monroe plan FOR MEDICAL CARE

YourCare A MONROE PLAN COMPANY

Application for Practitioner Enrollment

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:
Physician Email Address:		
Date of Birth:	Social Security #:	Gender: ☐ Male ☐ Female
Language(s) spoken:	Are you CAQH registered: ☐ Yes ☐ No	If Yes, CAQH Provider ID:
Applying as: ☐ PCP ☐ Specialist ☐ Allies/Consulting Health Professional		Requested Effective Date:
Individual NPI #:	License/Registration #:	Licensed State:
DEA Certificate #:	Medicare #:	Medicaid #:
Primary Specialty:	Second Specialty:	Taxonomy Code:
Group Name:	Group Tax ID:	Group NPI:

Have you, your agent or managing employee ever been convicted of a crime relating to Medicare, Medicaid or any government health program or the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals? ☐ Yes ☐ No
If yes, please provider the following: Name/Title, DOB, Address, SSN:

Are you board-certified? ☐ Yes ☐ No — If yes, board name and date:

Please select only one provider type:

- ☐ Anesthesiologist
- ☐ Emergency Room
- ☐ Hospitalist
- ☐ Locum Tenens
- ☐ Pathologist
- ☐ Audiologist (AUD)
- ☐ Certified Diabetic Educator (CDE)
- ☐ Doctor of Podiatric Medicine (DPM)
- ☐ Enterostomal Therapy
- ☐ Medical Doctor (MD)
- ☐ Certified Nurse Midwife (CNM)
- ☐ Chiropractor (DC) *
- ☐ Occupational Therapist (OT)
- ☐ Optometrist
- ☐ Oral Maxillofacial Surgery (DMD/DDS)
- ☐ Osteopathic Doctor (DO)
- ☐ Registered Dietician (RDE)
- ☐ Physical Therapist (PT)
- ☐ Speech Pathologist (SP/SLP)
- ☐ Pain Management

**** Provider Type is applicable to Essential Plan Only***

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

Experienced HIV/AIDS Provider: ☐ Yes ☐ No			
Primary 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
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
All members can make an appointment and be treated at:		Primary Office: ☐ Yes ☐ No	Additional Office: ☐ Yes ☐ No

Please provide only **ONE** correspondence, **ONE** Remittance, 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:

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 Road, Pittsford NY 14534 •Fax 585-242-6206• PFMemails@monroeplan.com

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Hospital Affiliations

Hospital Name	Hospital Address

Office Hours

Primary Location:		
Day:	Office Open:	Office Close:
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Additional Location:		
Day:	Office Open:	Office Close:
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Office Contact Information

Contact Name:	Phone Number:
Contact Email Address:	
Contact Type: ☐ Billing Manager ☐ Office Manager ☐ Provider ☐ Office Staff ☐ Other:	

Include the completed form along with a copy of the W-9 and Malpractice (Liability) Insurance, and Mail or Fax to:
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Disclosure Questions for Non-Credentialed Practitioners

Anesthesiologist, Emergency Room, Hospitalist, Locum Tenens and Pathologist
Must 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 or certification 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:
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