integrapartners

dmension BENEFIT MANAGEMENT

APPLICATION

PLEASE TYPE ALL INFORMATION DIRECTLY INTO THIS FILE
networkdevelopment@accessintegra.com

All information obtained in this application and received for the provider credentialing process is Confidential

A. BUSINESS INFORMATION

ORGANIZATION (legal name)
DBA (operating name)
REFERRED BY (NAME)

TYPE OF PROVIDER

PLEASE INDICATE THE TYPES OF SERVICES YOUR BUSINESS PROVIDES (choose one below)

☐ DME	☐ O&P	☐ DME/O&P	☐ DME/PHARMACY	☐ DME-O&P/PHARMACY

TAX ID #

CORPORATE / MAIN OFFICE INFORMATION

ADDRESS		
CITY	STATE	ZIP
COMPANY WEBSITE	COMPANY EMAIL	
MAIN PHONE	MAIN FAX	

HOW DO YOU HANDLE BILLING?	☐ IN HOUSE	☐ BILLING AGENCY	☐ BOTH	
BILLING SOFTWARE TYPE:	☐ Brighttree	☐ Doc-tor.com	☐ Fastrack	☐ Lytec
☐ Opie	☐ Med3000	☐ Allscripts	☐ Other _____	

BILLING / REMITTANCE ADDRESS (if different from corporate office)

ADDRESS			
CITY		STATE	ZIP
PHONE	FAX	EMAIL	

BUSINESS LICENSE OR CERTIFICATE OF AUTHORITY (certificate of authority requires a copy)

TYPE [1]	EFFECTIVE / START	EXPIRATION / END	LICENSE #
1.			
2.			
3.			
4.			

[1] MetroPlus requires an active NY City Department of Consumer Affairs license.

MAIN CONTACT PERSON

NAME (first/last)		TITLE
PHONE	FAX	EMAIL

STAFF ROSTER WITH LEGAL FULL NAMES (include practitioners) may be submitted as an attachment

	NAME (first/last)	TITLE	PHONE	FAX	EMAIL
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

LANGUAGES SPOKEN

☐ English	☐ Hindi	☐ Korean	☐ Polish
☐ Chinese, Mandarin	☐ Hebrew	☐ Turkish	☐ Ukrainian
☐ Chinese, Cantonese	☐ Russian	☐ Bengali	☐ French
☐ Spanish	☐ Portuguese	☐ Vietnamese	☐ Other _____
☐ Arabic	☐ Japanese	☐ Italian	

PAYOR DEMOGRAPHICS

PLEASE INDICATE PREVIOUS YEAR'S SALES BREAKDOWN (SHOULD EQUAL 100%)

% MEDICARE	% MEDICAID	% HMO/PPO/POS	% CASH/NO INS.

LIST ALL DIRECT INSURANCE CONTRACTS _____

OWNERSHIP AND OFFICERS (required for verification with government entities)

INDIVIDUAL / ENTITY / DBA (first / last)	TITLE / RELATIONSHIP [1]	EMAIL	% OWNERSHIP	SS# / TIN	DOB
1.					
2.					
3.					
4.					

DISCLOSURE BY CONTRACTOR [2] (Name / Address / Ownership)

[1] Include whether this person is related to another person with ownership or control interest as a spouse, parent, child or sibling.
[2] Include subcontractors who the provider has ownership and business transactions totaling more than $25,000 during the past 12-month period, or any significant business transactions between the provider and any wholly owned supplier during the past 5-years.

B. CERTIFICATION & ACCREDITATION (additional Practitioner form available upon request)

PRACTITIONER CERTIFICATION

ABC (CPO, CP, CO)

NAME (first, last)	NUMBER	EXPIRATION	DATE OF BIRTH
1.			
2.			
3.			
4.			

BOC

NAME (first, last)	NUMBER	EXPIRATION	DATE OF BIRTH
1.			
2.			
3.			
4.			

RESPIRATORY (requires a copy of certificate)

NAME (first, last)	NUMBER	EXPIRATION	DATE OF BIRTH
1.			
2.			
3.			

PHARMACIST

NAME (first, last)	NUMBER	EXPIRATION	DATE OF BIRTH
1.			
2.			
3.			

OTHER (including ATP)

NAME (first, last)	NUMBER	EXPIRATION	TYPE	DATE OF BIRTH
1.				
2.				

