America's PPO®

America's PPO Network Application

Corporate entity name	
Facility contract manager	

Billing information

Legal entity name	
NPI number	
Address	
City/state/ZIP	
Phone number	
Fax number	
Billing manager name	
Billing manager phone	
Billing manager email	
Able to submit claims electronically?	○ Yes / No ○

Site information

Name (site 1)		Name (site 1)	
NPI number		NPI number	
Address		Address	
City/state/ZIP		City/state/ZIP	
County		County	
Phone number		Phone number	
Fax number		Fax number	
Email address		Email address	
Facility website		Facility website	
Hospital affiliation		Hospital affiliation	
Tax ID number		Tax ID number	

*Attach additional sheets as necessary

Provider information

Last name	First name, middle initial	Title	NPI number	Primary specialty	Site number

*Attach additional sheets as necessary

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Facility application

(Please print)

Contract legal entity

Name: _____

Address: _____

_____ County: _____

Requested effective date: _____

Phone: _____ Fax: _____

Federal tax ID number: _____ NPI: _____

Please complete attached W-9 forms and turn in with application

The facility is (check all that applies):

- ☐ Acute care
- ☐ Free-standing surgical center
- ☐ Chemical dependency rehabilitation
- ☐ Physical rehabilitation
- ☐ Pediatric
- ☐ Psychiatric
- ☐ Skilled nursing
- ☐ Other: _____

Billing information

_____ County: _____

Billing address

_____ Phone: _____

Billing manager: _____ Phone: _____

Billing office manager: _____ Phone: _____

Email address: _____

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Other information

Able to submit claims electronically? ○ Yes / ◉ No Contact name:_____

Phone:_____

Office hours: M-F_____ Sat._____ Sun._____

List any special clinic services (IE: Laboratory, imaging services):_____

List any languages spoken by clinic staff other than English:_____

Website address:_____

What year was the facility established:_____

The facility is (check all that applies):

☐ Privately owned ☐ Publicly held

☐ For profit ☐ Not for profit

☐ Other (please specify) _____

Outreach/secondary locations

Please include street address, city, state, and the area code with the phone number

_____ County: _____

Second office address

_____ Phone: _____

_____ County: _____

Third office address

_____ County: _____

Hospital/clinic affiliations

Primary: _____

Others: _____

_____

Professional liability insurance

Malpractice carrier (include copy): _____ Policy number: _____

Amount of coverage: _____ Effective date: _____ Effective date: _____

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Licensure:

_____ Exp. date: _____
State medical license number (include copy)

_____ Date: _____
National Board of Medical Examiners number

Please check off all accreditation or regulatory agency approvals for the facility:

- ☐ American Osteopathic Association
- ☐ Commission of Accreditation of Rehabilitation (CARF)
- ☐ Joint Commission on Accreditations of Hospitals (JCAHO)
- ☐ Department of Public Welfare (Medicaid)
- ☐ Department of Health
- ☐ Medicare
- ☐ Department of Health, Office of Alcohol and Drug Programs
- ☐ Other: _____

Please complete and sign the below questionnaire

	(check one) Yes	No
Is the facility currently under review or have you ever been disciplined by any State Board of medical Examiners or by any Professional Conduct Board (If yes, please complete Exhibit Two):	○	◉
Have any malpractice suits, arbitrations, or other proceedings ever been instituted against the facility? (If yes, please complete Exhibit One)	◉	○
Has the facility license to practice medicine in any jurisdiction (state or county) ever been revoked, suspended, or subject to probation or any conditions or limitations? (If yes, please complete Exhibit Two)	○	◉
To the best of your knowledge, has any information pertaining to the facility ever been reported to the National Practitioner Data Bank? (If yes, please attach a copy of the report/s)	○	◉

_____
Facility name

_____
Printed name

_____ _____
Signature Date

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Exhibit One - Malpractice details

Please attach a copy of the actual legal document or complete the following. If you have been involved in more than one malpractice suit, please photocopy this form and complete one copy per occurrence.

File number: _____

Date of summons and complaint: _____

Date of incident: _____

Plaintiff(s) name: _____

Defendant(s) name: _____

Insurance company involved: _____

Policy number: _____

Complaint: _____

_____

_____

_____

_____

Stage of suit: _____

Date expected to be resolved: _____

Court date: _____

Detailed outcome of suit (include dollar amount of any settlement: _____

_____

_____

_____

_____

_____

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Exhibit Two - Disciplinary actions

Please describe any disciplinary actions taken by the State Board of Medical Examiners, Professional Conduct Board, medical organization, state or county agency. Please photocopy this form and complete one copy per occurrence if you have been disciplined more than once.

Date of original action: _____

Nature of misconduct: _____

_____

_____

_____

_____

Agency(ies) taking action: _____

Action taken: _____

Specific restriction or orders with which to comply: _____

_____

_____

_____

_____

_____

_____

_____

Subsequent action and date: _____

_____

_____

_____

_____

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Application authorization

The undersigned, with the purpose of filing application to be considered for participation status with America's PPO of Minnesota, attests that the enclosed information presented for review is truthful, accurate, and complete. Therefore, it is understood that any deviation from completeness or false representation of required information, will result in delay or omission of the application for review.

It is understood that America's PPO will use this information in the application review process. It is further understood that the following criteria, but not exclusively, may be used in the evaluation of an applicant for potential inclusion within the America's PPO provider network:

A. The America's PPO current need of an applicant's geographic region, to meet growing America's PPO membership needs.

B. Good Standing with the State Board of Medical Examiners and the governing agencies.

C. Maintenance of current licensure, DEA Registration, and adequate malpractice insurance coverage.

D. Commitment to the America's PPO maximum authorized reimbursement, based on CPT-$ procedure codes.

With respect to the above, the undersigned understands the terms of application and has provided all relevant information in response to the application request.

I hereby authorize all individuals, institutions, and entities with which I have been associated to release relevant information to America's PPO, and associated Third Party Payers.

I agree to notify America's PPO of any changes or updates to the information contained in this application during or, if accepted, after such acceptance to America's PPO network within 15 days.

I understand that all information contained within this application will be used in confidence and solely to review my application. I further understand that this application does not constitute an agreement, and grants to rights nor privileges until I receive notification of acceptance.

Name (please print): _____

Signature: _____ Date: _____

Please return to:

America's PPO
Attn: Credentialing
7201 West 78th Street
Suite 100
Bloomington, MN 55439