https://providers.amerigroup.com

Individual physician and Allied Health professional application and information release form – Amerigroup Iowa, Inc.

Provider identification			
Last name:	First name:	MI:	Degree:
Date of birth:	Social Security number (**REQUIRED**):	Sex: Male ☐ Female ☐	
Iowa Medicaid number:	Drug Enforcement Administration (DEA) number:		
Medicare number:	Consumer Directed Services (CDS) number:		
EPSDT certified? Yes ☐ No ☐	NPI number:		
Email address:			
In order to meet 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: PCP ☐ 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)/specialization(s), 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:

___ Addiction medicine (00)
___ Adolescent medicine (01)
___ Allergy (02)
___ Allergy/immunology (03)
___ Anesthesiology (AA)
___ Anesthesiology hospital-based (04)
___ Anesthetist, nurse (AB)
___ Anesthetist, nurse hospital-based (AN)
___ Audiologist (AD)
___ Cardiac electrophysiology (38)
___ Cardiology (CA)
___ Certified addiction counselor (CC)
___ Certified nurse practitioner (85)
___ Child protection/abuse specialist (CP)
___ Chiropractic (82)
___ Critical care medicine (06)
___ Critical care medicine hosp-based (CM)
___ Cytopathology hospital-based (07)
___ Dermatology (08)
___ Dermatopathology hospital-based (09)
___ Dietitian/nutritionist (DT)
___ Emergency medicine (11)
___ Emergency medicine hosp-based (EM)
___ Endocrinology/metabolism (12)
___ Family practice (13)
___ Family practice nurse practitioner (FP)
___ Gastroenterology (14)
___ General practice (15)
___ Genetics (16)
___ Geriatric medicine (17)
___ Geriatric med. nurse practitioner (GM)
___ GYN nurse practitioner (GN)
___ Gynecologic oncology (18)
___ Gynecology, no OB (19)
___ Hand therapy (HT)
___ Hematology (20)
___ Hematology/oncology (37)
___ HIV specialist (HI)
___ Immunology (21)
___ Infectious diseases (22)
___ Internal medicine (23)
___ Licensed clinical social worker (SW)
___ Licensed marriage/family therapist (FT)
___ Licensed professional counselor (LP)
___ Maternal/fetal medicine (24)
___ Midwifery (WF)
___ Neonatal nurse practitioner (NE)
___ Neonatal/perinatal medicine (25)
___ Neonatology (NO)
___ Nephrology (26)
___ Neuro-ophthalmology (64)
___ Neurology (27)
___ Neuropathology (28)
___ Nuclear medicine (29)
___ Nuclear medicine hosp-based (NM)
___ OB-GYN nurse practitioner (93)
___ Obstetrics–no GYN (30)
___ Obstetrics/gynecology (31)
___ Occupational medicine (32)
___ Occupational therapist (OT)
___ Oncology (33)
___ Ophthalmology (34)
___ Osteopathic manipulative med. (AO)
___ Otolaryngology (35)
___ Pathology non hospital-based (39)
___ Pathology hospital-based (36)
___ Pathology, radio isotopic hospital-based (40)
___ Pediatric allergy/immunology (41)
___ Pediatric cardiology (42)
___ Pediatric critical care medicine (43)
___ Pediatric emergency medicine (88)
___ Pediatric emergency medicine hospital-based (PM)
___ Pediatric endocrinology (44)
___ Pediatric gastroenterology (45)
___ Pediatric hematology/oncology (46)
___ Pediatric infectious diseases (89)
___ Pediatric nephrology (47)
___ Pediatric neurology (48)
___ Pediatric nurse practitioner (90)
___ Pediatric otolaryngology (PY)
___ Pediatric pathology (49)
___ Pediatric PKU/lead poisoning (PP)
___ Pediatric pulmonology (50)
___ Pediatric rheumatology (91)
___ Pediatric surgery (51)
___ Pediatric urology (PU)
___ Pediatrics (52)
___ Pediatrics, developmental (92)
___ Perinatology (PE)
___ Physical medicine, rehabilitation (54)
___ Physical therapist (PT)
___ Physician assistant (PA)
___ Podiatry (55)
___ Proctology (PR)
___ Psychiatric nurse practitioner (PN)
___ Psychiatry (56)
___ Psychiatry, child (57)
___ Psychiatry, geriatric (58)
___ Psychology (PS)
___ Psychology, child (PC)
___ Pulmonary diseases (60)
___ Radiation oncology (61)
___ Radiation oncology hosp-based (RY)
___ Radiation therapy (62)
___ Radiation therapy hospital-based (RD)
___ Radiologist (63)
___ Radiologist hospital-based (RA)
___ Radiologist, nuclear (65)
___ Radiologist, nuclear hospital-based (RN)
___ Reproductive endocrinology (66)
___ Retinal diseases (68)
___ Rheumatology (67)
___ Speech therapist/pathologist (SP)
___ Sports medicine (SM)
___ Substance abuse (ZI)
___ Surgery, cardiothoracic (95)
___ Surgery, cardiovascular (69)
___ Surgery, colon and rectal (70)
___ Surgery, endoscopic (EN)
___ Surgery, general (71)
___ Surgery, hand (73)
___ Surgery, head and neck (SH)
___ Surgery, neurological (75)
___ Surgery, oculoplastic (SO)
___ Surgery, oral/maxillofacial (76)
___ Surgery, orthopedic (77)
___ Surgery, plastic (78)
___ Surgery, thoracic (79)
___ Surgery, vascular (72)
___ Surgical critical care (80)
___ Toxicology (TO)
___ Toxicology, med. hosp-based (TM)
___ Urology (81)

Individual physician and Allied Health professional application and information release form

Primary office/service address			
Practice location name:			
Street, suite:			
City:	State:	ZIP:	County:
Phone:	Fax:	Primary contact:	
Does provider bill from this address? ☐ Yes ☐ No			
Does this office meet Americans with Disabilities (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 Independent Physician Association [IPA] name):			
Street, suite:			
City:	State:	ZIP:	Phone:
Federal tax ID number (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:
TIN:			

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

Individual physician and Allied Health professional application and information release form

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 your 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 your current licensure)			
State:	License number:	Date of license:	Expiration date:
State:	License number:	Date of license:	Expiration date:

Laboratory services (attach a copy of Clinical Laboratory Improvement Amendments [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 # _____

Individual physician and Allied Health professional application and information release form

Hospital affiliations (If you do not have hospital privileges, please complete the attached Inpatient Admitting Certificate [IAC] form.)		
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 (NPI)	
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 five 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."**

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 of any changes thereto. I understand that this application does not entitle me to participation in the Amerigroup network. 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 nonmembers of Amerigroup 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 that 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 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/curriculum vitae including month and year and an explanation of 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. A copy of your current DEA number or current CDS certificate.
6. IAC for medical doctors, doctors of osteopathic medicine and midwives that do not have hospital privileges (Surgeons and OB-GYNs must have their own admitting privileges. IAC is **NOT** acceptable).

Are you interested in participating in an Amerigroup committee on credentialing, medical advisory, peer review or quality improvement? Yes ☐ No ☐

Amerigroup

Disclosure form for a provider person

Directions: Please answer all questions. For any "Yes" response, please provide an explanation. If you do not believe a question is applicable to you, you should answer the question "N/A." **All questions must either have a "Yes," "No" or "N/A."**

Incomplete forms will be returned to the provider and will delay processing of credentialing and recredentialing forms. Dates of birth and Social Security numbers (SSNs) must be provided for validation purposes, as outlined in 42 CFR455.104 (b)(1)(ii).

I. Identifying Information

Provider person full name:	SSN:	Date of birth (DOB):	NPI number:	Medicaid ID number:	
Provider person 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 doing business as (DBA) name (if different from provider entity name):	Provider entity address (If you have more than one practice location, list all locations):
Provider entity TIN:	Provider NPI:	Medicaid ID 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 pleaded guilty, nolo contendere, best interest plea or pretrial diversion or suspended sentence.
Yes ☐ No ☐ If "Yes," please provide the following information. If "No," go to the next question.

Name on court records:	SSN:	Matter of the offense:	Date of the conviction:	Sanction period of the offense (if you were sanctioned by the 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," please provide the following information. If "No," go to the next question.

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 Iowa Department of Human Services (DHS) and/or the OIG that they may no longer be a provider for any federally funded health care program.
Yes ☐ No ☐ If "Yes," please supply the following information. If "No," go to the next question.

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 program for a cause related to fraud or abuse.
Yes ☐ No ☐ If "Yes," please supply the following information. If "No," go to the next question.

State of practice when terminated:	Reason for termination:	Termination date:

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 health care program.
Yes ☐ No ☐ If "Yes," please provide the following information. If "No," go to Section III.

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 (e.g., sign contracts, mortgages, leases or other management transactions obligating the proprietor).

Name of managing employee or agent:	SSN:	DOB:	Address:	City:	State:	ZIP:

B) Has any person listed in III-A 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 pleaded guilty, nolo contendere, best interest plea, or pretrial diversion or suspended sentence.
Yes ☐ No ☐ If "Yes," please provide the following information. If "No," go to the next question.

Name on court records:	SSN:	Matter of the offense:	Date of the conviction:	Sanction period of the offense (if you were sanctioned by the federal OIG):

C) Has anyone on the list in III-A 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," please provide the following information. If "No," go to the next question.**

When the individual was debarred:	Length of debarment:	Reason for debarment:

D) Has any person on the list in III-A ever been **excluded** from participation in federal health care programs (Medicare, Medicaid, CHIP or TRICARE) in the past?

Yes ☐ **No** ☐ **If "Yes," please provide the following information. If "No," go to the next question.**

Name of individual:	Beginning date of exclusion or termination:	End date of exclusion or termination:	Reason for exclusion or termination:

E) Has any person on the list in III-A 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 provide the following information. If "No," go to the next question.**

State of practice when terminated:	Reason for termination:	Termination date:

F) Has any person on the list in III-A ever had **CMPs** assessed against them?

Yes ☐ **No** ☐ **If "Yes," please provide the following information. If "No," go to the next question.**

Name of individual:	State of practice when CMP assessed:	Reason for CMP:	Amount of CMP:	Date of CMP:

IV. Signature

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: