (optional) ☐ Married ☐ Divorced ☐ Widowed ☐ Single	
CAQH#	Taxonomy#	NPI #:
Medicare #:	Medicaid #:	
ECGMG # (if applicable):	Federal ID (TIN) #:	

Information below pertains to your practice

Practice/Group Name: _____ Effective Date: _____

Street Address: _____

City, State and Zip Code: _____ Office Contact Person _____

Telephone Number: _____ Facsimile Number: _____

E-Mail Address: _____ Answering Service Number: _____

Foreign Languages (spoken fluently by practitioner): _____

Foreign Languages (spoken fluently at practice): _____

Federal Tax ID # (if different than listed above) _____

Current Mailing Address (if different from above): ☐ Same as Above

Street Address: _____

City, State and Zip Code: _____

Telephone Number: _____ Facsimile Number: _____

Billing Address (if different from practice/mailing address): ☐ Same as Practice/Mailing Address

Contact Person: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Number: _____ Facsimile Number: _____

Other Practice Locations: (Attach a separate page for additional practice locations.)

Practice Name: _____ Tax ID #: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Number: _____ Facsimile Number: _____

Home Address:

Street Address: _____

City, State and Zip Code: _____

Telephone Number: _____ Pager Number: _____

Cell Phone Number:_____

PROFESSIONAL REFERENCES

Please list three professional peers with the **same type of license or a higher level of licensure** who are familiar with your professional performance in the past three (3) years.

Name and Title: _____ Specialty: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

E-Mail Address: _____

Name and Title: _____ Specialty: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

E-Mail Address: _____

Name and Title: _____ Specialty: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

E-Mail Address: _____

PROFESSIONAL LICENSES – Please list all licenses ever held.

State	License #	Type (Medical, Dental, etc.)	Effective Date	Expiration Date	Currently practice under this license?
					☐ Yes ☐ No

					☐ Yes ☐ No
					☐ Yes ☐ No

CONTROLLED SUBSTANCES REGISTRATION – Please list all licenses ever held.

Issuing Body	Certificate #	Expiration Date	Approved for all schedules? If NO, please explain.
Federal DEA			☐ Yes ☐ No
State:			☐ Yes ☐ No
State:			☐ Yes ☐ No

PROFESSIONAL LIABILITY INSURANCE – Please list current carrier and previous carrier if current carrier has covered you less than five (5) years. This includes coverage during residency training. **Please attach copy of Certificate of Insurance.**

Current Liability Carrier

Name of Company			Start Date (Month & Year)
Complete Address			Policy Number
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Per Claim Limits:	Type of Policy:
		Aggregated Limits:	☐ Claims Made ☐ Occurrence

Previous Liability Carriers

Name of Company			Start & Finish Dates (Month & Year)
Complete Address			Policy Number
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Per Claim Limits:	Type of Policy:
		Aggregated Limits:	☐ Claims Made ☐ Occurrence

Previous Liability Carriers

Name of Company			Start & Finish Dates (Month & Year)
Complete Address			Policy Number
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Per Claim Limits:	Type of Policy:
		Aggregated Limits:	☐ Claims Made ☐ Occurrence
Name of Company			Start & Finish Dates (Month & Year)

SPECIALTIES

Specialty	*Primary*	*Secondary*	*Board Certified (Yes or No)*		*Name of Board*	*Year Certified*	*Last Re-Certified*	*Expiration Date*
	☐	☐	☐	☐				

	☐	☐	☐	☐				
	☐	☐	☐	☐				
	☐	☐	☐	☐				

EDUCATION

Undergraduate Education:

College or University: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone: _____ Fax: _____

Dates Attended: From: ___/_____ To: ___/_____ Degree Earned: _____
Mo/Yr Mo/Yr

Graduate Education: (List all medical, osteopathic, dental or podiatric schools attended.)

College or University: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone: _____ Fax: _____

Dates Attended: From: ___/_____ To: ___/_____ Degree Earned: _____
Mo/Yr Mo/Yr

POST GRADUATE TRAINING ☐ N/A

List all hospitals where you received training and attach a copy of your certificate. Disclose every residency program initiated, whether completed or not, and all completed programs. Attach a separate page, if necessary.

