TEXAS
INDIVIDUAL ALLIED HEALTH PROFESSIONAL APPLICATION AND INFORMATION RELEASE FORM

PROVIDER IDENTIFICATION

Last Name	First Name	MI	Degree
Date of Birth	Social Security Number (Required!!)	Male ☐ Female ☐	

Texas State License Number:	DEA Number:
Medicaid/TPI Number:	DPS Number:
Medicare Number:	NPI Number:

Email Address:

In order to meet AMERIGROUP's diversity goals, please note your race/ethnic group. (This information is voluntary.)
Asian or Pacific Islander ☐ Black ☐ Hispanic ☐ Native American ☐ White ☐ Confidential – Do not ask ☐

What foreign languages are fluently spoken by you and your staff? ☐ English Only

PROVIDER SPECIALTY

Participation Preference: Primary Care Provider ☐ Specialist ☐ Both ☐

Age Range of Patients: All Ages ☐ Not younger than ___ years old and/or not older than ___ years old.

Please indicate your principal field (s) or specialization (up to three) in which you wish to participate by placing a (1) next to your primary; and a (2) next to your secondary specialty, if any. Please check only the specialties in which you currently practice.

___ Audiologist (AD)
___ Certified Addiction Counselor (CC)
___ Dietitian/Nutritionist (DT)
___ Genetics (16)
__ Hand Therapy (HT)
__ Licensed Clinical Social Worker (SW)
__ Licensed Marriage/Family Therapist (FT)
__ Licensed Professional Counselor (LP)
__ Occupational Therapist (OT)
___ Pediatrics, Developmental (92)
___ Physical Therapist (PT)
___ Psychology (PS)
___ Psychology, Child (PC)
___ Speech Therapist/Pathologist (SP)
___ Substance Abuse (ZI)

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PRIMARY OFFICE /SERVICE ADDRESS

Practice Location Name:			
Street, Suite:			
City:	State:	Zip:	County:
Phone:	Fax:	Primary Credentialing Contact/Phone#:	
Does Provider bill from this address? ☐ Yes ☐ No			
Does this office meet ADA accessibility requirements? ☐ Yes ☐ No			
Check all that apply: Handicap Accessible: ☐ Building ☐ Parking ☐ Restroom Services for Disabled: ☐ Text Telephone ☐ American Sign Language ☐ Mental/Physical Impairment Accessible by Public Transportation: ☐ Bus ☐ Subway ☐ Regional Train			

BILLING INFORMATION

Name (Physician, Group or IPA Name)			
Street, Suite:			
City:	State:	Zip:	Phone:
Federal Tax ID# (TIN)			

SECONDARY OFFICE /SERVICE ADDRESS

Practice Location Name:			
Secondary Office Street Address:			
City:	State:	Zip:	County:
Phone:	Fax:	Primary Contact:	
Does Provider bill from this address? ☐ Yes ☐ No			
Does this office meet ADA accessibility requirements? ☐ Yes ☐ No			
Check all that apply: Handicap Accessible: ☐ Building ☐ Parking ☐ Restroom Services for Disabled: ☐ Text Telephone ☐ American Sign Language ☐ Mental/Physical Impairment Accessible by Public Transportation: ☐ Bus ☐ Subway ☐ Regional Train			

BILLING INFORMATION

Name (Physician, Group or IPA Name)			
Street, Suite:			
City:	State:	Zip:	Phone:
Federal Tax ID# (TIN)			

If there are additional office/service locations, please attach a separate sheet indicating the address, phone/fax numbers.

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MAILING ADDRESS		
Name (Physician, Group or IPA Name)		
Street, Suite:		
City:	State	Zip

OFFICE HOURS (PCPs must have more than 20 hours per week available in their office(s) to see AMERIGROUP members.)

Primary Office		Secondary Office	
Monday		Monday	
Tuesday		Tuesday	
Wednesday		Wednesday	
Thursday		Thursday	
Friday		Friday	
Saturday		Saturday	
Sunday		Sunday	

MEDICAL/PROFESSIONAL EDUCATION		
Medical/Professional School	City	State
Degree Received	Date of Graduation	

RESIDENCIES/FELLOWSHIPS			
Institution		City	State
Type of Training	Specialty	From (MM/YY)	To (MM/YY)

INTERNSHIPS			
Institution		City	State
Type of Internship	Specialty	From (MM/YY)	To (MM/YY)

BOARD CERTIFICATION **(Attach a copy of board certificate.)**		
Are you board certified? Yes ☐ No ☐	Specialty	Certification Number
Name of Issuing Board	Initial Certification Date	Expiration Date

LICENSURE **(Attach a copy of current licensure.)**			
State:	License Number:	Date of License:	Expiration Date:
State:	License Number:	Date of License:	Expiration Date:

LABORATORY SERVICES **(Attach a copy of CLIA certification for each location, if applicable.)**

Providers performing laboratory procedures in their offices will need a Certificate of Waiver or a CLIA certification.

Do you perform laboratory procedures in your office? Yes ☐ No ☐

If Yes, do you have a CLIA certificate? Yes ☐ No ☐ If Yes, please indicate CLIA ID # _____

If No, do you have a CLIA waiver? Yes ☐ No ☐ If Yes, please indicate CLIA Waiver ID# _____

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HOSPITAL AFFILIATIONS

Primary Admitting Hospital	City	State
Department	Status (Active, Provisional, Courtesy, Etc.)	
Secondary Hospital Affiliation	City	State
Department	Status (Active, Provisional, Courtesy, Etc.)	

INSURANCE **(Attach a copy of liability insurance face sheet indicating professional coverage.)**

Current Carrier Name:	
Policy Number:	Coverage Type: ☐ Occurrence Based ☐ Claims Based
Effective Date:	Expiration Date:
Per Incident: $	Aggregate: $

NATIONAL PROVIDER IDENTIFIER

Name:	NPI#:
Taxonomy Code(s):	
Name:	NPI#:
Taxonomy Code(s):	

FAMILY AND GENERAL PRACTITIONERS WHO DELIVER BABIES

Please indicate the training you have in this area:

Please indicate the hospital(s) at which you are approved to deliver:

Please indicate an estimated monthly number of deliveries:

CREDENTIALING QUESTIONS

Do you have:

1. Reasons for any inability to perform the essential function of the position, with or without accommodation? . . . . . Yes ☐ No ☐
2. Any history or current problems with chemical dependency, alcohol or substance abuse? . . . . . Yes ☐ No ☐
3. A history of license revocation, suspension, voluntary relinquishment, probationary status or other licensure condition or limitation? . . . . . Yes ☐ No ☐
4. A history of conviction of a criminal offense other than minor traffic violations? . . . . . Yes ☐ No ☐
5. A history of loss or limitation or privileges or disciplinary activity, to include denial, suspension, termination or renewal of professional privileges? . . . . . Yes ☐ No ☐
6. A history of complaints or adverse action reports filed with a local, state or national professional society or Licensing Board? Yes ☐ No ☐
7. A history of refusal or cancellation of professional liability insurance? . . . . . Yes ☐ No ☐
8. A history of suspension or revocation of a DEA Certificate? . . . . . Yes ☐ No ☐
9. A history of any Medicare/Medicaid sanctions? . . . . . Yes ☐ No ☐
10. Any physical or mental health problems that may affect your ability to provide health care? . . . . . Yes ☐ No ☐
11. Any professional liability actions of $250,000 or more (pending, settled, arbitrated, mediated or litigated) within the past 5 years? . . . . . Yes ☐ No ☐

Have you ever been convicted of or pleaded no contest to a felony or other criminal offense, including, without limitation, a criminal offense related to Medicare, Medicaid or any other federal program? . . . . . Yes ☐ No ☐

Do you, your business entity or any family member have an ownership greater than 5% in any medical enterprise or business? . . . . . Yes ☐ No ☐

If YES, please complete attached Disclosure of Ownership and Control Interest Statement in accordance with Federal Regulations 42C.F.R.§455.104.

Please include an explanation for any question(s) answered YES.

AMERIGROUP DISCLOSURE FORM FOR A PROVIDER PERSON

Directions: Use this form if you are applying for network participation as a **Provider Person**. If the addition of the **Provider Person** will change the **Ownership** or **Control** structure of the **Provider Entity** that the **Provider Person** is joining (i.e., the new **Provider Person** will also be an owner or high ranking employee of the **Provider Entity**, then you must also fill out a new Disclosure form for the **Provider Entity** to reflect the new **Ownership** or **Control** arrangements.

Please answer ***all questions*** as of the current date. If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. Please return the original document Amerigroup and retain a copy for your files. Completely answer the applicable questions. If a question is not applicable, please respond **N/A** for that question. ***NO QUESTIONS SHOULD BE LEFT BLANK***. Website, and email addresses are not acceptable answers to any of the questions and should not be referenced in this statement.

Social Security Numbers (SSN) must be provided for validation purposes.

I. Identifying Information

Provider Person Full Name	SSN	DOB	NPI number	Medicaid Id number	
Provider Person Home Address			City	State	Zip

Provider Entity Name (Provider Entity is whom the Provider person works for. If you are a sole proprietor, you would list yourself as the Provider Entity also.)	Provider Entity DBA (If different from provider Entity Name)	Provider Entity Address (If you have more than one practice location list all locations)
Provider Entity T.I.N.	Provider N.P.I.	Medicaid I.D. number

II. Criminal Offense Attestation

A) Have you ever been **Convicted** of a criminal offense related to your involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? **"Convicted"** means been found guilty by a jury or judge, or pled guilty, nolo contendre , best interest plea or pre trial diversion or suspended sentence. **Yes** ☐ **No** ☐

If 'Yes' is checked, provide the following information:

Name on Court records	SSN	Matter of the Offense	Date of the Conviction	Sanction Period of the Offense if you were sanctioned by Federal Office of the Inspector general(OIG)

B) Have you ever been **Debarred** from participation in Federal Government contracts? **"Debarred"** means you are not allowed to participate in contracts paid for by the Federal government, whether or not those contracts are in the health care area. Yes ☐ No ☐

If 'Yes' is checked, provide the following information:

When you were debarred	Length of Debarment	Reason for Debarment

C) Have you ever been **Excluded** from participation in Federal health care programs (Medicare, Medicaid, CHIP or TRICARE) in the past? "Excluded" means that a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS,OIG) that they may no longer be a provider for any federally funded healthcare program.

Yes ☐ No☐ **If "Yes", please supply the following information:**

Start date of exclusion or termination	End date of exclusion or termination	Reason for exclusion or termination

D) Have you ever been **Terminated** from a State's Medicaid or SCHIP programs for reasons having to do with Program Integrity(fraud or abuse) ? **Terminated** means the Provider lost the right to bill a State's Medicaid or SCHIP programs for a cause related to fraud or abuse.

Yes ☐ No☐ **If "Yes", please supply the following information:**

State of practice when terminated	Reason for termination	Date of termination

E) Have you ever had **Civil Monetary Penalties (CMPs)** assessed against you? A CMP is a type of fine assessed against a Provider by a governmental agency that manages a federal healthcare program.

Yes ☐ No☐ **If "Yes", please supply the following information**:

State of practice when CMP assessed	Reason for CMP	Amount of CMP	Date of CMP

III. Questions for a Sole Proprietor

A) If you are a Sole Proprietor, please give the following information for your **Managing Employees and Agents.** A **Managing Employee** is someone who makes day-to-day decisions on the running of your business such as an office manager or billing manager**.** An **Agent** is someone besides yourself who can legally act for your business.

Name of Managing Employee or Agent	SSN	DOB	Home Address	City	State	Zip

B) Has any person listed in 3a been convicted of a criminal offense related to your involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? **"Convicted"** means been found guilty by a jury or judge, or pled guilty, nolo contendre , best interest plea or pre trial diversion or suspended sentence.

Yes ☐ No ☐ . **If yes, please provide the following information:**

Name on Court records	SSN	Matter of the Offense	Date of the Conviction	Sanction Period of the Offense if you were sanctioned by Federal Office of the Inspector general(OIG)

C) Has anyone on the list in 3a ever been **Debarred** from participation in Federal Government contracts? **"Debarred**" means someone is not allowed to participate in contracts paid for by the Federal government, whether or not those contracts are in the health care area. Yes ☐ No☐

If 'Yes' is checked, provide the following information:

When the individual was debarred	Length of Debarment	Reason for Debarment

D) Has any person on the list in 3a ever been **Excluded** from participation in Federal health care programs (Medicare, Medicaid, CHIP or TRICARE) in the past

Yes ☐ No☐ If "Yes", please supply the following information:

Name of Individual	Beginning date of exclusion or termination	End date of exclusion or termination	Reason for exclusion or termination

E) Have anyone on the list in 3a ever been terminated from a State's Medicaid or SCHIP programs for reasons having to do with Program Integrity(fraud or abuse)?

Yes ☐ No☐ **If "Yes", please supply the following information:**

State of practice when terminated	Reason for termination	Date of termination

F) Has any person on the list in 3a ever had **Civil Monetary Penalties (CMPs)** assessed against them?

Yes ☐ No ☐ **If "Yes", please supply the following information:**

Name Of Individual	State of practice when CMP assessed	Reason for CMP	Amount of CMP	Date of CMP

IV. Signature

Amerigroup, the State or Federal Medicaid agency may refuse to enter into, renew, or terminate an agreement with a Provider if it is determined that a Provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106. The signature below **MUST** be the written signature of the Provider;

Name of Provider Person (Printed)	Signature of Provider Person	Date

Name of person completing form	Phone number of person completing form

ATTESTATION AND INFORMATION RELEASE AUTHORIZATION

All information provided in this or in connection with this application is complete and accurate to the best of my knowledge, and I shall immediately notify AMERIGROUP Community Care of any changes thereto. I understand that this application does not entitle me to participation in AMERIGROUP. By applying for appointment as an AMERIGROUP Participating Provider, I authorize the Plan, its medical director and appropriate representatives to consult with administrators and members of medical staffs of hospitals or other institutions where I currently have or have had admitting privileges and others with which I have been associated, including past and present malpractice carriers who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by AMERIGROUP, its medical director and appropriate representatives of all records and documents, excluding medical records of non-members of AMERIGROUP's Plans at other hospitals, that may be material to an evaluation of any professional qualifications and competence to carry out the clinical privileges requested, as well as my moral and ethical qualifications for Participating Provider status with AMERIGROUP. I hereby release AMERIGROUP and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby release any individuals and organizations from any liability who provide information to AMERIGROUP or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the Participating Physician or Group Agreement between me or my Group and AMERIGROUP, as such terms may be applicable to me.

I understand that as an applicant for participation in AMERIGROUP, I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from AMERIGROUP, I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the Credentialing Committee, if they so request. I further understand that I may appeal the Committee's decision either in writing or by appearance before the Credentialing Committee, if they so request.

Signature _____ Date _____

ENCLOSURES:

Please submit all applicable documents, from the list below, with your completed and signed application. Failure to provide this information will prohibit AMERIGROUP from completing your credentialing and/ or contracting process.

1. Five or more years of continuous work history/resume/CV including month and year and explaining any gaps of six months or more.
2. A copy of your current malpractice face sheet with coverage amounts and the effective and expiration dates.
3. Any explanation requested on this application.
4. Any explanation of malpractice cases settled for $250,000 or more within the past five years.
5. If you do not have a current DEA number, submit a copy of your current CDS Certificate.

Are you interested in participating in an AMERIGROUP committee on Credentialing, Medical Advisory, Peer Review or Quality Improvement? Yes ☐ No ☐