MARYLAND PHYSICIANS CARE
FACILITY/ORGANIZATION PROVIDER APPLICATION

This Section to be completed by Maryland Physicians Care, Inc Provider ID: _____

INDRODUCTION AND INSTRUCTIONS:

This application is used for the provider network of Maryland Physicians Care. and its subsidiaries and affiliates, without limitation. Organizational providers include: agencies, programs, hospitals, facilities, treatment centers, and community mental health centers and others.

PLEASE COMPLETE ONE APPLICATOIN FOR EACH DIFFERENT SERVICE LOCATION WHERE CARE IS DELIVERED. One service location may include multiple programs and levels of care.

- ONE SERVICE LOCATION: If one location exists for all programs and levels of care, then only one copy of the application is required.
- MORE THAN ONE SERVICE LOCATION: Please complete one application for each location. This first page (through Section A) may be duplicated and attached to as many Sections B's (service location) as are required to complete an application for each different service location. Only one signature page is required for all service locations
- Incomplete applications will not be processed.

Current copies of the following documents must be submitted with this application for credentialing.
(Please attach credentials with the application for each specific service location in which care is delivered.)

- All current state and federal licenses and certificates (including those issued by HCFA).
- All accreditations (includes JCAHO, CARF, AOA, COA, AAHC).
- Verification of professional liability insurance (minimum $1M/$3M coverage required).
- Verification of general liability insurance.
- Completed W-9 form.
- Completed Professional Liability Questionnaire (if applicable).
- Copy of State Site visit report for non-accredited organization (if applicable).

SECTION A – CORPORATE ENTITY / MAIN SITE

PRIMARY SITE IDENTIFIYING INFORMATION

Legal name of provider organization:	TIN Number:
Other name(s) organization is known by (or d/b/a):	
If the organization is a subsidiary of, in partnership with, or otherwise administratively or organizationally linked with a health system, please identify the entity by name below Name of entity:	

MAILING ADDRESS

Mailing Address:

City: County: State: ZIP:

Primary contact person:

Telephone: ( ) Fax: ( ) E-Mail Address:

SECTION B – SERVICE LOCATION

SPECIFIC SERVICE DELIVERY LOCATION

Location name:

Street Address (No PO Box Please):

City: County: State: ZIP:

Clinical Contact Person: Title:

Telephone :( ) Fax: ( ) E-mail Address:

Is the location physically accessible for patients and visitors with disabilities? ☐ Yes ☐ No

Does The facility have a policy and procedure addressing Advanced Directives in accordance with the Federal Patient Self Determination Act? ☐ Yes ☐ No

BILLING INFORMATION

Billing Name:

Billing Address:

City: County: State: ZIP:

Business Contact Person: Title:

Telephone :( ) Fax: ( )

MAILING INFORMATION (If Different from Section A)

Mailing Name:

Mailing Address:

City: County: State: ZIP:

Contact Person: Title:

Telephone: ( ) Fax: ( )

JCAHO Accreditation Yes No Expiration Date:_____
If yes is checked, please check the levels of care covered by the accreditation
Inpatient Residential Intensive Outpatient Outpatient

CARF Accreditation Yes No Expiration Date:_____
If yes is checked, please check the levels of care covered by the accreditation
Inpatient Residential Intensive Outpatient Outpatient

CARF Accreditation Yes No Expiration Date:_____
If yes is checked, please check the levels of care covered by the accreditation
Inpatient Residential Intensive Outpatient Outpatient

AOA Accreditation Yes No Expiration Date:_____
If yes is checked, please check the levels of care covered by the accreditation
Inpatient Residential Intensive Outpatient Outpatient

Other Accreditation Yes No Expiration Date:_____
If yes is checked, please check the levels of care covered by the accreditation
Inpatient Residential Intensive Outpatient Outpatient

SECTION B (Continued)

LICENSE
Please provide information for all of your state licenses. If you hold more than three licenses, please use additional sheets of paper

Licensing State:_____ Licensing Body:_____

License Type:_____ License Number_____

Expiration Date:_____ Program(s) to which this license applies:_____

Licensing State:_____ Licensing Body:_____

Licensing Type:_____ Licensing Number:_____

Expiration Date:_____ Program(s) to which this license applies:_____

Licensing State:_____ Licensing Body:_____

Licensing Type:_____ Licensing Number:_____

Expiration Date:_____ Program(s) to which this license applies:_____

OTHER CERTIFICATONS AND MEMBERSHIPS

Please mark those that apply to this service location

Medicaid # ☐ Yes ☐ No Number:_____ Expiration Date:_____

Medicare (PIN)# ☐ Yes ☐ NO Number:_____ Expiration Date:_____

AFTER HOURS ACCESSIBLITY FOR PATIENTS IN TREATMENT

After hours accessibility for patients: ☐ Answering Machine ☐ Answering Service ☐ Beeper ☐ Not Available
After Hours Telephone Number: ( )

PROFESSIONAL LIABILITY INSURANCE

Please check all that apply and provide applicable information below:
☐ Independent Carrier ☐ Self-Insured ☐ Covered by State Tort Liability Claims Act

Current Carrier Name:_____ Policy Number:_____
Current Policy **Begin Date:** _____ **End Date:**_____ Date that coverage initially began_____
(Complete if self-insured)
Current Reinsurance Entity:_____ Risk Management Contact Name_____

GENEREAL LIABILITY INSURANCE

Please check all that apply and provide applicable information below:
☐ Independent Carrier ☐ Self-Insured ☐ Covered by State Tort Liability Claims Act

Current Carrier Name:_____ Policy Number:_____
Current Policy **Begin Date:** _____ **End Date:**_____ Date that coverage initially began_____
(Complete if self-insured)
Current Reinsurance Entity:_____ Risk Management Contact Name_____

