# MED CREDENTIAL PRO, LLC

https://medcredentialpro.com/

## PRACTICE INFORMATION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Group/Clinic Name (DBA): | | | | | | | |
| Name of EIN/TIN Registered with the IRS: | | | | | | | |
| Name of Owner(s): | | | Percentage of Ownership: | | | | |
| Office Hours: | Monday _____-_____ | Tuesday _____-_____ | Wednesday _____-_____ | Thursday _____-_____ | Friday _____-_____ | Saturday _____-_____ | Sunday _____-_____ |
| Practice Limitations: | Minimum Age: | Max Age: | Gender Limitation: Male | | ADA Accessibility requirements met? Yes No | Handicapped Acessible? Yes NO | |
| Language spoken at office: | | | | | | | |
| Physical Address: | | | | | | | |
| City: | | | State: | | Zip Code: | | |
| Phone: | | | Fax: | | | | |
| Office Contact Name: | | | Office Contact Email: | | | | |
| Billing Address (or specify if DAI billing client): | | | | | | | |
| City: | | | State: | | Zip Code: | | |
| Phone: | | | Fax: | | | | |
| Billing Contact Name: | | | Billing Contact Email: | | | | |
| Correspondence Address: | | | | | | | |
| City: | | State: | | Zip Code: | | | |
| Phone: | | | Fax: | | | | |
| Correspondence Contact Name: | | | Correspondence Contact Email: | | | | |
| Medical Record Address: | | | | | | | |
| City: | | State: | | Zip Code: | | | |
| Phone: | | | Fax: | | | | |
| Medical Records Contact Name: | | | Medical Records Contact Email: | | | | |

## CREDENTIALING INFORMATION

| | | |
|---|---|---|
| TID: | Group NPI: | Group Medicaid ID: |
| Group Medicare PTAN: | Railroad Medicare PTAN: | CLIA: |
| NPPES/PECOS User ID: | NPPES/PECOS Password: | |
| Specialty: | Taxonomy Code: | |

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| HOSPITAL AFFILIATIONS<br>(List Facility: Name, Address, Type of Privileges, Effective date of Privileges) |
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**REQUIRED MATERIALS**

PLease Supply a copy of all of the folowing documents that apply:

- Tax ID verification letter from the IRS
- Occupational License (If applicable)
- Acreditation (If applicable)
- Current Malpractice Polley
- Voided Check/Bank Letter
- W9
- Explanation to any licensures or clinical privileges ever being suspended, revoked, modified or restricted
- Explanation to any Malpractice cases
- Provide a list of any Managed Care Plans you are currently contracted with listing effective dates of contracts.

| AUTHORIZED OFFICIAL(S)<br>(Copy Page and submi for EACH authorized official) | |
|---|---|
| **Name:** | |
| **SSN:** | **Cell Phone:** |
| **Home Address:** | |
| **NPPES Login ID:** | **NPPES Password:** |
| **I authorize Doctor's Advantage to use my signature below for credentialing purpose.** | **Initials. __ _** |
| Signature of authorized signer for Group/Clinic (Please Keep Signature inside box)<br>** PLEASE USE SHARPIE OR ELECTRONIC SIGNATURE** | **Date:** |

**DISCLOSURE OF OWNERSHIP, BUSINESS TRANSACTIONS & EXCLUSIONS STATEMENT FOR PROVIDERS)**

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to managed care organizations that contract with the Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. **This statement must be completed whether or not you have any information to report.**

**OWNERSHIP & CONTROL INTERESTS (42 CFR 455.104)**

A. Please provide the following information for each Person with an Ownership or Control Interest in you as a Provider, or in any Subcontractor in which you, as a Provider, have direct or indirect ownership of 5% or more. If no such ownership exists, please indicate this with an "N/A."

| | Full Legal Name | Address | % of Owner | Interest | SSN or FEIN | Relationship |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |

B. If any Person with an Ownership or Control Interest listed in subsection IV (A) is related to another Person with an Ownership or Control Interest listed in section A as a spouse, parent, child or sibling, please complete the following section. If no such relationship exists, please indicate this with an "N/A."

| | Full Legal Name | Address | % of Owner | Interest | SSN or FEIN | Relationship |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |

C. For each Person with an Ownership or Control Interest listed in subsection IV (A) who also has an ownership or control interest in an organization other than those indicated in section A, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

| | Full Name of Business or Organization | Name of Other | Address | SSN or FEIN | % of Ownership Interest |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |

**SIGNIFICANT BUSINESS TRANSACTIONS (42 CFR 455.405)**

A. Please report your ownership of any Subcontractor with whom you as a Provider have had business transactions totaling more than twenty five thousand dollars ($25,000.00) during the previous twelve (12) month period ending on the date of this request. If no such ownership exists please indicate this with an "N/A."

| | Full Legal Name | Address | SSN or FEIN | Reason |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

B. Please report any Significant Business Transactions between you as a Provider and any Wholly Owned, Supplier, or between you as a Provider and any Subcontractor, during the previous five (5) year period ending on the date of this request. If no such business transactions exist, please indicate this with an "N/A."

| | Name of Wholly Owned Supplier | Address | SSN or FEIN | Nature of Business Transactions |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |