

Application Section I.

CHECKLIST

- _____ Completed Application
- _____ Copy of Member Agreement or Shareholder Agreement (**if applicable**)
- _____ Completed Attached W-9
- _____ Medicare Acceptance Letter or Recent Remittance
- _____ Surety Bond (**mandatory with Medicare acceptance**)
- _____ Medicaid Acceptance Letter or Recent Remittance
- _____ NPI acceptance letter
- _____ Copies of all Respiratory Therapist Certificate
- _____ Business License (State or City)
- _____ Certificate of Authority
- _____ **Letter attesting to your professional liability history for past five years on company letterhead signed by applicant's principal owner**
- _____ Certificate(s) of current malpractice, commercial and general liability coverage
(COVERAGE MUST BE FOR \$1,000,000 - \$3,000,000)
- _____ Copy of your ABC, BOC certification for site and practitioner (**if applicable**)
- _____ JHACO or National Accreditation Certificate (DME)
- _____ Copy of your HIPAA compliance policy
- _____ Annual membership fee (\$500)
- _____ Annual billing software fee (\$500)
- _____ Complete and Sign Disclosure of Lobbyists Activities
- _____ Signed and Dated Attestation & Insurance Consent Forms

Credentiaing Committee (for office use only)	
Credentiaing Recommendation	
Pass	<input type="checkbox"/>
Failed	<input type="checkbox"/>
OMIG	<input type="checkbox"/>
OIG	<input type="checkbox"/>
OPT OUT	<input type="checkbox"/>
Medicare	<input type="checkbox"/>
Verification	
Medicaid	<input type="checkbox"/>
Verification	
NPDB	<input type="checkbox"/>
Comments	_____

Signatures	
Credentiaing Coordinator _____	Date ____/____/____
Credentiaing Officer _____	Date ____/____/____
Board Approval _____	Date ____/____/____

C. OTHER ACCREDITATION INFORMATION (<i>attach copies of certificates</i>)		
Name of accrediting organization:		
Contact person for the accrediting organization:		
Date of last accreditation:	Expiration date of current accreditation:	
Please list accredited specialties:		
<input type="radio"/> Provider not accredited <input type="radio"/> The Provider, including its facility located in Section A, is in the process of obtaining accreditation. Complete Below.		
Name of accrediting organization:		
Please list and attach copies of all accreditation and certification documents and licenses held by the applicant and its practitioners:		
D. GENERAL & PROFESSIONAL LIABILITY INSURANCE INFORMATION (<i>attach copies of certificates</i>)		
Insurance company name:		
Policy number:	Issue date:	Exp. date:
Agent name:	Agent phone:	Agent fax:
Carrier address:		
City:	State:	ZIP code:
Coverage per occurrence:	Aggregate coverage:	
Has Provider's liability insurance or coverage been denied, cancelled, suspended, lapsed or not renewed within the last 5 years? (Please circle):		
YES - Continue below NO		
Action:	Carrier:	Date:
Resolution (attach documentation):		
Action:	Carrier:	Date:
Resolution (attach documentation):		
Comments:		

E. FACILITY LOCATIONS							
Attach additional copies of this Section as needed.							
Location 1:							
Address						Handicap accessible? Yes No	
City:		State:		ZIP Code:		Contact:	
Phone:			Fax:			E-Mail:	
<input type="checkbox"/> Mail order- Nationwide (please attach a list of all the counties that you service)							
Office hours:	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Services: <input type="radio"/> Prosthetics <input type="radio"/> Orthotics <input type="radio"/> Pedorthics <input type="radio"/> Soft goods <input type="radio"/> DME							
Location 2:							
Address						Handicap accessible? Yes No	
City:		State:		ZIP Code:		Contact:	
Phone:			Fax:			E-Mail:	
Counties Served:							
Office hours:	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Services: <input type="radio"/> Prosthetics <input type="radio"/> Orthotics <input type="radio"/> Pedorthics <input type="radio"/> Soft goods <input type="radio"/> DME							
Location 3:							
Address						Handicap accessible? Yes No	
City:		State:		ZIP Code:		Contact:	
Phone:			Fax:			E-Mail:	
Counties Served:							
Office hours:	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Services: <input type="radio"/> Prosthetics <input type="radio"/> Orthotics <input type="radio"/> Pedorthics <input type="radio"/> Soft goods <input type="radio"/> DME							
Location 4:							
Address						Handicap accessible? Yes No	
City:		State:		ZIP Code:		Contact:	
Phone:			Fax:			E-Mail:	
Counties Served:							
Office hours:	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Services: <input type="radio"/> Prosthetics <input type="radio"/> Orthotics <input type="radio"/> Pedorthics <input type="radio"/> Soft goods <input type="radio"/> DME							

F. OWNERSHIP AND MANAGEMENT STRUCTURE			
Individuals and entities holding ownership interest in Applicant:			
Name of individual or entity (include DBA if applicable)	SS no./EIN	% Ownership interest	Title
1.			
2.			
3.			
4.			
5.			
G. BILLING AND INTAKE INFORMATION			
How do you handle billing:	<input type="radio"/> In house	<input type="radio"/> Billing agency	<input type="radio"/> Both
Do you have Internet access: (Please circle)	Yes No	If yes, do you have T1 DSL Dial-up Other_____	
Billing agent/clerk name:			
Phone:	Fax:	E-mail:	
Name of individual responsible for authorizations:			
Phone:	Fax:	E-mail:	
H. BUSINESS INFORMATION			
Please indicate previous year's sales proportional breakdown:	% Medicare:	% Medicaid:	% HMO/PPO
Please list all your current insurance contracts:			
Does provider employ dedicated sales or marketing personnel?		If yes, how many:	
Please name all trade networks/organizations in which you participate:			
Do any of your employees serve as an Officer, Director or consultant in a trade network/organization? (Please circle)			
YES - Continue below		NO	
Name:	Organization:	Title:	
Phone:	Fax:	E-mail:	
I. COMPLIANCE (attach copies of certificates)			
Is provider HIPAA-compliant: (Please circle)		Yes No	
Please describe your HIPPA practices or plans:			
Please indicate location where medical records are kept:			
Name of individual responsible for HIPAA compliance:			
Phone:	Fax:	E-mail:	

