Dear Practitioner,

The TGH Entities' Provider Enrollment Intake Form must be completed in its entirety to ensure accurate enrollment into applicable payors and insurance plans.

- Complete and accurate information received in a timely fashion significantly speeds what can be a very time-consuming process.
- All data is kept strictly confidential.
- The organization will not discriminate or base credentialing decisions on an applicant's race, ethnicity or language and that providing the information is optional.

Please feel free to contact the Managed Care department at managedcarecred@tgh.org if you have any questions.

Provider Enrollment/Credentialing Intake Application

General Information:

Start Date-

Provider's Legal Name (**per social security card**): Degree(s):

Any other names used: Date used:

Date of Birth: Sex: SS#: Place of Birth:

Primary Specialty: Secondary/Subspecialty:

Florida State License #: Other State License #: State:

NPI **: DEA#: State

Home Address:

Email address: Cell phone #:

Languages spoken by provider other than English:

Ethnicity: Race:

**Note: If you have NOT obtained or applied for your NPI number please apply at https://nppes.cms.hhs.gov/NPPES/Welcome.do and provide NPI# to Managed Care upon receipt.

Education and Training:

Undergraduate Education:

Institution Name:

Institution Address:

Institution Tel #: Fax#:

Start Date (MM/YYYY): Completion Date (MM/YYYY):
Major:

Medical School/Graduate School:

Institution Name:

Institution Address:

Institution Tel #: Fax#:

Start Date (MM/YYYY): Completion Date (MM/YYYY):

Major:

Internship:

Institution Name:

Institution Address:

Institution Tel #: Fax#:

Start Date (MM/YYYY): Completion Date (MM/YYYY):

Specialty:

Primary Residency:

Institution Name:

Institution Address:

Institution Tel #: Fax#:

Start Date (MM/YYYY): Completion Date (MM/YYYY):

Specialty:

Secondary Residency/Fellowship (Please Indicate)

Institution Name:

Institution Address:

Institution Tel #: Fax#:

Start Date (MM/YYYY): Completion Date (MM/YYYY):

Specialty:

Additional Residency/Fellowship (Please Indicate):

Institution Name:

Institution Address:

Institution Tel #: Fax#:

Start Date (MM/YYYY): Completion Date (MM/YYYY):

Specialty:

Please use separate sheet of paper for any additional training.

Board Certifications:

Primary Practicing Specialty:

Specialty: Date Originally Certified:

Name of Board: Date of Expiration:

Certificate #:

Secondary Practicing Specialty: Practicing

Specialty: Date Originally Certified:

Name of Board: Date of Expiration:

Certificate #:

Additional Specialty: Practicing

Specialty: Date Originally Certified:

Name of Board: Date of Expiration:

Certificate #:

If you are not Board Certified: (Please enter N/A if board certification does not apply)

Are you Board qualified/eligible?

As of what date?

Are you scheduled to sit for the Exam? Date of Exam:

Professional References:

1.) Name: Title/Degree: Specialty:

Mailing Address:

Tel #: Fax#: Email address:

2.) Name: Title/Degree: Specialty:

Mailing Address:

Tel #: Fax#: Email address:

3.) Name: Title/Degree: Specialty:

Mailing Address:

Tel #: Fax#: Email address:

Professional Malpractice Liability History:

If you do **NOT** have malpractice liability history (judgment, settled, dismissed, or pending), please sign here:

Professional Malpractice Liability History (continued):

If you have judgments, settlements, dismissed or pending cases complete the following:
(If more than one case please use separate sheet and provide requested information)

All questions must be answered completely. Please complete a separate page for each action and provide additional information if necessary. Duplicate pages are included.

Date of alleged incident: _____ Date suit filed: _____
(if no suit filed, please indicate this)
County / State where filed: _____

Present Status
❑ Open / Pending
❑ Dismissed / Withdrawn
❑ Closed Claim – Date Closed: _____
❑ Mediation
❑ Arbitration
❑ Judgment for Defendant(s)
❑ Judgment for Plaintiff(s)
❍ Settlement/Amount $_____ ❍ Judgment/Amount $_____

Plaintiff Name: _____

Allegation: _____
_____
_____
_____

Professional Liability Insurer at time of Incident: _____
Professional Liability Insurer Complete Address: _____
Phone: _____ Policy Number: _____
Your attorney in this action: _____

Describer your role in the incident: ❑ Primary defendant ❑ Co-Defendant
Additional Defendant(s) _____

Your Involvement in the Case (Attending, Consulting, Etc.): _____
Description of Alleged Injury to the Patient: _____
Did the Alleged Injury Result in Death: _____
To the best of your knowledge, is the case included in the National Practitioner Data Bank (NPDB)? Y / N

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative which describes your care and treatment of this patient. Include detail to allow proper evaluation by a committee of physicians: _____
_____
_____
_____

Questions:

Did you attend Medical School outside of the United States?

If you answered yes: ECFMG Certificate Number: Date Issued:

Please list hospitals where you currently hold privileges?

You will be receiving an email from "CMS I&A Connection Request" this email will be asking for approval for Tampa General surrogacy for your account. Please approve this request.

Website Username and Passwords

Fl Medicaid:

Florida Medicaid Username: Florida Medicaid Password:

FL Medicaid Log In Information *** Please call 800-289-7799, option 5 to obtain log-in information if you are enrolled in Florida Medicaid. Website is https://public.flmmis.com

CAQH

If you have enrolled or applied for your CAQH number please provide it below and submit the user ID and password along with your application. If you are currently enrolled in health plans, you likely have a CAQH ID. If you do not have your ID, please call (888) 599-1771, option 1, to obtain your CAQH ID and log-in information. https://upd.caqh.org/oas/

CAQH Number:

CAQH User ID:

CAQH Password:

If you have NOT enrolled or applied for your CAQH number Tampa General Medical Group will apply and obtain your CAQH number for you.

Work History:

Please list information requested for the last **five years in MM/YYYY format.**

Please be sure to explain any gaps of more than **six months.**

From: To:

Employer Name:

Address:

Tel#: Fax: Email:

From: To:

Employer Name:

Address:

Tel#: Fax: Email:

From: To:

Employer Name:

Address:

Tel#: Fax: Email:

From: To:

Employer Name:

Address:

Tel#: Fax: Email:

From: To:

Employer Name:

Address:

Tel#: Fax: Email:

Please use this space to explain any gaps of six months or more

DEA Attestation and Waiver

I, , agree that during any time that I do not have a current/valid DEA certificate, I will not write prescriptions for any drugs that require a DEA certificate.

I, , attest that I will not write prescriptions for drugs that are not covered under the Schedules on my current/valid DEA certificate.

Please complete the below two questions if you do not have a DEA

I, , attest that I have applied for my DEA certificate on .

I, , do not have a current/valid DEA certificate currently because:

Covering providers with current/valid DEA certificate will provide prescription writing coverage as required by patient need.

Provider Printed Name:

Covering Provider DEA Number:

Provider Signature:

Date:

Authorization and Release of Information
To Designated Contacts

I hereby consent to, authorize, and release from liability CAQH, its agents, and CAQH affiliated vendors to release access to my application data, as it relates to the completion and maintenance of the provider credentialing data contained therein, as long as this information is provided in good faith and without malice, unless such acts are due to the gross negligence or willful misconduct of CAQH, its agents, and any CAQH affiliated vendors, to:

1.) **Jennifer Feierabend** of **Tampa General Hospital** who may be reached at **jfeierabend@tgh.org**

and/or

2.) **Sandra Bruneau** of **Tampa General Hospital** who may be reached at **sbruneau@tgh.org**

Of the information to be released, to the delegated authorized party (or parties) as specified above, includes my CAQH Provider ID number, CAQH ProView Username, and Primary Method of Contact.

I understand that a photocopy or facsimile of this Authorization and Release form shall be as effective as the original when so presented, unless canceled by me in writing.

_____ _____

Printed Name of Provider **CAQH ID Number**

X_____ _____

Signature of Provider **Date of Signature**

Expiration of Authorization

Valid for up to 3 years

(Providers please note, if an expiration date is not included, your letter will expire three years from the date the letter was received by CAQH.)

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8 — Disclosure Questions

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

Allied Health Providers

If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".

LICENSURE

1. ☐ YES ☐ NO — 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?*

2. ☐ YES ☐ NO — Has there been any challenge to your licensure, registration or certification?*

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. ☐ YES ☐ NO — Have your clinical privileges or medical staff membership at any hospital or healthcare institution, 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 healthcare institution, medical staff or committee, or governing board?*

4. ☐ YES ☐ NO — Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*

5. ☐ YES ☐ NO — 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 (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*

EDUCATION, TRAINING AND BOARD CERTIFICATION

6. ☐ YES ☐ NO — Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*

7. ☐ YES ☐ NO — Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*

8. ☐ YES ☐ NO — Have any of your board certifications or eligibility ever been revoked?*

9. ☐ YES ☐ NO — Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

10. ☐ YES ☐ NO — Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

11. ☐ YES ☐ NO — Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*

OTHER SANCTIONS OR INVESTIGATIONS

12. ☐ YES ☐ NO — Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or 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 a sexual offense or sexual misconduct?*

13. ☐ YES ☐ NO — To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*

14. ☐ YES ☐ NO — Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*

15. ☐ YES ☐ NO — Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*

16. ☐ YES ☐ NO — Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. ☐ YES ☐ NO — Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*

18. ☐ YES ☐ NO — Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

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Secti n 8 — Discl sure Questions (Continued)

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

IMPORTANT
If you answered "Yes" to **question #19**, you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.

