monroe plan
FOR MEDICAL CARE

Non-Credentialed Health Care Practitioner Application

To begin the enrollment process, please complete all information as it applies to your specialty. Information that does not apply to your specialty may be left blank.

Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security #:	Gender: ☐ Male ☐ Female
Individual NPI #:	License/Registration #:	Licensed State:
DEA Certificate #:	Medicare #:	Medicaid #:
Primary Specialty:	Second Specialty:	Taxonomy Code:
Group Name:	Group Tax ID:	Group NPI:
Requested Effective Date:	Malpractice Insurance Policyholder: ☐ Self ☐ Facility ☐ Collaborating Physician	

Please select only one provider type:

☐ Nurse Practitioner ☐ Registered Dietician ☐ Anesthesiologist
☐ Physician Assistant ☐ Emergency Medicine ☐ Locum Tenen
☐ CRNA ☐ Pathology ☐ Hospitalist (If yes, list specialty) _____

If you selected Anesthesiologist, Emergency Room, Hospitalist, Locum Tenens or Pathologist, you must complete the disclosure questions on the last page

Primary Office Address (Servicing Location only, No PO Box):			Suite:
City:	County:	State:	Zip Code:
Office Phone:	Office Fax:	Handicap Accessible: ☐ Yes ☐ No	Public Transportation: ☐ Yes ☐ No
Email Address:			
Additional Office Address (Street Level only, No PO Box):			Suite:
City:	County:	State:	Zip Code:
Office Phone:	Office Fax:	Handicap Accessible: ☐ Yes ☐ No	Public Transportation: ☐ Yes ☐ No
Collaborating Physician Name:		Specialty:	
Collaborating Physician NPI:		Group NPI:	
Group Name:		Billing Tax Id:	

Please provide only **ONE** Remittance, **ONE** Correspondence, and **ONE** Medical Records address. Each address can be the same or different, but ***must*** be identified as a valid United States Postal Service mailing address. If **PO BOX** information is used, the corresponding City, State and ZIP Code for the PO Box must be provided and no street level information present.

Same As: ☐ Primary Address	Remittance Address:			Suite:
	City:	State:		Zip Code:
	Office Phone:	Office Fax:		
Same As: ☐ Primary Address ☐ Remittance	Correspondence Address:			Suite:
	City:	State:		Zip Code:
	Office Phone:	Office Fax:		Email
Same As: ☐ Primary ☐ Remittance ☐ Correspondence	Medical Record Address:			Suite:
	City:	State:		Zip Code:
	Office Phone:	Office Fax:	☐ EMR ☐ Paper	EMR Vendor:
	Medical Record Contact Name:			Phone:

ATTESTATION: I, the undersigned, hereby verify and attest that I am the collaborating physician for the above-named applicant. As required by applicable laws, I have satisfied myself as to the ability and competency of this applicant and that the functions that the applicant will carry out are performed under my collaboration and oversight. (If additional collaborating physician signatures are required, please attach additional signatures of attestation to this form.)

Collaborating Physician Name (Print):	
Collaborating Physician Name (Signature):	Date:

Include the completed form along with a copy of the W-9 and Malpractice (Liability) Insurance, and Mail or Fax to:
•Monroe Plan for Medical Care • 1120 Pittsford-Victor Rd, Pittsford NY 14534 •Fax 716-748-6987• PFMemails@monroeplan.com

Non-Credentialed Health Care Practitioner Application

Disclosure Questions for Non-Credentialed Practitioners

Anesthesiologist, Emergency Room, Hospitalist, Locum Tenens and Pathologist
<u>Must</u> complete the following disclosure questions:

1. Has your license, registration or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration orcertification board?
   ☐ Yes ☐ No ☐ NA

2. Have your clinical privileges or medical staff membership at any hospital or health care institution (either voluntarily or involuntarily) ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected), or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee or governing board?
   ☐ Yes ☐ No ☐ NA

3. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action by any managed care organizations or health plans (including HMOs, PPOs, or provider organizations such as independent practice associations or private health organizations)?
   ☐ Yes ☐ No ☐ NA

4. Has your federal Drug Enforcement Administration and/or state controlled dangerous substances (CDS) certificates(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?
   ☐ Yes ☐ No ☐ NA

5. Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS-authorizing entities, education or training program, Medicare or Medicaid program, regulatory agency, or any other private, federal or state health program or been a defendant in any civil action that is reasonably related to your qualifications, competence, functions or duties as a medical professional for alleged fraud, an act of violence, child abuse or sexual offense or sexual misconduct?
   ☐ Yes ☐ No ☐ NA

6. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Databank or Healthcare Integrity and Protection Data Bank?
   ☐ Yes ☐ No ☐ NA

7. Has your Professional liability coverage ever been cancelled, restricted, declined, or not renewed by the carrier based on your individual liability history?
   ☐ Yes ☐ No ☐ NA

"I hereby attest, to the best of my knowledge that the information on this form is true accurate, and complete."

Provider Signature:_____Date: _____

Include the completed form along with a copy of the W-9 and Malpractice (Liability) Insurance, and Mail or Fax to:
•Monroe Plan for Medical Care • 1120 Pittsford-Victor Rd, Pittsford NY 14534 •Fax 716-748-6987• PFMemails@monroeplan.com