P.O. Box 5001
New Port Richey, FL 34656
Phone: 1-800-881-4474
Fax: (727) 485-1203
Email: contracting@ehsppo.com

PRACTITIONER CREDENTIALING INSTRUCTIONS

Provide complete, typed or printed information for all sections of the Practitioner Application. If additional space is required, attach separate, typed or printed pages referencing the section addressed. Sections that do not apply to your discipline should be marked "N/A". Please note that "Yes" Responses to Board, Insurance, Disciplinary, Legal & Health Status Questions Require Additional Explanations Attached.

SIGN AND DATE THE APPLICATION ATTESTATION AND CONSENT AND RELEASE FORM WHERE INDICATED. **(NOTE THAT "STAMPED" SIGNATURES CANNOT BE ACCEPTED.)**

Provide all educational, practice and affiliation history in chronological order, indicating inclusive dates, and an explanation for any gaps in chronology on an attached sheet. Copies of education certificates/diplomas should be attached.

Please return the completed and signed application and consent and release form with copies of the following additional documents:

_____ Current Medical License(s);

_____ Current Federal DEA Certificate or CDS Certificate (if applicable)

_____ Certificates of Education (Not required if Board Certified)

_____ Current Certificate of Medical Malpractice Insurance, indicating amounts and type of coverage, indicating practitioner as named insured, with inclusive dates of coverage;

_____ ECFMG Certificate (foreign medical school graduates); Not required if Board Certified)

_____ Summary of all medical malpractice actions, open and closed, indicating the status or outcome, and a brief clinical explanation for the basis of the claim(s);

_____ Current Board Certification by a Board recognized by the ABMS, AOIA, or the American Podiatric Medical Association; (Must be submitted if Board Certification is checked)

_____ Curriculum Vitae **updated to the present time**, since completing medical training (without gaps in chronology)

_____ Copy of W-9

N/A Attach copy of **AHCA Form 3160-0020** *certification for Workers Compensation* **(FLORIDA ONLY)**

Please call the Network Development Department of Evolutions Healthcare Systems, Inc. at (727) 938-2222 if we can assist you in the credentialing process.

Mail Within 30 Days of Physician Signature Date on page 7 to:

Evolutions Healthcare Systems, Inc.
Network Development
P.O. Box 5001
New Port Richey, FL 34656
ATTN: Network Development

You may email to: Contracting@ehsppo.com

PCP

	Family Practice		Internal Medicine		Pediatrics
	General Practice		Obstetrics & Gynecology		

SPECIALISTS

	Adolescent Medicine		Neurology		Pediatric Otolaryngology
	Allergy, Asthma & Immunology		Neurosurgery		Pediatric Phys Medicine & Rehab
	Alternative Medicine		Nuclear Medicine		Pediatric Plastic Surgery
	Anesthesiology		Nurse Midwife		Pediatric Podiatry
	Arthroscopic Surgery		Obstetrics ONLY		Pediatric Pulmonology
	Audiology		Occupational Medicine		Pediatric Radiology
	Cardiology		Oncology		Pediatric Respiratory Therapy
	Cardiovascular Disease		Oncology Surgery		Pediatric Rheumatology
	Cardiovascular Surgery		Ophthalmic Surgery		Pediatric Speech
	Cardiovascular Thoracic Surgery		Ophthalmology		Pathology
	Chiropractic		Optometry		Pediatric Surgery
	Colon & Rectal Surgery		Oral & Maxillofacial Surgery		Pediatric Urology
	Critical Care Medicine		Orthopedic Surgery		Physical Medicine & Rehab
	Dermatology		Orthopedics		Physical Therapy
	EENT		Pain Management		Plastic Reconstructive Surgery
	Electrophysiology		Pallative Care		Podiatry
	Emergency Medicine		Pathology		Proctocology
	Endocrinology Diabetes & Metabolism		Pediatric Allergy & Immunology		Pulmonary Medicine
	Gastroenterology		Pediatric Cardiology		Radiation Oncology
	General Surgery		Pediatric Cardiovascular Surgery		Radiology
	Genetics		Pediatric Critical Care Medicine		Radiology Diagnostic
	Geriatric Medicine		Pediatric Dermatology		Radiology Vascular & Intervention
	Gynecologic Oncology		Pediatric Developmental		Reproductive Endo & Infertility
	Gynecology ONLY		Pediatric Emergency Medicine		Respiratory Therapy
	Head & Neck Surgery		Pediatric Endocrinology		Rheumatology
	Hematology		Pediatric Gastroenterology		Speech Pathology
	Hepatology		Pediatric Genetics		Sports Medicine
	Hospitalist		Pediatric Hematology & Oncology		Therapeutic Radiology
	Industrial Medicine		Pediatric Infectious Disease		Toxicology
	Infectious Disease		Pediatric Nephrology		Transplant Surgery
	Maternal & Fetal Medicine		Pediatric Neurosurgery		Urological Surgery
	Neonatal Perinatal Medicine		Pediatric Ophthalmology		Urology
	Nephrology		Pediatric Orthopaedics		Vascular Surgery
			Pediatric Orthopedic Surgery		Wound Care/Hyperbarics

MENTAL HEALTH

SPECIALISTS

	Counseling		Counseling – Pediatrics		Pediatric Psychiatry (MD only)
	Counseling – Adolescent		Counseling – Stress & Anxiety		Pediatric Psychology (PhD only)
	Counseling – Depression		Counseling – Substance Abuse		Psychiatry (MD only)
	Counseling – Eating Disorders		Neuro Psychology (MD only)		Psychology (PhD or PsyD)
	Counseling – Marriage & Family		Pediatric Developmental		

evolutions Healthcare Systems

CREDENTIALING APPLICATION

To initiate your request for participation, please return this form completed and signed within thirty (30) days of the date received. Please print or type the answers. **Complete all sections.** If the space is not sufficient, please attach a separate sheet. Responses to certain questions require an attached explanation. Blanks or insufficient information will cause the application to be considered incomplete, which will delay the credentialing process.

*** * * * Attach a CV and copies of all licenses, insurance, and certificates as necessary. * * * ***

Last Name	First Name	MI	Rank (Jr, Sr, *etc*)	Degree (*MD, DO, etc*)

Social Security Number (for ID) NPI Number	Date of Birth *(for identification purposes)* ____/____ / _____	Gender M / F	*Birthplace (City, State or Country)*

Citizenship	If not a US Citizen give Visa #	Visa Status	Expiration Date ____/____ / _____

Contract Type: ____ **IPA/PHO** ____ **Solo/Individual** ____ **Group**

Name of IPA/PHO *(if applicable)*	**Date** *(Month/Date/Year)* the Provider Started _____/_____/_____
Name of Group or Solo/Individual Practice	**Date** *(Month/Date/Year)* the Provider Started _____/_____/_____

Name of Primary Practice

Email Address for Office	Email Address for Office Manager
Billing Tax ID #	Office Manager
Primary Office Address (*Street*)	Primary Office (*City, State, Zip)*

County	Telephone #	24 Hr Telephone #	Fax #

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Practice Limitations (*Age/Gender, Type of medical problem, etc. of patients whom you do not treat*)

Billing Address (*Street, City, State, Zip*) *If different from office address*	Telephone #

Name of Secondary Practice

Email Address for Office	Email Address for Office Manager
Billing Tax ID #	Office Manager
Secondary Office Address (*Street*)	Secondary Office (*City, State, Zip)*

County	Telephone #	24 Hr Telephone #	Fax #

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Practice Limitations (*Age/Gender, Type of medical problem, etc. of patients whom you do not treat*)

Billing Address (*Street, City, State, Zip*) *If different from office address*	Telephone #

****** Please attach a separate sheet for any additional addresses ******

Accepting New Patients? Yes ☐ NO ☐ *Please check one.*

Other Languages Spoken: _____

Physicians in Group Practice

Name	Specialty/ Sub-specialty	Address	Telephone #

Hospital Affiliation

Primary Hospital	City/State	Privileges (Specialty)	Status __ Active __ Pending __ Courtesy __ Other __ Consultant _____ __ Provisional _____	Dates (Mo/Yr – Mo/Yr) ___/___- ___ / ___

If you do not hold Hospital Privileges, please provide the name(s) of EHS providers who will admit for you:

Provider Name	Address (Street, City, State, Zip)	Telephone #

Specialty(ies) and Education (Attach Copies of Certificates)

Specialties to be listed in the EHS database, web-site, and directories. Please choose from those listed on page 2.

Primary Specialty	Secondary Specialty (*Sub-specialty*)

Medical (*Other Professional*) **School**

Institution Name	Address	Specialty	Dates (Mo/Yr to Mo/Yr) ____/____-____/____

Internship

Institution Name	Address	Specialty	Dates (Mo/Yr to Mo/Yr) ____/____-____/____

Residency(ies) (*If additional residencies, please attach on a separate sheet*)

Institution Name	Address	Specialty	Dates (Mo/Yr to Mo/Yr) ____/____-____/____
Institution Name	Address	Specialty	Dates (Mo/Yr to Mo/Yr) ____/____-____/____

Fellowship (*If Applicable*)

Institution Name	Address	Specialty	Dates (Mo/Yr to Mo/Yr) ____/____-____/____

WORK HISTORY: Please provide a chronological listing of professional (work) history since completing medical training.