_____ Specialty: _____
Specify Internship, Residency, or Fellowship

Institution: _____ Dates Attended: From: ____/_____
Mo/Yr

Street Address: _____ To: ____/_____
Mo/Yr

City, State, Country and Zip Code: _____

Telephone: _____ Fax: _____

_____ Specialty: _____
Specify Internship, Residency, or Fellowship

Institution: _____ Dates Attended: From: ____/_____
Mo/Yr

Street Address: _____ To: ____/_____
Mo/Yr

City, State, Country and Zip Code: _____

Telephone: _____ Fax: _____

_____ Specialty: _____
Specify Internship, Residency, or Fellowship

Institution: _____ Dates Attended: From: ____/_____
Mo/Yr

Street Address: _____ To: ____/_____
Mo/Yr

City, State, Country and Zip Code: _____

Telephone: _____ Fax: _____

☐ Teaching Appointments ☐ N/A

Institution: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone: _____ Fax: _____

Dates Attended: From___/____ To ___/____ Department/Position:_____

MILITARY EXPERIENCE: *List all military experience that has occurred since completion of medical school.*			
☐ N/A			
Name of Institution		**Rank**	Start & Finish Dates (Month & Year)
Street Address		City	State / Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address	Supervisor's Name

WORK HISTORY:

NEW APPLICATIONS: *Please list all medical practice history over the past ten years including employment which has occurred since Medical or Professional school.* ***This should not include hospital or facility affiliations.*** *Attach a separate page, if necessary.*

Organization: _____ From: ____/_____ To: ____/_____
Mo/Yr Mo/Yr

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Fax Number: _____

Organization: _____ From: ____/_____ To: ____/_____
Mo/Yr Mo/Yr

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Fax Number: _____

Organization: _____ From: ____/_____ To: ____/_____
Mo/Yr Mo/Yr

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Fax Number: _____

Organization: _____ From: ____/_____ To: /

Mo/Yr Mo/Yr

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Fax Number: _____

Organization: _____ From: ____/____ To: ____/____
Mo/Yr Mo/Yr

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Fax Number: _____

EXPLANATION OF WORK HISTORY GAP: Any time periods or gaps since graduation from medical school of greater than **30 days**, which are not explained in the application thus far, must be addressed here. If the application is found to have any unexplained time periods or gaps since medical school of greater than **30 days,** the application **will not** be processed and will be returned to the applicant as incomplete. Please explain any such gaps in the space provided below

From Date	To Date	Explanation of Work History Gap

Please list all hospital staff membership and/or healthcare organization affiliations in the past ten (10) years, and your status (active, courtesy, consulting, etc.). If an institution is no longer in existence, please provide an alternative source of verification. Use a separate page, if necessary.

Current Primary Admitting Facility (Hospital Name, if applicable): _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Appointment Dates: From: _____ To: _____ Type of Appointment/Status: _____

Privileges Assigned: _____

Facility Name: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Appointment Dates: From: _____ To: _____ Type of Appointment/Status: _____

Privileges Assigned: _____

Facility Name: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Appointment Dates: From: _____ To:_____ Type of Appointment/Status: _____

Facility Name: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Appointment Dates: From: _____ To:_____ Type of Appointment/Status: _____

Facility Name: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Appointment Dates: From: _____ To:_____ Type of Appointment/Status: _____

	DISCLOSURE QUESTIONS - If you answer "YES" to question number 1, please provide details on the Professional Liability Action Explanation Form. Include a copy of any order or settlement where applicable.	
1.	Have you ever had any professional liability insurance coverage voluntarily or involuntarily canceled, declined or modified (i.e., reduced limits, restricted coverage), or has any renewal ever been refused, or have you voluntarily given up coverage?	☐ Yes ☐ No
2.	Have you ever been denied, or have you voluntarily or involuntarily given up membership, or renewal of membership, or been subject to any disciplinary action in any hospital, IPA, HMO, PHO, PPO, managed care organization or professional society, or is any such action pending?	☐ Yes ☐ No
3.	Have your clinical privileges, membership or employment at any hospital, healthcare institution or healthcare plan been voluntarily or involuntarily limited, suspended, revoked, refused, relinquished, refused, terminated, limited, not renewed, or subject to probationary or other disciplinary conditions, or have proceedings toward any of those ends been instituted or recommended by a hospital administration, medical staff or committee or governing board?	☐ Yes ☐ No
4.	Has your request for any specific clinical privileges been voluntarily or involuntarily denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation been recommended by a medical staff or committee or governing board?	☐ Yes ☐ No
5.	Have you ever had any previous or pending challenges to, or voluntarily or involuntarily relinquished any medical staff membership, clinical privilege(s), professional license(s), or narcotics registration as the result of any investigation or disciplinary action?	☐ Yes ☐ No
6.	Have you ever been reprimanded, censured, excluded, suspended or disqualified by Medicare, Medicaid, CLIA or any other health plan for which you provide services?	☐ Yes ☐ No
7.	Have you ever been disciplined by any State Board of Medical Examiners, or by any Professional Conduct Board, or have you ever been reprimanded, or fined by any state or federal agency that disciplines physicians or allied health professionals?	☐ Yes ☐ No
8.	Have you ever received notice of a proposed or actual exclusion from any health care program funded in whole or part by the federal government or any state health care program, including Medicare or Medicaid?	☐ Yes ☐ No
9.	Has your Drug Enforcement Agency or other controlled substances authorization ever been voluntarily or involuntarily denied, revoked, suspended, reduced or not renewed, or have proceedings toward any of those ends been instituted?	☐ Yes ☐ No
10.	Has your specialty board certification or eligibility ever been voluntarily or involuntarily denied, revoked, relinquished, not renewed, suspended, reduced, or have any proceedings toward any of those ends been instituted?	☐ Yes ☐ No
11.	Has your authorization to practice in any jurisdiction (state or county) ever been voluntarily or involuntarily revoked, suspended, or subject to probation or any conditions or limitations?	☐ Yes ☐ No
12.	Have you ever been convicted of, or pleaded guilty or no contest to, a felony, serious or gross misdemeanor, or any crime or municipal violation, involving dishonesty, assault or sexual misconduct or abuse, or abuse of controlled substances or alcohol, or are charges pending against you for any such crimes by information, indictment or otherwise?	☐ Yes ☐ No

13.	To your knowledge, has any information pertaining to you ever been reported to the National Practitioner Data Bank (NPDB)?	☐ Yes ☐ No
14.	Will practicing to the fullest extent of your licensure, qualifications, and privileges, with or without reasonable accommodation, in any way pose a risk of harm to your patients?	☐ Yes ☐ No
15.	In the past five years, up to, and including the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?	☐ Yes ☐ No
16.	Have you ever been court-martialed, investigated, sanctioned, reprimanded or cautioned by a hospital or other healthcare facility of any military agency, been involuntarily terminated or forced to resign, or have you resigned voluntarily while under investigation or threat of sanction from a hospital or healthcare facility of any military agency?	☐ Yes ☐ No
17.	If you perform clinical research, have you ever had any clinical research study terminated involuntarily, been asked to terminate a clinical research study before it was completed or had any other discipline or sanctions with respect to your clinical research?	☐ Yes ☐ No
18.	Is your professional liability insurance current? (Please read this question carefully)	☐ Yes ☐ No
19.	Do your professional liability insurance amounts meet state minimum requirements? (Please read this question carefully)	☐ Yes ☐ No
20.	Has your professional liability insurance coverage ever been terminated by action of the insurance company?	☐ Yes ☐ No
21.	Have you ever been denied professional liability insurance coverage?	☐ Yes ☐ No
22.	Have any professional liability claims or civil lawsuits ever been filed against you?	☐ Yes ☐ No
23.	Have any professional liability suits been filed against you that are presently pending?	☐ Yes ☐ No
24.	Have any judgments or settlements been made against your in professional liability cases?	☐ Yes ☐ No
If the answer to any questions below is **yes**, please provide a full explanation. A license is defined as any license past or present to practice in health-related field.		
25.	Have there ever been any previously successful or currently pending challenges, disciplinary actions, or investigations to any of your licensure/license or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration?	☐ Yes ☐ No
26.	Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (e.g. Medicare or Medicaid)?	☐ Yes ☐ No
27.	Have you ever been the subject or an investigation by an private, federal, or state agency concerning your license to practice or participate in any private, federal or state health insurance program (for example, a managed care organization, insurance company, Medicare, Medicaid, Civilian Health and Medical Program Uniformed Service [formerly TRICARE], etc)?	☐ Yes ☐ No
28.	Have you ever undergone a voluntary or involuntary termination, limitation, reduction, investigation, denial, suspension, revocation, or loss of the following? **If Yes,** please explain and provide detail. • Narcotics registration certificate? • Clinical privileges? • Professional registration or license (other than state)? • State-controlled substance registration? • DEA registration? • Board Certification? • ECFMG Certification? • Medical Staff membership? • State medical license?	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
29.	Have your ever been asked to surrender your license?	☐ Yes ☐ No
30.	Is your narcotics registration certificate being challenged?	☐ Yes ☐ No
31.	Have your ever been named as a defendant in any criminal proceeding or been convicted of a felony? **If Yes,** please explain.	☐ Yes ☐ No
32.	Have you ever been the subject of disciplinary proceedings or investigations at any hospital or healthcare facility?	☐ Yes ☐ No
33.	Are any such investigations pending?	☐ Yes ☐ No

APPLICANT'S CONSENT AND RELEASE

APPLICANT'S RESPONSIBILITY

1. I am applying for credentialing with various managed healthcare plans. I am willing to make myself available for interviews in regard to this application and intend to be legally bound by the terms of this consent and release.

2. As an applicant for credentialing with various managed healthcare plans, I understand that it is **my responsibility** to produce adequate information so that the organization can perform a proper evaluation of my qualifications. I agree to provide the organization with updated information regarding all questions on the application form as new information becomes available. I also agree to provide the organization with additional information that it or one of its authorized representatives may request. Failure to produce any requested information will prevent my application from being processed.

Terms and conditions of credentialing

1. By applying for credentialing with the managed healthcare plans, I accept the terms and conditions set forth below and intend to be legally bound by them.
    a. Credentialing approval is not a right of every licensed professional who makes application;

    b. My request will be evaluated in accordance with prescribed procedures defined in the GMIPA credentialing policies and procedures;

    c. All recommendations relative to my application are subject to the ultimate action of the credentialing committee, whose decision shall be final;

    d. I have the responsibility to keep this application current by informing the GMIPA, through the credentialing contact, of any changes, including but not limited to any change in my professional liability insurance coverage, the filing of a lawsuit against me, and any change in my medical staff status at any other organization; and

    e. Credentialing, recredentialing and GMIPA provider member services remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the organization, and acceptable performance of all related responsibilities, as well as the other factors deemed relevant by the organization.

_____ _____

Print or Type Name Date

_____

Signature

RELEASE AND IMMUNITY

By applying for GMIPA credentialing services, I accept the following conditions, and intend to be legally bound thereby. These conditions shall remain in effect for the duration of my GMIPA Provider Membership.

1. I extend absolute immunity to, release from any liability, including civil liability, and agree not to sue the GMIPA, its authorized representatives, and any third parties, as defined below and by any provisions in the GMIPA bylaws or the GMIPA participation agreement, for any actions, recommendations, reports, statements communications, or disclosures involving me and related—but not limited to—the following:
    a. applications for credentialing services;
    b. denial of provider membership;
    c. termination of membership;
    d. utilization reviews;
    e. any other GMIPA service, or committee activities;
    f. matters or inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or behavior; and
    g. any other matter that might directly or indirectly have an effect on my competence, on patient care, or on the orderly operation of this or any other hospital or healthcare facility.

2. I authorize the GMIPA and its authorized representatives to consult with any third party who may have information bearing on my professional qualification (credentials), clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter bearing on my qualifications for Provider membership in the GMIPA or Provider Member credentialing services. This authorization includes the right to inspect or obtain any documents, recommendations, reports, statements or disclosures relating to such questions.

I also expressly authorize said third parties to release this information to the GMIPA and its authorized representatives upon request.

3. The term "GMIPA and its authorized representatives" means the Gila Multi-specialty Independent Practice Association and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, acting upon my application:

    a. GMIPA's credentialing committee and their appointed representatives;
    b. GMIPA Board of Managers;
    c. other GMIPA employees; and
    d. the GMIPA appointed attorney as required.

4. The term "third parties" means all individuals from whom information has been requested by GMIPA including the following:
    a. government agencies; and
    b. organizations, associations, partnerships, and corporations

ATTESTATION AND LIABILITY NOTICE

"Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws."

AFFIRMATION

I declare that information provided in or attached to this application is correct and complete. I understand that a condition of submitting this application is that any misrepresentation, misstatement, or omission from this application –whether intentional or not—may be cause for automatic and immediate rejection of this application. Upon subsequent discovery of such misrepresentation, misstatement, or omission, the GMIPA may immediately terminate my Provider Membership and cease providing services.

_____ _____

Print or Type Name Date

_____

Signature

PROFESSIONAL LIABILITY ACTION EXPLANATION FORM

This form must be fully completed if you answered "yes" to question #1 of the Disclosure Questions on the Application Form

Please complete this form if there have ever been, or is currently, any professional or work-related claims, settlements or judgments against you, your employer, or third party, even if not resulting in monetary damages or if you have received any notice of "Intent to File". If additional sheets are required, please photocopy this page prior to completing. Please provide us with a separate sheet for each malpractice action.

P l e a s e P r i n t

Date of Alleged Incident	Date Suit Filed
Docket Number	**Hospital/City/State of Incident**

Your Relationship to Patient (Attending Practitioner, Surgeon, Assistant Surgeon, Consultant, etc.)

Allegation

Liability Carrier when Incident Occurred

Additional Named Defendant(s)

Claim Status

☐ ***OPEN*** *– If open, amount sought:*	☐ ***CLOSED*** *– If closed, indicate method of closing* ☐ ***Dismissal*** ☐ ***Settlement*** ☐ ***Judgment***	***Amount of settlement or judgment:***

Case Description: - *Please print*. **If additional space is necessary, attach adequate clinical detail to allow proper evaluation by a committee of physicians.**

1) Summarize the circumstances giving rise to the action. If the action involves patient care, describe a narrative that provides your care and treatment of the patient.

2) Condition And Diagnosis At Time Of Incident

3) Dates And Description Of Treatment Rendered

4) Condition Of Patient Subsequent To Treatment

GMIPA Member Applicant's Attestation and Release

The undersigned ("Provider") hereby applies for participation as a Provider Member in **Gila Multi-specialty IPA , L.L.C.** ("GMIPA"). In consideration of evaluating this Provider Member's Credentialing Application ("Application"), Provider Member warrants and covenants that the information and representations provided within this application and presented to the credentialing office of GMIPA are true, correct, and complete in all respects, and there have been no material changes in such information. Provider Member further acknowledges and understands that a summary profile of his/her background, experience, and qualifications, shall be based on the information previously provided to the GMIPA Credentialing staff for credentialing purposes. Provider understands any material omission or inaccuracy therein may constitute grounds for denial of this Application. Violations of GMIPA bylaws or standards for Provider Membership may constitute cause for revocation of membership in the GMIPA.

Provider recognizes and acknowledges that GMIPA has full authority to determine whether the criteria and information set forth in this Application and in the performance data reviewed by the Credentialing Committee meet the standards, requirements, and needs for a participating Provider Member in the GMIPA to utilize credentialing services.

Provider hereby authorizes and releases the New Mexico Medical Board (or any other comparable state Provider licensing body), New Mexico Medical Society, any educational institution, the National Practitioner Data Bank, and his/her professional liability insurance carrier to release and provide to the GMIPA, and any person or entity specifically authorized by the GMIPA, any and all information, records, and documents verifying and/or regarding any of the items set forth in this Application. Provider Member specifically waives any and all rights of confidentiality and/or nondisclosure that he/she may have in any such information, records, and documents, but only for the purpose of this Application and continued participation and membership in the GMIPA. Provider Member hereby releases any and all persons and/or entities from any and all claims for damages based on the disclosure of information, records and documents to the GMIPA in response to a request by the GMIPA for such information, records and documents.

The undersigned hereby agrees to provide information and statistics regarding his/her practice of medicine (in a format maintaining patient confidentiality) as requested by GMIPA from time to time and that is reasonably available to him/her.

Provider acknowledges that the GMIPA Board or Credentialing Committee may from time to time request further specific information about his/her medical training, background, experience, and practice, and he/she agrees to provide such information promptly upon request therefore.

I hereby attest that the information provided within this application and attachments as stated are true, correct and complete to the best of my knowledge.

_____ _____

Print or Type Name Date

_____

Signature

Gila Multi-specialty IPA s, L.L.C.

Disclosure of Ownership and Control Interest Statement

The federal regulations set forth in 42 CFR §455.100 - §455.106 require providers to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to Managed Care Organizations that contract with a State Medicaid Agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR §455.105 and 3) the identity of any excluded individual with an ownership or control interest in the provider entity or who is an agent or managing employee of the provider entity.

Completion and submission of this Statement is a condition of participation in the Medicaid or CHIP program and is also/will be a contractual obligation with WS Health Care for services to members under Medicaid and CHIP benefit plans. Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements and contracts.

This Statement should be submitted with your initial credentialing and recredentialing application and any time there is a revision to the information. A Statement must also be provided within 35 days of a request for this information. If a physician or health care professional is a member of a group practice and is credentialed or enrolled into the Medicaid program, **both** the individual member and group practice must submit a signed Statement attesting to the requirements under these regulations at the time of credentialing, enrollment or contracting. If a physician or health care professional is a member of a group practice that completes its own credentialing or is a hospital employee, such disclosure information should be submitted directly to the medical group or hospital, which will attest on behalf of its members and employees.

Detailed instructions and a glossary can be found at the end of this form. If attachments are included, please indicate to which section those attachments refer.

Provider Entity Information

Please fill out the entire section. Every field must be complete. If fields are left blank, the form will not be processed and will be returned for corrections/completeness. If the form is unreadable due to illegible handwriting, the form will not be processed. If Provider Entity is a medical group or facility, attach a roster of individual providers covered under this Disclosure Form

Type of disclosing entity. **Please choose appropriate category.** **_____Individual Member of a Medical Group** **_____Individual Practitioner** **_____Partnership** **_____Non-Profit** **_____Corporation or LLC** **_____Government/Public Entity** **_____HCBS Provider** **_____Other:_____**	**Name of Person Completing the Form** Title Phone Number Fax Email

Legal Name of individual or entity ("**Provider Entity**"): DBA Name (if different from Provider Entity Legal Name):

If Provider Entity is a member of a group practice add the Medical Group Name:

Complete Address (must include at least one street address; corporations must include the primary business address *and* every business location and P.O. Box address):
STREET STATE ZIP

Additional Addresses (list **all** Practice locations – attach a separate sheet if necessary):

*Federal Tax Identification #:	*Medicaid ID #:	*National Provider ID (NPI) #:	*Provider CAQH #:
*Entity Federal Tax ID#	*Entity Medicaid ID#	*Entity NPI#	*Entity CAQH#

These fields cannot be left blank; "N/A" non-applicable is an acceptable response.

Disclosure of Ownership and Control Interest Statement

Section I: Ownership Information

Are there any individuals or organizations with an Ownership or Control Interest of 5% or more in the Provider Entity?____**Yes**___**No**

List the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each person having an Ownership or Control Interest in the Provider Entity of 5% or greater.