MALPRACTICE CLAIMS HISTORY

19. ☐ YES ☐ NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?* If yes, provide information for each case.

CRIMINAL/CIVIL HISTORY

20. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*

21. ☐ YES ☐ NO In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*

22. ☐ YES ☐ NO Have you ever been court-martialed for actions related to your duties as a medical professional?*

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.

ABILITY TO PERFORM JOB

23. ☐ YES ☐ NO Are you currently engaged in the illegal use of drugs?*
("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

24. ☐ YES ☐ NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*

25. ☐ YES ☐ NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*

26. ☐ YES ☐ NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

APPLICANT ACKNOWLEDGMENT AND CONSENT

I fully understand that any significant misstatements in, or omissions from this application constitute cause for denial of appointment/enrollment/credentialing or cause for summary dismissal from any entity for which I am appointed/enrolled or credentialed. All information submitted by me and/or on my behalf in this application is true, correct and complete, to my best knowledge and belief. I acknowledge that all files pertaining to my credentialing are considered privileged and confidential and access is limited to TGH Entities, its Staff and its representatives, as well as certain government and regulatory entities, as provided by applicable law, for the purpose of credentialing, enrollment, appointment and re-credentialing, reappointment, enrollment functions.

I acknowledge that I have received (or have had access to) and have read (or been given the opportunity to read) the current Credentialing Manual which includes applicable confidentiality policies and procedures.

By submitting my applications for enrollment/appointment to the contracted entities, health plans, payers, I:

1. Signify my willingness to fully cooperate in the submission and application process
2. Authorize TGH Entities to conduct provider enrollment services on behalf of myself and/or the institution where I am primarily employed
3. Authorize TGH Entities to consult with others who have been associated with me or who may have information bearing on my competence and qualifications
4. Consent to TGH Entities inspecting all records and documents that may be material to an evaluation of my professional qualifications and competence to carry out the clinical duties in my applying specialty I request, of my physical and mental health status and of my professional ethical qualifications
5. Release from any liability all TGH Entities for their acts performed in good faith and without malice in connection with evaluating me and my credentials
6. Release from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to TGH Entities in good faith and without malice concerning my competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for enrollment, appointment and credentialing
7. Authorize and consent to TGH Entities providing hospitals, medical associations, licensingboards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that TGH Entities may have concerning me, and release TGH Entities from liability for so doing, provided that such furnishing of information is done in good faith and without malice.

The term “TGH Entities" includes all staff members, contracted vendors and which have responsibility for collecting or evaluating the applicant’s credentials or acting upon his/her application; and any authorized representative of any of the foregoing. I understand and agree that I, as an applicant for provider enrollment and/or physician credentialing, have the burden of producing adequate and accurate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

Provider Signature:

Print Name: Date:

Practitioner Rights

The purpose of this section is to define a practitioner's right to review information obtained during the credentialing or recredentialing process and to correct erroneous information or information that varies substantially from what the practitioner supplies.

Upon submission of an application for credentials or re-credentialing, the practitioner has the following rights:

1. The practitioner has the right to review certain information submitted to support their credentialing application.
    a. The practitioner may review information provided to the Organization by outside sources (i.e. malpractice insurance carriers, state licensing boards).
    b. The practitioner may not review information provided to the Organization by personal references or any other peer review protected information.
2. The practitioner has the right to correct any erroneous information.
    a. The practitioner will be notified in writing by regular mail or email when credentialing information is received that varies substantially from the information provided by the practitioner.
    b. The practitioner's response to correct erroneous information must be submitted in writing to the Managed Care department within the specified timeframe dictated by the Managed Care department.
    c. Receipt of the practitioner's response will be confirmed with the practitioner and/or designee by the Managed Care department and documented in the practitioner's file.
3. The practitioner has the right to receive information regarding the status of their credentialing or re- credentialing application upon request.
    a. All requests regarding the status of the credentialing or re-credentialing process must be submitted in writing or verbally to the Managed Care department.
    b. The Managed Care Department shall have two (2) weeks to respond to any requests for the current status of an application.
    c. Response to requests for credentialing or re-credentialing status shall be made in writing or verbally.
    d. No information regarding the deliberations or decisions of the reviewing parties shall be provided to the practitioner.

Provider Signature:

Print Name: Date: