



APPENDIX A

The Provider represents that the information contained herein is true. In the event any representation becomes false in any respect during the term of this Agreement, the Provider shall immediately furnish the Plan in writing with the information necessary to correct representation.

GENERAL INFORMATION

Name _____ Title (i.e. MD, DO, DC, PT etc.) _____

Sex: Female Male

Date of Birth: _____

Birthplace _____ Citizenship _____

Practice Name _____

Office Address _____

Office Phone _____ Office Fax _____

Office Contact Person _____

Office Hours: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____

Billing Address (if different from above) _____

Email Address _____

Federal Tax ID Number _____

NPI Number _____

License Number _____

DEA Number (if applicable) _____

Medicare ID Number _____

Malpractice Insurance Carrier _____

Type of Practice (i.e. Family Practice, Multi-specialty, etc.) _____

Specialties _____

SPECIALTY BOARDS - BOARD CERTIFIED: YES NO

If Yes, in what specialties? _____

Please complete for each specialty:

Name of Board _____

Eligible Certified Recertified Date _____

Name of Board _____

Eligible Certified Recertified Date _____

Please attach evidence of board certification or your application to take board examination.

If not board certified, have you ever been examined by any specialty board but failed to pass? Yes No

INTERNSHIPS IF APPLICABLE

Name of Institution _____ Rotating _____ Dates _____

Name of Institution _____ Special _____ Dates _____

Name of Institution _____ Other _____ Dates _____

If more than one Internship was completed, please supply the same information on a separate sheet and attach.

MEDICAL SCHOOL NAME(S) AND DATES GRADUATED IF APPLICABLE

Undergraduate _____ Degree _____ Date _____
Address _____

Professional School _____ Degree _____ Date _____
Address _____

Professional School _____ Degree _____ Date _____
Address _____

If medical or other professional school was not in the United States, please attach copy of ECFMG certificate.

FELLOWSHIPS: YES NO If Yes, please provide the following information on a separate sheet and attach: Name and Address of Institution, Department Chairperson (current), Type of Fellowship, and Dates.

MEDICAL FACILITY AFFILIATION IF APPLICABLE

List all medical facility affiliations, past and present, in chronological order including dates, and complete address for each facility. Please copy and complete this form if additional space is needed.

_____	_____
Current Hospital Name and Department	Hospital Department Name
_____	_____
Address	Address
_____	_____
City State zip	City State zip
_____	_____
Dates of Affiliation: From _____ To _____	Dates of Affiliation: From _____ To _____

Do you participate with any other PPO? Yes No
If Yes, Please list _____

Do you participate with: Blue Shield Keystone Medicare Medical Assistance

Please identify the name of the physician(s) who provide coverage for your patients when you are unavailable.

_____	_____	_____
Name	Address	City, State, Zip
_____	_____	_____
Telephone	Fax	Specialty
_____	_____	_____
Name	Address	City, State, Zip
_____	_____	_____
Telephone	Fax	Specialty

OTHER: GROUP PRACTICE INFORMATION IF APPLICABLE

Group Name _____
Group Address _____
Group Telephone & Fax _____

THE FOLLOWING DOCUMENTS ARE REQUIRED AND MUST BE ATTACHED TO THIS FORM AND RETURNED BEFORE A PROVIDER CAN BE ADDED TO THE VANTAGE PPO PANEL OF PROVIDERS:

- COPY OF DEA LICENSE (IF APPLICABLE)
- COPY OF STATE LICENSE
- CURRENT CERTIFICATE OF MALPRACTICE INSURANCE
- FEDERAL DEA NUMBER (IF APPLICABLE)
- VERIFICATION OF BOARD STATUS (IF APPLICABLE)

DELINEATION AND VERIFICATION OF FULL HOSPITAL PRIVILEGES (IF APPLICABLE)

SIGNED RELEASE OF INFORMATION

CONFIDENTIAL PROVIDER INFORMATION (IF APPLICABLE)

Please check your response to each question below. If any response is "YES", attach a supplement page with a detailed description of dates and circumstances.

1. A. Are you now, or have you ever been involved in any malpractice suit, including arbitration?
 Yes No
- B. Has any malpractice claim settlement, not involving litigation or arbitration, ever been paid by you or paid on your behalf?
 Yes No

If the answer to either of the above questions is YES, please attach the following information for each suit or settlement. Your application cannot be processed if the following information is not provided. Please obtain this information from your insurer if necessary.

- Date and details of the incident(s) leading to the suit or settlement
- Professional liability insurer involved
- Your status in any suit or other legal action (Primary Defendant, Co-Defendant, Other)
- Amount reserved by carrier for each claim, amount paid as an out-of-court settlement, or amount of jury or court award
- Date of suit or settlement
- Your role in the incident(s)
- Subsequent events, including patient outcome
- Current status of suit or other legal action

2. Has your professional liability insurance ever been denied, suspended, canceled, or not renewed?
 Yes No

3. A. Are you unable to perform the essential functions of the position for which you are requesting to be contracted, with or without an accommodation? Yes No
- B. Are you currently using any illegal drugs? Yes No

4. Have you ever had any of the following items denied, revoked, suspended, not renewed, placed under probation, subjected to disciplinary action, or otherwise limited or curtailed, or have you voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items?

State License	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DEA Registration or other Narcotic License	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hospital or other Health Care Facility Staff/Membership of Privileges	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Professional Organization Membership	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medicare, Medicaid, or other Government Program Participation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HMO, PPO, or other Prepaid Health Plan Participation	<input type="checkbox"/> Yes	<input type="checkbox"/> No

5. If you have ever been employed as a physician by a military service, hospital, or an HMO or any other Health Care Organization, was your employment ever terminated by the employer?
 Yes No N/A (not applicable)
6. Have you ever been convicted of a crime, other than a traffic offense, or are you currently under indictment for an alleged crime? Yes No
7. Has the scheduling of any hospital review of your privileges become more frequent than the regularly scheduled reviews of every 2-3 years? Yes No
8. Has your clinical training ever been interrupted, terminated or placed on probationary status?
 Yes No
9. Have you ever been involved in state agency action or a National Practitioner Data Bank reportable incident? Yes No
10. Have you ever received a warning or censure for Quality Assurance or over-utilization by a hospital, Medicare, HMO, etc?
 Yes No

11. Have you completed such continuing medical education courses as required by state law?

Yes No

APPLICANT'S CONSENT AND RELEASE

- A. I hereby apply for a contract with Vantage to act as a participating provider. I agree to provide Vantage with updated current information regarding all questions on this application form as such information becomes available and such additional information as may be requested by Vantage or its authorized representatives.
- B. I certify that the information given in or attached to this application is accurate and complete to the best of my knowledge, information and belief.
- C. I accept the following conditions regardless of whether or not I enter into a contract with Vantage.
 - 1. I extend absolute immunity to, and release from any and all liability, Vantage and its authorized representatives and any third parties, as defined in subsection (3) below, for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, performed, made, requested or received by Vantage and its authorized representatives to, from, or by any third party, including otherwise privileged or confidential information, relating, but not limited to, this application as well as the following:
 - (a) Vantage contract termination or any other disciplinary sanction imposed by Vantage;
 - (b) Vantage or other required governmental, utilization or quality management review procedures;
 - (c) Matters or inquiries concerning my professional qualifications or credentials, including but not limited to, licensure, professional liability insurance coverage, participation in private or governmental insurance programs, specialty board certification or continuing education, or any other matter relevant to this application.
 - 2. I specifically authorize Vantage and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, or any other matter bearing on my satisfaction of the criteria for eligibility as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties relating to such questions. I also specifically authorize and direct said third parties to release said information to Vantage and its authorized representatives upon request.
 - 3. The term "Vantage and its authorized representatives" means Vantage, its affiliates, and any individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application including, but not limited to, the members of the Vantage Board of Directors and their appointed representatives, committees authorized by said Board, the President or his designees, other employees, consultants to Vantage, Vantage's attorneys and their partners, associates or designees. The term "third parties" means all individuals, government agencies, organizations, associations, partnerships and corporations, from whom information has been requested by Vantage and its authorized representatives, including but not limited to hospitals where I have been granted medical staff appointment or clinical privileges.

Date _____

BY

Signature of Applicant

Printed/Typed Name of Applicant

VANTAGE PPO

BY _____

Chief Executive Officer