NATIONAL ACCREDITATION CERTIFICATE

• ABC #	EXP. DATE	• HQAA #	EXP. DATE
• ACHC #	EXP. DATE	• Compliance Team #	EXP. DATE
• BOC #	EXP. DATE	• Joint Commission #	EXP. DATE
• CHAP #	EXP. DATE	• NABP #	EXP. DATE
• Other			EXP. DATE

NOTES

C. FACILITY LOCATIONS (additional locations form available upon request)

LOCATION 1

NAME (include DBA)					Handicap Accessible? ☐ yes ☐ no		
NPI #		Medicare #			Medicaid #		
Address				County			
City	State			Zip		Contact	
Phone	Fax			Email			
Physical Delivery Counties Served (non-mail order) _____ ☐ Mail / Commercial Service							
OFFICE HOURS	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

LOCATION 2

NAME (include DBA)					Handicap Accessible? ☐ yes ☐ no		
NPI #		Medicare #			Medicaid #		
Address				County			
City	State			Zip		Contact	
Phone	Fax			Email			
Physical Delivery Counties Served (non-mail order) _____ ☐ Mail / Commercial Service							
OFFICE HOURS	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

LOCATION 3

NAME (include DBA)					Handicap Accessible? ☐ yes ☐ no		
NPI #		Medicare #			Medicaid #		
Address				County			
City	State			Zip		Contact	
Phone	Fax			Email			
Physical Delivery Counties Served (non-mail order) _____ ☐ Mail / Commercial Service							
OFFICE HOURS	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

D. SERVICES

What age limits do you accept? Lowest Age _____ Highest Age _____

ORTHOTICS AND PROSTHETICS SERVICES		
SERVICES	**ADULT**	**PEDIATRICS**
Breast Prosthesis and Mastectomy Supplies [1]	☐	
Compression Garments [1]	☐	
Cranial Orthotics		☐
Diabetic Shoes & Inserts [1]	☐	☐
Myoelectric Prosthetics	☐	☐
Orthopedic Footwear [1]	☐	☐
Upper / Lower Extremity Orthotics [1]	☐	☐
Upper / Lower Extremity Prosthetics [1]	☐	☐
Voice Prosthesis	☐	☐
Other _____	☐	☐

DURABLE MEDICAL EQUIPMENT SERVICES

COMPETITIVE BID CATEGORIES		
☐ CPAP, RADs, and Related Supplies and Accessories	☐ Enteral Nutrients, Equipment and Supplies	☐ Hospital Beds and Related Accessories
☐ Diabetic Testing Supplies (Mail Order)	☐ Negative Pressure Wound Therapy Pumps and Related Supplies and Accessories	☐ Oxygen Supplies and Equipment
☐ Standard (Power and Manual) Wheelchairs, Scooters, and Related Accessories	☐ Support Surfaces (mattresses and overlays)	☐ Walkers and Related Accessories
Competitive Bid Area _____		

NON-COMPETITIVE BID CATEGORIES		
☐ Apnea Monitor and Supplies	☐ Hospital Beds and Accessories	☐ Seat Lift Mechanisms
☐ Blood Glucose Monitors & Diabetic Supplies	☐ Home Infusion Therapy	☐ Shower Chairs
☐ Blood Pressure Monitor and Supplies	☐ Incontinence Supplies	☐ Speech Generating Devices
☐ Bone Growth Stimulator	☐ Insulin Pump and Supplies	☐ Suction Pumps
☐ Breast Pumps	☐ Lymphedema Pump and Supplies	☐ TENS Unit and Supplies
☐ Canes/Crutches/Walkers	☐ Miscellaneous Supplies	☐ Tracheostomy Supplies
☐ Cervical Traction Equipment	☐ Nebulizer Equipment and Supplies	☐ Transfer Boards
☐ Chest Wall Oscillation	☐ NMEs	☐ Urological Supplies
☐ Commodes/Urinals/Bed Pans	☐ NPWT - Wound Vac	☐ UV Light Therapy
☐ Continuous Glucose Monitoring System	☐ Ostomy Supplies	☐ Wheelchairs - Manual [1]
☐ Continuous Passive Motion (CPM) Devices	☐ Other Supplies and Devices	☐ Wheelchairs - Miscellaneous
☐ Cough Assist Device and Supplies	☐ Oxygen Equipment Supplies [1]	☐ Wheelchairs - Pediatric [1]
☐ Cpap / Bipap and Accessories [1]	☐ Patient Lifts	☐ Wheelchairs - Power Mobility Devices [1]
☐ Enteral / Parental Feeding and Supplies	☐ Penile Pumps	☐ Wheelchairs - Accessories
☐ Gait Trainer	☐ Power Operated Vehicles / Scooters	☐ Wheelchair Cushions
☐ Hearing Aid Supplies (batteries ONLY)	☐ Power Pressure Reducing Mattresses	☐ Wound Care Supplies and Dressings
☐ Heat / Cold Application	☐ Protective Helmets	
☐ Other _____		

[1] These services require practitioners with licenses/certifications. Please see page 9 for further information.

E. CONFIDENTIAL QUESTIONAIRE

ALL QUESTIONS MUST BE ANSWERED

WRITE AN EXPLANATION TO ANY QUESTION(S) YOU RESPOND 'YES' TO BELOW.

For purposes of this section, the term "Applicant" includes its owners, officers, directors, practitioners, subcontractors, billing agents and management companies.

	YES	NO
1. Has Applicant ever been denied, reprimanded, censured, excluded, suspended (even if the suspension was stayed), or disqualified to any extent from participation in Medicare, Medicaid or any other governmental program?	☐	☐
2. Have any professional liability judgments been entered against Applicant in the past 10 years?	☐	☐
3. Have any professional liability claim settlements, not involving litigation or arbitration, been paid by you or paid on Applicant's behalf in the past 10 years?	☐	☐
4. Is any professional liability or malpractice or similar claims now pending against Applicant?	☐	☐
5. Has Applicant's license to practice in any jurisdiction ever been denied, limited, suspended (even if the suspension was stayed) or revoked, either voluntarily or involuntarily?	☐	☐
6. Has Applicant ever been denied or subject to suspension, cancellation, investigation, limitation, non-renewed or refused participation in a HMO, PPO, PHO, IPA or any prepaid health plan or managed care network?	☐	☐
7. Has Applicant been subject to any disciplinary action or investigation by any accreditation, certification body, medical society or licensing authority?	☐	☐
8. Has Applicant ever been convicted of a crime (other than a minor traffic offense) or have any criminal charges pending including related to participation in any governmental program?	☐	☐
9. Is Applicant's physical or mental health such that it may impair your ability to practice within the scope of privileges for which you have applied even with reasonable accommodation?	☐	☐
10. Has Applicant's Federal DEA and/or State Controlled Dangerous certificate ever been challenged, denied, suspended, revoked, or voluntarily or involuntary relinquished (if applicable)?	☐	☐
11. Has the Applicant or anyone employed by the organization, been involved in the sale, purchase or use of illegal drugs and/or use of any chemical substance that would in any way impair or limit the ability to perform the functions of their job?	☐	☐
12. The Applicant attests that neither they nor anyone employed by the organization is under the influence of alcohol or is permitted to consume alcohol during business hours and while interacting with patients? Answer "No" to affirm compliance.	☐	☐
13. Has the Applicant used or will use Federal appropriated funds for the purpose of influencing or attempting to influence any state official, federal official or employee of any government agency?	☐	☐
14. Has the Applicant made payment(s) of $100,000 or greater for lobbying activities to state and/or federal officials?	☐	☐

EXPLAIN ANY 'YES' IN SECTION E HERE OR ATTACH ON A SEPERATE SHEET.

F. PROFESSIONAL LIABILITY / MALPRACTICE HISTORY

☐ This organization has not had any professional liabilities or malpractice suits in the past five (5) years.
☐ This organization has had a professional liabiity or malpractice in the past five (5) years.

PLEASE COMPLETE THE FORM BELOW FOR EACH OCCURANCE.

CLAIM 1

DATE OF OCCURANCE	DATE CLAIM WAS FILED
PROFESSIONAL LIABILITY CARRIER	
PATIENT NAME	NAME OF CLAIMANT/PLAINTIFF (if other than Patient)
DESCRIBE YOUR ROLE IN THE CLAIM / LAWSUIT ☐ primary defendant ☐ co-defendant	
DESCRIBE ALLEGATIONS AGAINST YOU	
DESCRIBE ALLEGED INJURY TO THE PATIENT	
IDENTIFY ALL THE OTHER DEFENDANTS	
HAS THE CLAIMANT/PLAINTIFF FILED SUIT IN COURT? ☐ yes ☐ no	
PRESENT STATUS OF THE CLAIM OR CASE ☐ Case or claim is pending ☐ Verdict or judgement entered in the amount of $ _____ The portion of the verdict or judgement attributed to me was $ _____	☐ Case or claim settled for $ _____ The portion of the verdict paid on my behalf was $ _____ ☐ Case was dismissed by the court ☐ Claimant/Plaintiff voluntarily withdrew from the claim/lawsuit ☐ Claimant/Plaintiff voluntarily dismissed from the claim/lawsuit

CLAIM 2

DATE OF OCCURANCE	DATE CLAIM WAS FILED
PROFESSIONAL LIABILITY CARRIER	
PATIENT NAME	NAME OF CLAIMANT/PLAINTIFF (if other than Patient)
DESCRIBE YOUR ROLE IN THE CLAIM / LAWSUIT ☐ primary defendant ☐ co-defendant	
DESCRIBE ALLEGATIONS AGAINST YOU	
DESCRIBE ALLEGED INJURY TO THE PATIENT	
IDENTIFY ALL THE OTHER DEFENDANTS	
HAS THE CLAIMANT/PLAINTIFF FILED SUIT IN COURT? ☐ yes ☐ no	
PRESENT STATUS OF THE CLAIM OR CASE ☐ Case or claim is pending ☐ Verdict or judgement entered in the amount of $ _____ The portion of the verdict or judgement attributed to me was $ _____	☐ Case or claim settled for $ _____ The portion of the verdict paid on my behalf was $ _____ ☐ Case was dismissed by the court ☐ Claimant/Plaintiff voluntarily withdrew from the claim/lawsuit ☐ Claimant/Plaintiff voluntarily dismissed from the claim/lawsuit

NOTES

G. ATTESTATION, CONTRACT ACCEPTANCE AND SIGNATURE

The undersigned attests, represents and warrants that they have reviewed all the information and material included and provided by the undersigned in all the sections of this application, and that all such material and information is complete and accurate. The undersigned authorizes any individual or entity in the possession of any information bearing on me or my facilities' qualifications to release such information to Integra Partners IPA, LLC ("Integra") upon Integra's request.

The undersigned hereby release Integra and its owners, officers, directors, agents and employees, as well as any individual or entity and its owners, officers, agents and employees releasing above-referenced information from liability for any damages resulting from the release of any such information to Integra. The undersigned further agree to notify Integra in a timely manner, not to exceed thirty (30) days, of any change in the status of the information or material included in the Application.

The undersigned understands that the mere submission of the Application does not entitle them or their facilities to be an independent contractor providing services on behalf of Integra, or to bill or collect payment from Integra for services I or my facilities provide, or to bill or collect payment from insurance companies with which Integra has entered into agreements for services I or my facilities provide.

The individual undersigned represents and warrants that they are authorized to obligate the applicant as contemplated by this application, and that no corporate or other entity action is necessary to obligate the Applicant. Whoever knowingly and willfully makes or cause to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws.

The undersigned consents to the release of a copy of my professional liability certificate indicating the category, and to the release of information concerning the non-renewal, cancellation, revocation, and change in policy limits or added special limitations of such insurance. Additionally, I hereby release my professional liability carrier, its agents, and employees for acts performed in good faith in connection with the release of such information, and I hereby consent to the release of all such information to Integra.

V05012014

PROVIDER CONTRACT

☐ I agree to an electronic signature and have read the Provider Agreement.

SIGNATURE * (first and last)		
NAME OF APPLICANT		EMAIL
TITLE	DATE	
ADDRESS		
CITY	STATE	ZIP

*** Electronic Signature**

You now have the option to sign this form electronically. If you elect to do so, you hereby consent and agree that your use of key pad, mouse or device to click the "I Agree to an Electronic Signature" button constitutes your signature, acceptance and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand. Further, you agree that the lack of certification authority or other third party verification will not in any way affect the validity or enforceability of your signature or any resulting contract.

Please ensure that you have reviewed the application for accuracy and completeness before applying your Electronic Signature.

APPLICATION CHECKLIST

YOUR APPLICATION CANNOT BE PROCESSED WITHOUT:

- ☐ **Completed Application:** Application and W-9 should be completed. Fields that do not apply should be indicated with "N/A".
  - ☐ **Certificate of Authority:** If you operate with a Certificate of Authority, a copy is required.
- ☐ **Practitioner Requirements in Order to Service:**
  - ☐ Oxygen/CPAP/BiPAP - Requires Respiratory Therapist (license / certification)
  - ☐ Custom Shoes / Braces - Requires a Prosthetist / Orthotist / Pedorthist or Fitter, where applicable (certification)
  - ☐ Custom Wheel Chairs - Requires Assistive Technology Professional "ATP" (certification)
- ☐ **Copy of Surety Bond:** A copy of the bond and power of attorney is required. A receipt or binder letter is not acceptable.
- ☐ **Copy of Certificate(s) of malpractice, commercial and general liability coverage:** (minimum coverage must be for $1,000,000; $3,000,000).

  Certificate should list Integra Partners as a holder, with the following address:
  Integra Partners _____