TRISTAR MANAGED CARE

TRISTAR Managed Care
Participating Physician Application

Completion of this application does not indicate a binding agreement. If accepted, the appropriate Agreement must be executed by both parties.
** SEE ATTACHED is not an acceptable response. Please fill out all applicable fields with the requested information. **

INSTRUCTIONS	
This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on the original, attach additional sheets and reference the question being answered. Please DO NOT use abbreviations when completing the application. Current copies of the following documents must be submitted with this application.	
☐ State Medical License(s)	☐ Face Sheet of Professional Liability Policy of Certification
☐ DEA Certificate (if applicable)	☐ Curriculum Vitae
☐ Board Certifications (if applicable)	☐ ECFMG (if applicable)

** FEDERAL TAXID#: (*Please attach a copy of the W9 form submitted to the IRS for each TIN listed.*) **			
Primary Tax ID #:		Secondary Tax ID #:	
Note: All Federal Tax Identification Numbers listed in association with this application WILL BE PARTY TO THE CONTRACT. List only those Tax ID Numbers that are to be affiliated with the TRISTAR Managed Care PPO Contract.			

PROVIDER IDENTIFICATION *Information will be used in directories.*							
First:		Last:		MI:		Degree:	
Date Of Birth:		SSN:		Gender:	☐Male ☐Female		
Do you, the provider, fluently speak a language other than English? If Yes, list language(s): ☐ Yes (please specify); ☐ No							
1.)	2.)	3.)	4.)				

BOARD CERTIFICATION / SPECIALTY BOARD STATUS *If additional space is needed, attach a separate page.*					
Primary Specialty:		Board Name:		Cert Expires:	
Sub-Specialty:		Board Name:		Cert Expires:	

LICENSURE INFORMATION *List all licenses. If additional space is needed, attach a separate page.* ** Must submit hard copies of all license and DEA registrations. **							
State:		License #:		Expires:		Status:	☐Active ☐Inactive ☐Pending
State:		License #:		Expires:		Status:	☐Active ☐Inactive ☐Pending
DEA Registration:				State:		Expires:	
DEA Registration:				State:		Expires:	
NPI #:		UPIN #:		Medicare #:			

PRIMARY SERVICE LOCATION *Information will be used in directories.* *Check the box to exclude from directories* ☐					
Practice Name (if applicable):					
Address:		City:			
		State:			
		Zip:			
		County / Parish:			
Phone:		Fax:		Email:	

Do you provide 24 hour coverage? ☐Yes ☐No			Does this location accept new patients? ☐Yes ☐No				
Hours of Operation	MONDAY From / To	TUESDAY From / To	WEDNESDAY From / To	THURSDAY From / To	FRIDAY From / To	SATURDAY From / To	SUNDAY From / To

SECONDARY SERVICE LOCATION							
Information will be used in directories. *Check the box to exclude from directories* ☐							
Practice Name (if applicable):							
Address:					City:		
					State:		
					Zip:		
					County / Parish:		
Phone:		Fax:		Email:			

Do you provide 24 hour coverage? ☐Yes ☐No			Does this location accept new patients? ☐Yes ☐No				
Hours of Operation	MONDAY From / To	TUESDAY From / To	WEDNESDAY From / To	THURSDAY From / To	FRIDAY From / To	SATURDAY From / To	SUNDAY From / To

BILLING					
Is there a 'Universal Billing Address'? ☐ YES; ☐ NO					
▪ If YES, please attach a copy of a HCFA 1500 form with the billing information (Please complete boxes 31, 32, and 33).					
CONTACT INFORMATION					
General Correspondence		Billing Contact		Contracting/Credential Contract	
Name:		Name:		Name:	
Phone:		Phone:		Phone:	
Fax:		Fax:		Fax:	
Email:		Email:		Email:	

WORK HISTORY					
List complete 5 YEAR work/education history – if present position IS NOT listed on page 2, include below. All entries must include MONTH and YEAR each position began/ended. Explain ALL gaps 6 months or greater in the 5 year period. "See CV" is not sufficient. If additional space is needed, attach a separate page.					
Practice Name:		Start Date:		End Date:	
Address:		City, State:			
Practice Name:		Start Date:		End Date:	
Address:		City, State:			
Explain all gap(s) 6 months or greater, *if applicable:*					

HOSPITAL AFFILIATIONS – List hospitals where you maintain privileges. If additional space is needed, attach a separate page.			
Primary Hospital Name:			
City:		State	
Additional Hospital Name:			

City:		State:	

HOSPITAL AFFILIATIONS – *If no hospital affiliation(s) are listed above*	
I currently do not maintain admitting privileges for the following reason(s):	
In the event of hospitalization, I:	

EDUCATION *List all institutions attended. If additional space is needed, attach a separate page. PLEASE PRINT LEGIBLY.*							
MEDICAL/PROFESSIONAL SCHOOL							
School Name:				Start:		End:	
City:		State:		Country:			
INTERNSHIP							
Institution Name:				Start:		End:	
City:		State:		Country:			
RESIDENCY							
Institution Name:				Start:		End:	
City:		State:		Country:			
FELLOWSHIP/POST GRADUATE EDUCATION							
Institution Name:				Start:		End:	
City:		State:		Country:			
FOREIGN MEDICAL GRADUATES – *If you are not Board Certified or did not graduate from a US Residency Program, provide your ECFMG # and the date of issuance.*							
ECFMG #:				Certification Date:			

REFERENCES *List three current professional references in your specialty type.*					
Name:		Specialty:		Phone:	
				Fax:	
Name:		Specialty:		Phone:	
				Fax:	
Name:		Specialty:		Phone:	
				Fax:	

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INSURANCE COVERAGE *If additional space is needed, attach a separate page.*					
Current Carrier:		Telephone #:			
Address:		City:			
		State:		Zip:	
Coverage Amt – Occurrence:	$	Coverage Amt – Aggregate:	$		

PROFESSIONAL STATUS

All questions must be answered. All questions answered as "Yes" or "Pending" must be explained. Please use the space(s) provided below for explanations. If a specific question is not applicable to your specialty, select the "No" box.

CLAIMS, SUITS AND SETTLEMENTS All questions must be answered. All questions answered as "Yes" or "Pending" must be explained on Attachment I.				
1	Within the last 5 years, have you had any claims, suits or settlements?	☐ Yes	☐ No	☐ Pending
2	Any pending claim, which involved the death of a patient?	☐ Yes	☐ No	☐ Pending
3	Within the last 10 years, has your medical/professional license been voluntarily or involuntarily surrendered, limited or restricted, suspended or revoked, or have you received a reprimand, fine or sanction?	☐ Yes	☐ No	☐ Pending
4	Within the last 10 years, have you been denied a medical/professional license in any jurisdiction?	☐ Yes	☐ No	☐ Pending
5	Within in the last 10 years, have your narcotics registrations, state and/or federal, been surrendered, limited, revoked, sanctioned or involuntarily not renewed?	☐ Yes	☐ No	☐ Pending
6	Within in the last 10 years has your board certification(s) or eligibility been revoked or sanctioned?	☐ Yes	☐ No	☐ Pending
7	Within the last 10 years, have your privileges at any hospital been limited as the result of disciplinary conditions, denied, suspended, revoked, sanctioned or involuntarily not renewed?	☐ Yes	☐ No	☐ Pending
8	Within the last 10 years, have you been sanctioned or investigated for any reason by a federal or state Medicare or Medicaid agency, medical organization or been terminated from a managed care organization (i.e. HMO, PPO)?	☐ Yes	☐ No	☐ Pending
9	Within the last 10 years, have you had impairment due to chemical dependency or substance abuse?	☐ Yes	☐ No	☐ Pending
10	Within the last 7 years, have you been convicted, pled guilty or pled nolo contendre to a felony?	☐ Yes	☐ No	☐ Pending
11	Do you currently have a physical or mental impairment that would impede or limit your ability to carry out the essential functions of a practitioner within your area of practice on behalf of this organization?	☐ Yes	☐ No	☐ Pending
12	Are there any times in which provider coverage (i.e. pager, answering service, covering physician, etc.) is not available to a patient 24 hrs a day, every day of the year at all locations referenced within this application?	☐ Yes	☐ No	☐ Pending

Explanation of Professional Status Adverse Events Please be sure to insert the number associated with the question for which the explanation is being provided			
Question #:		Explanation:	
Question #:		Explanation:	

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INSURANCE ATTESTATION

I currently have and agree to maintain professional liability insurance in the amounts of One million ($1,000,000) per occurrence and Three million ($3,000,000) aggregate or other coverage amounts as indicated in the Provider Application, Insurance Section, if deemed appropriate by TMC Corporation.

PARTICIPATION STATEMENT / ACKNOWLEDGMENTS

I fully understand by completing and signing this application that my credentials are being evaluated for participation in TRISTAR Managed Care's provider network. In the event I choose to contract for any other product or service offered by TMC, the credentials associated with this application may be used to satisfy the credentialing requirements of that product.

I fully understand that if any matter stated in this application is or becomes false, my agreement may be terminated for breach of contract. All information submitted by me in this application is warranted to be correct, complete and true.

I authorize TMC and/or its Credentials Verification Organization (CVO) to consult with the National Practitioners Data Bank, state licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, Educational Council for Foreign Medical Graduates, hospital, professional references and any other person or entity from whom/which information may be needed and/or reasonably relevant to complete the credentialing process or to obtain information concerning my membership, professional competence, character and moral/ethical qualifications, including information relating to any disciplinary action or suspension or curtailment of privileges.

I hereby release TRISTAR Managed Care, its employees, its Agents, its customers and all those whom TMC and/or its Agents contacts for credentialing information from any and all liability for their acts performed in good faith and without malice in obtaining, providing and/or verifying information used in the evaluation of my application and in evaluating and making decisions regarding my application for participation.

I understand that I have the right to review information obtained to evaluate this credentialing application, including information obtained from outside primary source(s). This excludes references, recommendations or other information that is peer review protected, unless required by state and/or federal law. I understand that I will be notified, in writing, by the Credentialing Committee panel of any information obtained during the credentialing process that varies substantially from the information I have provided and that I will be given the opportunity to address these discrepancies.

SIGNATURES

STAMPED SIGNATURES WILL NOT BE ACCEPTED

I attest to the fact all of the information submitted by me in this document are true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from the application may constitute cause for denial of participation or cause for summary dismissal.

Provider's Name (Please Print):			
Provider's Signature:		Date:	
Person Submitting the Form:		Title:	
Phone:		Fax:	Email:

INFORMATION WILL BE KEPT CONFIDENTIAL

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ADDENDUM A

CLAIMS, SUITS AND SETTLEMENTS SUMMARY FORM

Please provide the following information for EACH closed, settled or pending case within the last 5 years. Copy this form for each additional claim

Health of Patient:		Date of Occurrence:		Date of Claim:	

Claim Status					
☐ Closed w/Payment:	Payment Amount:	$	☐ Closed No Payment	☐ Dismissed	☐ Pending

Do you believe there is merit to this case? (If yes, please explain):	☐ Yes ☐ No	

Please describe the pertinent details of the patient's history and the allegations made against you:

Please provide clinical details regarding treatment and care of patient:

What Insurance Company was involved, if any?					
City:		State:		Telephone #:	

SIGNATURES

STAMPED SIGNATURES WILL NOT BE ACCEPTED

I attest to the fact all of the information submitted by me in this document are true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from the application may constitute cause for denial of participation or cause for summary dismissal.

Provider's Name (Please Print):			
Provider's Signature:		Date:	
Person Submitting the Form:		Title:	

Phone:		Fax:		Email:	

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Participating Physician Application ADDENDUM B CONFIDENTIAL QUESTIONS – HEALTH HISTORY			
1.	Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? ▪ If yes, please describe any accommodations that could reasonably be made to facilitate your performance of such functions without risk or compromise:	☐ YES	☐ NO
2.	Are you a certified Worker's Compensation provider? ▪ If yes, please attach a copy of your certificate.	☐ YES	☐ NO
3.	Are you a reservist? If yes, what branch of the military? Anticipated date of separation from reserve duty?	☐ YES	☐ NO
4.	Medicaid/Medi-Cal #:		

SIGNATURES ***STAMPED SIGNATURES WILL NOT BE ACCEPTED*** I attest to the fact all of the information submitted by me in this document are true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from the application may constitute cause for denial of participation or cause for summary dismissal.					
Provider's Name (Please Print):					
Provider's Signature:			Date:		
Person Submitting the Form:			Title:		
Phone:		Fax:		Email:	

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Addendum C
HIV/AIDS Specialist Designation

This Addendum is submitted to: herein, this Healthcare Organization.

Health plans and health care organizations must implement regulations related to AB 2168 (Ch. 426, 2000). This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS– 34–01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist. ** We will use your information for internal referral procedures. **

As always, if information about your practice changes, please notify us promptly.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine.

OR

I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV medicine by a member board of the American Board of Medical Specialties;

OR

☐ I am board certified in Infectious Disease and in the past 12 months have clinically managed at least 25 HIV patients and completed 15 hours of category 1 CME in HIV medicine, five hours of which was related to antiretroviral therapy;

OR

☐ In the past 24 months I have provided clinical management to 20 HIV patients and in the past 12 months have completed board certification in Infectious Disease;

OR

☐ In the past 24 months I have provided clinical management to 20 HIV patients and in the past 12 months have completed 30 hours of category 1 CME in HIV medicine;

OR

☐ In the past 24 months I have clinically managed at least 20 HIV patients and in the past 12 months have completed 15 hours of category 1 CME in HIV medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

SIGNATURES

STAMPED SIGNATURES WILL NOT BE ACCEPTED

I attest to the fact all of the information submitted by me in this document are true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from the application may constitute cause for denial of participation or cause for summary dismissal.

Provider's Name (Please Print):			
Provider's Signature:		Date:	
Person Submitting the Form:		Title:	
Phone:		Fax:	
Email:			