



Dear Provider:

Attached is a provider application and supplemental enrollment form that Virginia Premier Health Plan, Inc. (VPHP) is requesting that you complete and return along with the credentialing documents. Please carefully review the supplemental enrollment form section(s) entitled ***Company Ownership/Control Interest Statement and Disclosure of Business Transactions***. This is new to the provider participation process. All providers are required to complete this section in accordance with federal regulations 42 CFR 455.105 and 42 CFR 455.106. The form must be submitted with the application and signed by the owner otherwise; the provider participation process may be delayed.

Under federal regulations, providers entering into or renewing a provider agreement must disclose to the Department of Health and Human Services Secretary/Department, State Medicaid Agency and/or VPHP, on request, the identity of any excluded individual with an ownership or controlling interest in the provider entity. VPHP is contracted with the Department of Medical Assistance Services (DMAS), as a Medicaid Managed Care Health Plan. It is required to obtain this information from providers, in addition to the names of all individuals/entities having a five percent (5%) or more direct or indirect ownership or a controlling interest in the entity.

Below are practitioner rights in accordance to the National Committee for Quality Assurance (NCQA). Practitioners have the right to:

- Review information submitted to support their credentialing application.
- Correct erroneous information.
- Receive the status of their credentialing or re-credentialing application, upon request.
- Receive notification of these rights

Please use the application check-off list to ensure all items have been completed and included in your application. The credentialing process generally can take up to 180 days to complete. Incomplete information will certainly delay this process. If you have questions regarding the information or process, please call your Provider Services Representative or Contracting Specialists at (800) 727-7536.

Sincerely,

A handwritten signature in blue ink, appearing to read "Patrick McMahon".

Patrick McMahon
Vice-President, Network Development

A handwritten signature in blue ink, appearing to read "Jamie McPherson".

Jamie McPherson
Vice-President, Quality & Accreditation



PROVIDER APPLICATION CHECK-OFF LIST/SUPPLEMENTAL FORM

If you participate with Council for Affordable Quality Healthcare (CAQH), you do not need to complete the attached application. However, you are required to provide your CAQH number so VPHP can download application to start the credentialing process. If you would like to participate with CAQH or to request more information, go to www.CAQH.org.

Provider Name _____	CAQH Number _____
Practice Name _____	Tax ID Number _____
Group NPI # _____	Individual NPI #*: _____
VA Medicaid Number: _____	(*All applications must have a NPI number.)
Race/Ethnicity: (Please circle below which applies):	
American Indian/ Alaskan Native	Native Hawaiian/or other Pacific Islander
Not Hispanic or Latino	Black/ African American
Asian	White
Hispanic / Latino	Other _____
Language _____	
**If billing company is used: indicate name, address, phone number and name used to bill under: _____	
Are you serving as a PCP: Yes ☐ No ☐ Both ☐	
Primary Specialty: _____	Secondary Specialty: _____

- ☐ **Completed Application:** All sections must be completed. If the section is not applicable, please write "N/A". If space is not sufficient, please attach a separate sheet referencing which section the information is pertinent to. Not completing a section by indicating "See Attached" is not acceptable.
- ☐ **Signed Contract(s):** This is applicable to a new group requesting participation. **Note:** If you are joining a current participating group you will not need to return a contract.
- ☐ **Consent and Release Form:** Original signature and date required.
- ☐ **Curriculum Vitae:** Must include a current/updated 5-year work history (including the group for which the application is being submitted). Gaps greater than one month must be explained.
- ☐ **Malpractice Certificate:** Copy of current malpractice insurance (not to expire in 30 days)
- ☐ **Professional License Certificate:** Current copy of license.
- ☐ **Federal DEA Certificate:** Current copy.
- ☐ **IRS W-9 Form:** Please complete, sign and date according to the instructions provided.
- ☐ **Company Ownership/Controlling Interest:** Please complete, sign, date and return form with the credentialing application. If section is not applicable, please write "N/A". If space is not sufficient, please attach a separate sheet referencing which section the information is pertinent to.

Please mail information to:
VIRGINIA PREMIER HEALTH PLAN, INC.
ATTN: NETWORK DEVELOPMENT
P.O. BOX 5307
RICHMOND, VA 23220-0307



VIRGINIA PREMIER
HEALTH PLAN, INC.

P.O. Box 5307 • Richmond, VA 23220-0307 • (804) 819-5151 (O) • (804) 819-5171 (F)

APPLICATION FOR PRIVILEGES TO PARTICIPATE

To initiate your request for participation, please complete this application, provide current copies of the following information, and submit the complete packet to the Virginia Premier Health Plan, Inc. office within 30 days:

- Curriculum Vitae
- Malpractice Certificate
- Professional Reference Form
- Consent / Release Form
- Professional License Certificate
- Federal DEA Certificate

Please print or type. Complete all sections and if the space is insufficient, attach information/explanation and reference the section/question (not completing a section by indicating “see attached CV” is not acceptable). Only original and signed (no stamped signature) applications and consent and release forms shall be accepted.

Please submit your **Cultural Sensitivity or Cultural Competency Completion Certificate** along with your credentialing application. If you have not taken a course, please call 800-727-7536 ext. 5269 to get instructions on how to access the course offered by VPHP.

FOR OFFICE USE ONLY:

DATE APPLICATION MAILED:	INITIALS:	DATE APPLICATION RECEIVED:	INITIALS:
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PERSONAL DATA:

LAST NAME:		FIRST NAME:		MIDDLE NAME:	
Jr., Sr., Maiden, Other (include names under which you were enrolled or licensed):			MALE OR FEMALE:		
PROVIDER TYPE: (i.e. MD., DO, Other)		SPECIALTY:		SECONDARY SPECIALTY:	
☐ PRIMARY CARE PHYSICIANS ☐ SPECIALIST		RACE:		DATE OF BIRTH: (MM, DD, YY)	
				BIRTHPLACE:	
SOCIAL SECURITY NUMBER:		INDIVIDUAL NPI		IN ADDITION TO ENGLISH OTHER LANGUAGES SPOKEN:	
ECFMG CERTIFICATION NO. (if applicable)		CITIZENSHIP:		IF NOT CITIZEN OF THE UNITED STATES, STATUS OF YOUR VISA:	

LICENSURE:

LIST ALL CURRENT PROFESSIONAL LICENSE NUMBERS, STATE, EXPIRATION DATES, AND PROFESSION			
STATE	LICENSE NUMBER	EXPIRATION DATE	PROFESSION

LIST ALL CURRENT DRUG ENFORCEMENT ADMINISTRATION NUMBERS, STATE AND EXPIRATION DATES			
STATE	LICENSE NUMBER	EXPIRATION DATE	PROFESSION

OFFICE DATA:

PRACTICE TYPE ☐ SOLO ☐ GROUP ☐ INPATIENT		DATE STARTED AT PRACTICE	NAME OF PRACTICE	
PRIMARY OFFICE ADDRESS (No., Street, City, State, Zip)				
FEDERAL TAX ID. NO.	MEDICAID NO.	GROUP NPI		COUNTY
OFFICE HOURS:			CONTACT PERSON / OFFICE MANAGER	
TELEPHONE NO.:		24 HOUR TELEPHONE NO.:		FAX NO.:
EMAIL ADDRESS:				
BILLING ADDRESS (No., Street, City, State, Zip) (If different from primary office)				
MAILING ADDRESS (If different from primary address) (No., Street, City, State, Zip)			CREDENTIALING ADDRESS (If different from primary address) (No., Street, City, State, Zip)	

SECONDARY ADDRESS:

PRACTICE TYPE ☐ SOLO ☐ GROUP ☐ INPATIENT		DATE STARTED AT PRACTICE	NAME OF PRACTICE	
SECONDARY OFFICE ADDRESS (No., Street, City, State, Zip)				
FEDERAL TAX I.D. NO.	MEDICAID NO.	GROUP NPI		COUNTY
OFFICE HOURS:			CONTACT PERSON / OFFICE MANAGER	
TELEPHONE NO.:		24 HOUR TELEPHONE NO.:		FAX NO.:
ATTACH SEPARATE SHEET FOR ADDITIONAL OFFICE ADDRESSES				

PARTICIPATING PROVIDERS RENDERING COVERAGE AFTER HOURS OR IN ABSENCE

NAME	SPECIALTY	ADDRESS	TELEPHONE NO.
MEDICAID #/NPI			
MEDICAID #/NPI			
MEDICAID #/NPI			

IF YOU ARE IN A GROUP PRACTICE, PLEASE LIST THE OTHER PROFESSIONALS IN THE PRACTICE AND INDICATE IF THEY ARE PARTICIPATING OR APPLYING BY AN "X"

NAME	SPECIALTY	PARTICIPATING	APPLYING
MEDICAID #/NPI			
MEDICAID #/NPI			
MEDICAID #/NPI			

EDUCATION:**UNDERGRADUATE**

INSTITUTION NAME	ADDRESS & PHONE NO.	DEGREE	DATE GRADUATED

PROFESSIONAL

INSTITUTION NAME	ADDRESS & PHONE NO.	DEGREE	DATE GRADUATED

IF MORE PROFESSIONAL SCHOOLS WERE BEGUN OR COMPLETED, PLEASE ATTACH INFORMATION.

INTERNSHIPS:

INSTITUTION NAME	ADDRESS	TELEPHONE NO.	INTERNSHIP TYPE	BEGIN/END DATE

IF MORE INTERNSHIPS WERE BEGUN OR COMPLETED, PLEASE ATTACH INFORMATION.

RESIDENCIES:

INSTITUTION NAME	ADDRESS	TELEPHONE NO.	RESIDENCY TYPE	BEGIN/END DATE

IF MORE RESIDENCIES WERE BEGUN OR COMPLETED, PLEASE ATTACH INFORMATION.

FELLOWSHIPS:

INSTITUTION NAME	ADDRESS	TELEPHONE NO.	FELLOWSHIP TYPE	BEGIN/END DATE

IF MORE FELLOWSHIPS WERE BEGUN OR COMPLETED, PLEASE ATTACH INFORMATION.

BOARD CERTIFICATION:

BOARD NAME	SPECIALTY	CERTIFICATE NO.	CERT. DATE	EXP. DATE	RE-CERT. DATE	EXP. DATE

PLEASE CHECK YES OR NO FOR EACH QUESTION AND ANSWER QUESTIONS COMPLETELY

YES	NO

1. Has your board certification ever been suspended or revoked, or are such actions currently pending?

IF THE ANSWER TO QUESTION ONE (1) IS YES, PLEASE ATTACH A SHEET WITH DETAILED INFORMATION

2. If you are **not** board certified, are you eligible? If yes, on what date were you eligible?

Date: _____ If no, reason _____

3. If you are board eligible, please name the board(s) for which you are eligible.

Board(s) _____

HOSPITAL ADMITTING PRIVILEGES:

List your current admitting facilities. Please indicate category (staff status), and all departmental privileges including nature and extent of such privileges. **Complete address must be included.** If more affiliations, please attach information.

NAME THE HOSPITAL YOU CONSIDER YOUR CURRENT PRIMARY ADMITTING FACILITY: _____

FACILITY/ ORGANIZATION	ADDRESS	TELEPHONE NO.	CONTACT PERSON	DATES WORKED	STATUS/ PRIVILEGES	# OF ADM/MONTH	RESTRICTIONS

INSURANCE:

PRESENT MALPRACTICE INSURANCE CARRIER		ADDRESS		CITY, STATE		ZIP CODE	
Policy #: _____	Retroactive Date: _____	Policy Type: _____			Effective Date: _____		
Claim Limit: _____	Aggregate Limit: _____	_____ Occurrence _____ Claims Made			Expiration Date: _____		

PLEASE CHECK YES OR NO FOR EACH QUESTION AND ANSWER QUESTIONS COMPLETELY	YES	NO
1. Has your professional liability insurance coverage ever been terminated for any reason by an insurance company? (liability, non-payment, etc.)		
2. Have you ever been denied professional liability insurance coverage or rated in a higher than average risk class for your professional specialty?		
3. If the answer to question 1 or 2 is Yes , please state when and name of company:		
4. List all malpractice insurance carriers for the past five (5) years: a) _____ d) _____ b) _____ e) _____ c) _____		
IF ANSWER(S) TO ANY OF THE ABOVE QUESTIONS ARE YES , PLEASE ATTACH DETAILED INFORMATION		

DISCIPLINARY ACTIONS:

PLEASE CHECK YES OR NO FOR EACH QUESTION. IF ANY OF THE ANSWERS ARE YES, PLEASE ATTACH DETAILED INFORMATION.	YES	NO
1. Have any disciplinary actions ever been initiated and/or are any pending now against you by any state licensure board? (voluntary or involuntary)		
2. Has your license to practice medicine in any state ever been denied, limited suspended, revoked, or voluntarily relinquished?		
3. Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (for example, Medicare, Medicaid, or any managed care company)?		
4. Have you ever been the subject of an investigation by any state, federal, or private agency concerning your participation in any state, federal, or private health insurance program?		
5. Have any of your federal DEA number(s) or other controlled substance numbers ever been limited, suspended, revoked, or voluntarily relinquished, or are proceedings toward any of those ends currently pending? (voluntary or involuntary)		
6. Has your application for appointment or reappointment, or your privileges at any hospital or other health care facility, ever been denied, reduced, suspended or revoked? (voluntary or involuntary)		
7. Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings in any professional organization?		

LEGAL ACTIONS:

PLEASE CHECK YES OR NO FOR EACH QUESTION. IF THE ANSWER TO EITHER OR THE FOLLOWING QUESTIONS IS YES, PLEASE ATTACH DETAILED INFORMATION. EXPLANATIONS MUST INCLUDE COUNTY JURISDICTION IN WHICH THE SUIT WAS FILED, NAME OF THE PLAINTIFF, THE DATE THE SUIT WAS FILED, AND ANY JUDGMENTS OR SETTLEMENTS.	YES	NO
1. Have any professional liability claims, suits or judgments ever been made against you or are any such claims, suits, or judgments currently pending?		
2. Have you ever been convicted of a felony or misdemeanor other than minor traffic violations?		

HEALTH STATUS:

IF THE ANSWER TO THE FOLLOWING QUESTION IS YES, PLEASE ATTACH INFORMATION.	YES	NO
1. Have you ever had, or are you currently aware of having any physical, mental, or emotional condition, or chemical dependency/substance abuse problem which may interfere with your ability to perform the necessary functions of this position?		

Ages Treated: _____

* Do you provide Services to *Children with Special Health Care Needs*? ☐

MEDICAL PROVIDERS

Services Provided

Hospital admissions	☐	Nursery care	☐
Hospital Consultation	☐	OB/Delivery	☐
Pre-Op history	☐	Circumcision	☐
Newborn evaluation	☐		

Other (specify):

Procedures Performed in the Office

EKG	☐	Immunizations	☐
Venipuncture	☐	Gynecological exam	☐
Screening Tonometry	☐	Fracture care (minor)	☐
Sigmoidoscopy	☐	Minor surgery	☐
Screening Audiometry	☐	X-ray	☐
Vision screening	☐	Lab	☐

Other (specify)

BEHAVIORAL HEALTH PROVIDERS

Problems/Disorders Treated

Job Stress	☐	Grief	☐
AIDS/ARC	☐	MPD / PTSD	☐
Anxiety / Phobias	☐	Chemical Dependency	☐
Eating Disorders	☐	ADD	☐
Crisis Intervention	☐	Parenting	☐
Depression	☐	Psychotic Disorders	☐
Sexual / Physical Abuse	☐	Personality Disorders	☐
Anger / Violence	☐		

Other (specify):

Specialty Areas

Medical Evaluation/Psychopharmacology	☐
Psychological Testing	☐
Neuropsychological Assessment	☐
ECT	☐
Sexual Dysfunction	☐

Other (specify):

For members who request therapists with these specific characteristics/orientations, do identify yourself as:

Male	☐
Female	☐
Religious Counselor	☐
Gay/Lesbian Counselor	☐
Bicultural Counselor (specify)	☐
Bilingual (specify)	☐

Other (specify):

* As defined by the Maternal and Child Bureau: "Children (under the age of 21) with special health care needs are those who have or are at elevated risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount not usually required by children."



VIRGINIA PREMIER HEALTH PLAN, INC.

**VIRGINIA PREMIER HEALTH PLAN CONSENT AND RELEASE FORM
(PLEASE PRINT)**

I, _____ hereby apply for privileges to participate with Virginia Premier Health Plan (hereafter VPHP) as requested in the application and am willing to make myself available for interviews in regard to said application.

As an applicant, I agree to produce adequate and accurate information for proper evaluation of my qualifications. I also agree to update VPHP with current information and hereby authorize and direct all third parties, as hereinafter defined, to furnish release and disclose to VPHP or its authorized representative (as herewith defined) all and any information requested by VPHP or its authorized representatives. I understand and agree that failure to produce such information may prevent my application from being evaluated and acted upon, and may affect any existing privileges I have with VPHP.

Information given in or attached to the application, consent form and other applicable documents for the purpose of credentialing is true and complete to the best of my knowledge. I understand and agree that in making this application, any misrepresentation or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application resulting in denial of request for participation. In the event that participation has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of participation and require me to forfeit the right to receive any and all unpaid benefits and monies, whether accrued or to accrue in the future.

For the purpose of obtaining and maintaining credentialing or privileges with VPHP, I agree to release and hold harmless from any and all liability, VPHP, its authorized representatives and any third parties, for any acts performed in good faith and without malice relating to any communications or disclosures of any kind, involving me which are performed, made, requested, or received by VPHP and its authorized representatives to, from, or by any third party, including otherwise privileged or confidential information. Such information may relate to, but not be limited to information bearing on my professional qualifications, credentials, clinical competence and any other matter which might directly or indirectly relate to or reflect on my competence, on patient care or on the orderly operation of a health care facility on an ongoing basis.

The term "VPHP and its authorized representatives" means VPHP and the corporation(s) or other entities affiliated with or contracting with VPHP to which I have applied for participation, and any individuals who may act on VPHP's behalf in obtaining or evaluating my credentials, or acting upon my application. The term "third parties" means all individuals and entities from whom information has been requested by VPHP or its authorized representatives or who have requested such information from VPHP and its authorized representatives.

In consideration of VPHP's acceptance of my application for privileges and in support of VPHP's commitment to continuous quality improvement and peer review, I hereby authorize VPHP and its authorized representatives to disclose and communicate with my employer, partners or affiliates, as applicable in relation to my provision of medical services to VPHP members, regarding actions or information relating to VPHP credentialing, re-credentialing and quality management programs, and the quality thereof, and for all of such communications, if any, VPHP and its authorized representatives are fully released and acquitted by me from any claims or liability.

I attest to the correctness and completeness of the information provided in the application.

I hereby acknowledge that this Consent and Release Form will be valid for a period of three years from the date it is signed by me, that a photocopy or fax of this Consent and Release Form will serve as an original.

Applicant's Signature: _____

Date: _____



SUPPLEMENTAL PROVIDER ENROLLMENT FORM

COMPANY OWNERSHIP/CONTROL INTEREST STATEMENT:

Please list names, addresses, and Social Security Numbers (SSN) for individuals and Employer Identification Numbers (EIN) for organizations having 5% or more direct or indirect ownership or a controlling interest in the entity or practice. Please provide a separate sheet with required information if necessary.

Individual/Organization _____ SSN/EIN _____
Address _____

Individual/Organization _____ SSN/EIN _____
Addresses _____

Individual/Organization _____ SSN/EIN _____
Address _____

Individual/Organization _____ SSN/EIN _____
Address _____

Are there any individuals/organizations having a 5% or more direct or indirect ownership or control interest in the entity or practice that have ever been debarred, suspended or otherwise excluded from federal or state health care programs (Medicare, Medicaid), or been convicted of a criminal offense related to their involvement in any Medicare, Medicaid or Title XX program? If yes, please provide the following information. Yes No

Name _____	Dates _____	SSN/EIN _____
Name _____	Dates _____	SSN/EIN _____

Please list all officers, directors and managing employees. Please provide a separate sheet with the required information if necessary.

Name _____	Position _____	SSN _____
Name _____	Position _____	SSN _____
Name _____	Position _____	SSN _____
Name _____	Position _____	SSN _____
Name _____	Position _____	SSN _____
Name _____	Position _____	SSN _____
Name _____	Position _____	SSN _____

Are there any directors, officers, agents, or managing employees of the entity or practice that have ever been debarred, suspended or otherwise excluded from federal or state health care programs (Medicare, Medicaid), or been convicted of a criminal offense related to their involvement in any Medicare, Medicaid or Title XX program? If yes, please provide the following information. Yes No

Name _____	Dates _____	SSN _____
Name _____	Dates _____	SSN _____

SUPPLEMENTAL PROVIDER ENROLLMENT FORM
(Continuation)

DISCLOSURE OF BUSINESS TRANSACTIONS:

Please describe any business transactions during the past 12 months totaling more than \$25,000 between you and any subcontractor owned by you or your company. Please include the name of the subcontractor and the nature of the business transaction.

Please describe any significant business transactions during the past 5 years between you and any wholly owned supplier or between you and any subcontractor. Please include the name of the supplier or subcontractor and the nature of the business transaction.

I certify that all information provided is current, true, correct, accurate, and complete to the best of my knowledge.

Signature _____

Date _____

Name (Print) _____

Position _____