MENTAL HEALTH/SUBSTANCE ABUSE PROFESSIONAL AND GENERAL LIABILITY HISTORY SECTIONS
(THIS SECTION IS NOT REQUIRED IF LOCATION IS JCAHO ACCREDITED)

If the answer to any questions below is "yes", submission of the documentation describing the incidents or cases involved is required. Please delete any PHI/patient's names from all documents. Examples of documents that will help Maryland Physicians Care, to process your credentialing or recredentialing application include:

- Five year claim history from your insurance carrier (Required if you answer yes to any of the following questions.)
- Sanction letters and related documents from any licensing, certifying or credentialing entity naming the organization.
- Settlement agreements, petitions, complains, answers, and demands letters regarding malpractice claims naming the organization
- A chronology of the events involved in the sanction or lawsuit, settlement , etc., including: the actions taken by you and date(s) assessments and diagnostic information related to the incident and how it was managed, and a description of any policies and procedures that were changed as a result of the event(s) or incident(s).
- Description of relevant quality assurance activities.

Please note that these documents will be reviewed in order to determine the applying organization's network status including acceptance or denial of this application for credentialing or recredentialing. Submitting complete information will facilitate a more informed decision.

A. Has the organization or program or members of the organization's/program's staff been Named in any malpractice action within the last five (5) years ☐ Yes ☐ No

B. Has the organization or program or any of the organization's or program's staff members Malpractice insurance been canceled, non renewed, restricted or special rated within the Last five (5) years?	☐ Yes	☐ No
C.		
1. Has any government agency investigated, suspended, revoked or taken any other Action against the organization or program or any of the organization's or program's Staff members' license to practice within the last five (5) years?	☐ Yes	☐ No
2. At any time, has any license, specialty board certification or eligibility been revoked, Reduced, denied, or suspended by the issuing entity or voluntarily given up by the Organization or program or members of the organization's or program's staff within the Last five (5) years or are any actions which could possibly lead to such actions now Under way?	☐ Yes	☐ No
D. Has the organization or program or members of the organization's or program's staff Had any legal actions brought against them within the last five (5) years or are there Any legal actions currently pending against them?	☐ Yes	☐ No
E. Has the organization or program or members of the organization's or program's staff Been expelled or suspended from receiving payment under the Medicare and/or Medicaid Program within the last five (5) years?	☐ Yes	☐ No
F. At any time, have any memberships in a professional organization been revoked Reduced, denied, or suspended by others voluntarily given up by the organization or Program or members of the organization or program's staff, within the last five (5) years Or are there any actions that may lead to such conclusions now under way?	☐ Yes	☐ No
G. Has the organization or program or members of the organization's or program's staff Been removed, sanctioned or suspended form membership in a professional Association for violation(s) of its ethical code of practice within the last five (5) years?	☐ Yes	☐ No

BEFORE YOU SIGN, BE SURE TO CHECK YOUR APPLICATION FOR COMPLETENESS AND CORRECTNESS. MARYLAND PHYSICIANS CARE, CANNOT PROCESS YOUR APPLICATION IF THE FORM IS INCOPLETE OR IF DOCUMENTATION IS MISSING

Declarations And Consent:

The Applicant hereby warrants and represents that all information supplied to Maryland Physicians Care including but not limited to , licensure, insurance and malpractice history, is true, accurate, and complete. The Applicant further understands that any information entered in this document by Applicant that subsequently is found to be false could result in removal from the network and/or termination of any agreement with Maryland Physicians Care, and/or its affiliated companies. The Applicant agrees to maintain professional and general liability coverage as stated in this document. The Applicant attests each service location associated with the organization follows the policies and procedures as defined by the organization's primary service location.

The Applicant grants permission and consent for Maryland Physicians Care and/or its designee, to obtain and verify information contained or the application and consents to the release by any person, organization, or other entity to Maryland Physicians Care and or its designee, of all information that may be reasonably relevant to an evaluation of , including, but not limited to , the Organization's ability to render clinical services, character and moral and ethical qualifications. The Applicant expressly waives any privilege, confidentiality right or privacy right to which the organization may be entitled. The Applicant agrees to hold harmless any such person, organization or other entity from any cause of action based on the release of such information, in good faith to Maryland Physicians Care and/or its designee pursuant to this consent. The applicant releases Maryland Physicians Care and its designees from any liability for any reports, records, recommendations, claims information and claims history or any other information related to the Organization that are provided to Maryland Physicians Care or its designee by a third party including otherwise privileged and confidential information given in good faith and related to the credentialing process. The Organization further understands that participation, as a provider for Maryland Physicians Care, is dependant upon successful completion of the credentialing process. A photo copy of this authorization shall be deemed equivalent to the original.

I certify that I am authorized to make the above warranties, representations, authorizations and releases on behalf of this provider organization and to sign this application on behalf of this organization.

Name of Provider Organization (Please print)	Name of Authorized Representative (Please Print)
Date	Signature of Authorized Representative

PLEASE RETAIN A COPY OF THIS APPLICATION FOR YOUR FILES

Return this application to:

Maryland Physicians Care, Inc
Provider Relations Department
509 Progress Drive
Linthicum, MD 21090
800-953-8854

Maryland Medical Facility Credentialing Checklist

PROVIDER NAME: _____

Task	Date	Intials	Comments
Facility Application received by MPC			
Accreditaton Certificate			
Liability Certificate			
Copy of Current State License			
Business License			
Facility Materials reviewed/completed			
Materials faxed to Credentialing for Committee review			
Facility entered into Credentialing System			
Facility Credentialed By Committee			
Facility approved by Board			