Does Provider have a Quality Assurance/Control program?		Yes	No
Please describe your QA practices or plans:			
Name of person responsible for Quality Assurance/Control program:			
Phone:		Fax:	E-Mail:
Do you understand that, subject to confidentiality restrictions and authorizations, your office medical records may be subject to inspection by HMO or insurance company representatives, including for peer and utilization purposes? <input type="radio"/> Yes <input type="radio"/> No			
J. CONFIDENTIAL INFORMATION			
ALL QUESTIONS MUST BE ANSWERED IN ORDER TO PROCESS THIS APPLICATION.			
For purposes of this Section J, the term "Applicant" additionally includes its officers, directors and practitioners.			
<i>PLEASE ATTACH AN EXPLANATION ON AN ATTACHED PAGE FOR ANY QUESTION(S) TO WHICH YOU RESPONDED YES.</i>			
1.	Has Applicant ever been denied participation in Medicare, Medicaid or any other governmental program?	<input type="radio"/> Yes	<input type="radio"/> No
2.	Has Applicant ever been reprimanded, censured, excluded, suspended (even if the suspension was stayed), or disqualified to any extent from participating in Medicare, Medicaid or any other governmental program?	<input type="radio"/> Yes	<input type="radio"/> No
3.	Have any professional liability judgments ever been entered against Applicant?	<input type="radio"/> Yes	<input type="radio"/> No
4.	Have any professional liability claim settlements, not involving litigation or arbitration, ever been paid by you or paid on Applicant's behalf?	<input type="radio"/> Yes	<input type="radio"/> No
5.	Is any professional liability or malpractice or similar claims now pending against Applicant?	<input type="radio"/> Yes	<input type="radio"/> No
6.	Has Applicant's license to practice in any jurisdiction ever been denied, limited, suspended (even if the suspension was stayed) or revoked, either voluntarily or involuntarily?	<input type="radio"/> Yes	<input type="radio"/> No
7.	Has Applicant ever been subject to suspension, cancellation, investigation, limitation, non renewed or refused participation in a HMO, PPO, PHO, IPA or any prepaid health plan or managed care network?	<input type="radio"/> Yes	<input type="radio"/> No
8.	Has Applicant been subject to any disciplinary action or investigation by the ABC, AOPA or any medical society or licensing authority?	<input type="radio"/> Yes	<input type="radio"/> No
9.	Has Applicant ever been convicted of a crime (other than a minor traffic offense) in the past 10 years or do you have any criminal charges pending?	<input type="radio"/> Yes	<input type="radio"/> No
10.	Is Applicant's physical or mental health such that it may impair your ability to practice within the scope of privileges for which you have applied with or without reasonable accommodation?	<input type="radio"/> Yes	<input type="radio"/> No
11.	Has your facility ever been denied membership or renewal of membership, or been subject to any disciplinary action in any hospital, HMO, IPA, PHO, PPO, managed care organization, with the exception of "no network need" or professional society, or such action pending?	<input type="radio"/> Yes	<input type="radio"/> No
12.	Does applicant or anyone employed by organization, involved in the sell, purchase or use of Illegal Drugs?	<input type="radio"/> Yes	<input type="radio"/> No
K. OTHER INFORMATION			

CONSENT TO RELEASE OF INSURANCE INFORMATION

INTEGRAPARTNERS IPA

1701 Utica Avenue
Brooklyn, NY 11234
Tel. 718.369.0012

In connection with the submission of ² _____'s application to perform independent contracting practitioner work on behalf of ***Integra Partners IPA***, the undersigned hereby authorizes

¹ _____ and its staff to release information ***Integra Partners IPA*** and its designee with respect to my medical malpractice and professional liability insurance, malpractice and professional liability history, the number of pending malpractice and professional liability cases, as well as all details and circumstances in connection therewith.

I additionally consent to the release of a copy of my professional liability certificate indicating the category, and to the release of information concerning the non-renewal, cancellation, revocation, and change in policy limits or added special limitations of such insurance.

I hereby release ¹ _____, its agents, and employees for acts performed in good faith in connection with the release of such information, and I hereby consent to the release of all such information.

NAME OF APPLICANT: ² _____

SIGNATURE: _____

PRINT NAME/TITLE: _____

PHONE NUMBER: _____

POLICY #: _____

DATE: ____/____/____

¹ Please indicate the name of your professional liability carrier.

² Please indicate applicant's legal name.

Application Section IV.

PROSTHETIC AND ORTHOTIC SERVICE

Please complete this form in multiple copies, one for each facility.

What age limits do you accept? Lowest Age _____ Highest Age _____

Facility Name: _____

Facility Address: _____

Facility Hours: _____

Staff Roster (Please include names and titles):

Please indicate all services that Applicant provides in this service location by responding “yes” or “no”.

ADULT SERVICES:

Upper extremity prosthetics _____

Lower extremity prosthetics _____

Myoelectric prosthetics _____

Upper extremity orthotics _____

Lower extremity orthotics _____

Spinal orthotics _____

Halos _____

Pedorthotics _____

Post mastectomy _____

Compression stockings _____

Other (please specify) _____

PEDIATRIC SERVICES:

Upper extremity prosthetics _____

Lower extremity prosthetics _____

Myoelectric prosthetics _____

Upper extremity orthotics _____

Lower extremity orthotics _____

Spinal orthotics _____

Pedorthotics _____

Cranial orthotics _____

Reciprocating gait orthosis _____

Other (please specify) _____

Application Section V.

DURABLE MEDICAL EQUIPMENT SERVICES

Please check off the following services your company provides

What age limits do you accept? Lowest Age _____ Highest Age _____

- | | |
|--|---|
| <input type="checkbox"/> Commodes/Urinals/Bed Pans | <input type="checkbox"/> Off the Shelf Orthotics |
| <input type="checkbox"/> Continuous Passive Motion (CPM) Devices | <input type="checkbox"/> Ostomy Supplies |
| <input type="checkbox"/> Blood Glucose Monitors and Supplies (Mail Order) | <input type="checkbox"/> Tracheostomy Supplies |
| <input type="checkbox"/> Blood Glucose Monitors and Supplies (Non-Mail Orders) | <input type="checkbox"/> Urological Supplies |
| <input type="checkbox"/> Heat & Cold Application | <input type="checkbox"/> Nebulizer Equipment and Supplies |
| <input type="checkbox"/> Hospital Beds Electric | <input type="checkbox"/> Oxygen Equipment and Supplies |
| <input type="checkbox"/> Hospital Beds Manual | <input type="checkbox"/> Respiratory Therapy |
| <input type="checkbox"/> Enteral Nutrients, Equipment, and Supplies | <input type="checkbox"/> Respiratory Suction Pumps |
| <input type="checkbox"/> Continuous Positive Airway Pressure (CPAP/BIPAP) Devices | <input type="checkbox"/> Tracheostomy Care Supplies |
| <input type="checkbox"/> Support Surfaces: Pressure reducing Beds/Mattresses/Overlays Pads | <input type="checkbox"/> Surgical Dressing |
| <input type="checkbox"/> Traction Equipment | <input type="checkbox"/> Diabetic Shoes Inserts (off the shelf) |
| <input type="checkbox"/> Transcutaneous Electrical Nerve Simulations (TENS) | <input type="checkbox"/> Related Accessories |
| <input type="checkbox"/> Canes and Crutches | <input type="checkbox"/> Wheelchairs (Standard Power) |
| <input type="checkbox"/> Patients Lifts | <input type="checkbox"/> Wheelchairs (Standard Manual) |
| <input type="checkbox"/> Walkers | <input type="checkbox"/> Power Operated Vehicles (Scooters) |
| <input type="checkbox"/> Seat Lift Mechanisms | <input type="checkbox"/> Wheelchair Seating Cushions |

Any additional specialties not listed please specify below:

Application Section VI.

ATTESTATION AND SIGNATURE

The undersigned attests, represents and warrants that they have reviewed all the information and material included and provided by the undersigned in all the sections of this application, and that all such material and information is complete and accurate.

The undersigned authorizes any individual or entity in the possession of any information bearing on me or my facilities' qualifications to release such information to *Integra Partners IPA* ("Integra") upon Integra's request.

The undersigned hereby release Integra and its owners, officers, directors, agents and employees, as well as any individual or entity and its owners, officers, agents and employees releasing above-referenced information from liability for any damages resulting from the release of any such information to Integra.

The undersigned further agree to notify *Integra Partners IPA* in a timely manner not to exceed thirty (30) days of any change in the status of the information or material included in the Application.

The undersigned understands that the mere submission of the Application does not entitle them or their facilities to be a independent contractor providing services on behalf of Integra, or to bill or collect payment from Integra for services I or my facilities provide, or to bill or collect payment from insurance companies with which Integra has entered into agreements for services I or my facilities provide.

The individual undersigned represents and warrants that (s) he is authorized to obligate the applicant as contemplated by this application, and that no corporate or other entity action is necessary to obligate the Applicant.

Legal Name of Applicant _____

Signature _____

Title _____

Social Security Number _____

Date _____

Address _____