List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having an Ownership or Control Interest of 5% or greater. (42 CFR §455.104)

Name of Owner	DOB	Complete Address(Street/City/State)	**SSN and TIN, as applicable	% Interest

**** SSN and TIN required under Sect 4313 of Balanced Budget Act of 1997, amended Sect 1124 and Federal Register Vol. 76 No. 22***

Section II: Other Entities

Does the Provider Entity's owner have an Ownership or Control Interest in any other provider or entity?_____**Yes**____**No**
List the name of **any other** provider or entity in which a person with an Ownership or Controlling Interest in the Provider Entity **also has an Ownership or Controlling Interest in another provider or entity**. This requirement applies to the extent the information can be obtained by requesting it in writing from the person with the Ownership or Controlling Interest. (42 CFR §455.104)

Name of Owner from Section I	Name of Other Provider or Entity	SSN (if listing an individual) TIN (if listing an entity)

Section III: Subcontractor Information

Does the Provider Entity have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor that another individual or organization also has an Ownership or Controlling Interest in such Subcontractor?_____**Yes**____**No**
List the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which the Provider Entity also has Direct or Indirect Ownership Interest of 5% or more. (42 CFR §455.104)

Name of Owner	DOB	Complete Address (Street/City/State)	SSN and TIN	% Interest

Section IV: Relationship

Are any of the individuals identified in Sections I, II or III related to each other? ____**Yes** ____**No**
If yes, list the individuals identified and the relationship to each other (spouse, sibling, parent, child). (42 CFR §455.104)

Name of Owner 1:	Name of Owner 2:	Relationship

Section V: Criminal Convictions- Has the Provider Entity, or Provider Member who has an Ownership or Control Interest in the Provider Entity, or is an Agent or Managing Employee of the Provider Entity ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program?_____**Yes**____**No**
(verification exclusion status may be obtained through the HHS-OIG List of Excluded Individuals/Entities (LEIE) at http://exclusions.oig.hhs.gov/search.aspx and review any applicable State specific exclusion databases.)

If yes, please list those persons below. (42 CFR §455.106)

Name/Title	DOB	Complete Address (Street/City/State)	SSN

Section VI: Business Transaction Information

Business Transactions - Subcontractors: Has the Provider Entity had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period?_____**Yes** **_No**

If yes, list the information for Subcontractors with whom the Provider Entity has had business transactions totaling more than $25,000 during the previous 12 month period ending on the date of this request (attach additional sheets).

Significant Business Transactions – Wholly Owned Suppliers: Has the Provider Entity had any Significant Business Transactions with a Wholly Owned Supplier exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period?_____**Yes**____**No**

If yes, list the information for any Wholly Owned Supplier with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period (attach additional sheets).

Significant Business Transactions – Subcontractors: Has the Provider Entity had any Significant Business Transactions with a Subcontractor exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period?

_Yes _No

If yes, list the information for Subcontractor with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period (attach additional sheets).

This information must be provided and/or updated within 35 days of a request. (42 CFR §455.105)

Type of Entity: **_____Subcontractor** **_____Wholly Owned Supplier**	**Name**	**SSN and TIN, as applicable**	**Complete Address**
Owner	**Owner SSN and TIN, as applicable**	**Owner's Address**	**Transaction Amount**

Section VII: Managing Employees, Agents and Board of Directors

Controlling Interest: Does the Provider Entity have any Managing Employees, Agents or Directors?_____**Yes**____**No**

List each member of the Board of Directors, Governing Board, Agents and Managing Employees (general manager, business manager, administrator or director), including the name, date of birth (DOB), Address, Social Security Number (SSN), and position

Name	DOB	Complete Address (Street/City/State)	SSN	Position

I certify that the information provided herein, is true, accurate and complete. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation in GMIPA and denial of credentialing and other GMIPA Provider Member services.

_____ _____

Signature Title (indicate if authorized Agent)

_____ _____

Name (please print) Date

Instructions and Definitions for Disclosure of Ownership and Control Interest Statement

Completion and submission of this Statement is a condition of participation in the Medicaid or CHIP program and is also/will be a contractual obligation with GRMC and GMIPA for services to members under Medicaid and CHIP benefit plans. Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements and contracts.

This Statement should be submitted with your initial credentialing and recredentialing application, or at initial and renewal of a contract or agreement and any time there is a revision to the information. A Statement must also be provided within 35 days of a request for this information. If a physician or health care professional is a member of a group practice and is credentialed or enrolled into the Medicaid program by GMIPA or by a delegate of GMIPA, **both** the individual member and group practice must submit a signed Statement attesting to the requirements under these regulations at the time of credentialing, enrollment or contracting. If a physician or health care professional is a member of a group practice that completes its own credentialing or is a hospital employee, such disclosure information should be submitted directly to the medical group or hospital, which will attest on behalf of its members and employees.

INSTRUCTIONS

If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the section number that is being continued. (For example: Section I Ownership Information, continued)

Section I: Ownership and Control Interest Information in Provider Entity:
List information about each individual or organization that has a direct or indirect Ownership of 5% or more or has a Controlling Interest in your entity. If the Owner is a corporation: the primary business address must be listed and every business location and P.O. Box address.
Providing the SSN and TIN (as applicable) is required under 42 CFR 455.104, Section 4313 of Balanced Budget Act of 1997, amended Section 1124 and Federal Register Vol. 76 No. 22. Any form without the required SSN and TIN (as applicable) is incomplete and will not be processed.

Section II: Ownership and Control Interest Information in Other Provider or Entity:
List information for other providers or Other Entities that are owned or controlled at least 5% by the individual or organization identified in Section I that has an Ownership or Control Interest in your entity.

Section III: Ownership and Control Interest Information in Subcontractor:
List each individual or organization that has an Ownership or Control Interest in a Subcontractor that your entity also has a direct or indirect Ownership of 5% or more.

Section IV: Relationship:
Report whether any of the persons listed are related to each other and identify the parties and their relationship.

Section V: Criminal Convictions:
List your own criminal convictions, as well as any person who has an ownership or control interest, or is an agent or employee of your entity, who has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Waivers, CHIP or the Title XX services since the inception of these programs. Review all of the databases necessary to verify this information.

Section VI: Business Transactions:

1. List the Ownership of any Subcontractors that you have had business transactions totaling more than $25,000 within the last twelve (12) month period ending on the date of the request.
2. List any ***Significant Business Transaction*** between your entity and any Wholly Owned Supplier during the past 5 years.
3. List any ***Significant Business Transaction*** between your entity and any Subcontractor during the past 5 years.

Remember that a ***Significant Business Transaction*** is defined as any transaction or series of related transactions that exceeds the lesser of $25,000 or 5% of a provider's operating expenses during any one fiscal year.

This information must be available within 35 days of a request by the U.S. Department of Health and Human Services, the State Medicaid Agency, or a Managed Care Organization.

Section VII: Controlling Interest of Managing Employees, Agents and Directors:
List any person who holds a position of Managing Employee within your entity, is an Agent, or is on the governing board or board of directors.

GLOSSARY

Provider Entity: an individual or entity who operates as a Medicaid provider and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services. For purposes of this Statement, the Provider Entity is the individual or entity identified on this form as the disclosing entity.

HCBS Provider: a provider of Home and Community Based Services for Medicaid beneficiaries.

Ownership or Control Interest: an individual or corporation that—
(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership.

Direct Ownership Interest**:** the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Indirect Ownership Interest**:** an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Controlling Interest**:** defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity; the ability or authority to nominate or name members of the Board of Directors or Trustees; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

Determination of ownership or control percentages **:**(a) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.
(b) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Other Entity**:** any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XV III, or XX of the Act. This includes:
(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XV III);
(b) Any Medicare intermediary or carrier; and
(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Significant Business Transaction**:** any business transaction or series of related transactions that, during any one fiscal year, exceeds the lesser of twenty-five thousand ($25,000) or five percent (5 %) of a Provider Entity's total operating expenses.

Subcontractor**:** (a) an individual, agency, or organization to which a Provider Entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier**:** an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, manufacturer of hospital beds, or pharmaceutical firm).

Wholly Owned Supplier**:** a Supplier whose total ownership interest is held by the Provider Entity or by a person(s) or other entity with an ownership or control interest in the Provider Entity.

Agent**:** any person who has been delegated the authority to obligate or act on behalf of a Provider Entity.

Managing Employee**:** a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.