Name of Practice	Address (Street, City, St & Zip)	Inclusive Dates (Mo/Yr – Mo/Yr)
Current Practice		____/____-____/____
Previous Practice		____/____-____/____
Previous Practice		____/____-____/____
Previous Practice		____/____-____/____
Previous Practice		____/____-____/____
Previous Practice		____/____-____/____

Board Certification (*Attach Copies of Certificates*)

Board Name	Specialty	Cert Date	Exp Date/Recert Date
Board Name	Specialty	Cert Date	Exp Date/Recert Date
Board Name	Specialty	Cert Date	Exp Date/Recert Date

If not Board Certified, are you board eligible? ***If so, Please attach letter***	Yes	No

ECFMG Cert # (*If Applicable*)	Medicare #	Medicare UPIN #	Medicaid #

List all Current/Past State License #'s

License #	State	Expiration Date	License #	State	Expiration Date
		____/____ / _____			____/____ / _____
		____/____ / _____			____/____ / _____
		____/____ / _____			____/____ / _____

List all DEA/CDS #'s where controlled substances are administered, dispensed or stored

DEA/CDS #	State	Expiration Date	DEA/CDS #	State	Expiration Date
		____/____ / _____			____/____ / _____
		____/____ / _____			____/____ / _____
		____/____ / _____			____/____ / _____

Malpractice Insurance (Attach Copy of Certificate of Insurance) FL only-if none, attach copy of FL Statute followed

Insurance Carrier	Policy #	Policy Type	Policy Limits	Eff. Date / Exp. Date
		____ Claims Made ____ Occurrence		Eff. Date ____/____ / _____ Exp. Date ____/____ / _____

Print Provider Name: **Please read and answer each question carefully**

Please attach explanations to those questions that require one.	**YES**	**NO**
1) Are you able to perform all of the procedures for the specialty you practice, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients? **(If NO, attach explanation)**		
2) Has your professional liability insurance coverage ever been terminated by action of an insurance company? **(If yes, attach explanation**)		
3) Have you ever been denied professional liability insurance coverage, or rated in a higher than average risk class for your professional specialty? **(If yes, attach explanation)**		
4) Have any disciplinary actions ever been initiated and/or pending now against you by any state licensure board? **(If yes, attach explanation)**		
5) Has your license to practice medicine in any state ever been denied, limited, suspended, revoked or voluntarily relinquished in order to avoid suspension, revocation, etc.?**(If yes, attach explanation)**		
6) Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program? (Ex., Medicare, Medicaid or managed care company) **(If yes, attach explanation)**		
7) 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? **(If yes, attach explanation)**		
8) Has your application for appointment/reappointment or your privileges at any hospital or other health care facility ever been denied, reduced, or limited, suspended or not renewed? **(If yes, attach explanation)**		
9) Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings in any professional organization? **(If yes, attach explanation)**		
10) Are you currently aware of having any physical, mental, emotion condition or chemical/alcohol dependency/substance abuse problem, which could interfere with your ability to care for patients? **(If yes, attach explanation)**		
11) Have any professional liability claims, suits or judgments **ever been made against you** or are any such claims, suits or judgments **currently pending**? **(If yes, attach explanation)**		
12) Have any professional liability claims, suits or judgments ever resulted in payments made on your behalf? **(If yes, attach explanation)**		
13) Have you ever been convicted of a felony or misdemeanor other than minor traffic violations? **(If yes, attach explanation)**		

EVOLUTIONS HEALTHCARE SYSTEMS, INC.

APPLICATION ATTESTATION & CONSENT AND RELEASE FORM FOR: _____

(Print Applicant's Name)

I acknowledge and agree that: I hereby apply for privileges to participate with EVOLUTIONS HEALTHCARE SYSTEMS, INC., as requested in this application, and am willing to make myself available for interviews in regard to said application. Privileges to participate as a provider with EVOLUTIONS HEALTHCARE SYSTEMS, INC. is not a right, and applications and requests will be evaluated in accordance with EVOLUTIONS HEALTHCARE SYSTEMS, INC. Credentialing and Re-Credentialing Process. I understand that I have the right to be advised of adverse information received in the course of EHS credentialing process, which substantially differs from information I submitted in my application, including information submitted by any outside primary source. I agree to allow EHS or its delegate to conduct a site survey of each of my practice locations at the time of initial application and reapplication with reasonable notice of said survey. I certify that this application is complete to the full extent of my knowledge and any unanswered areas have been explained in full on an attached sheet of paper.

Information given in or attached to this application is accurate and complete to the best of my knowledge. As a condition to 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 such participation. As a component of the credentialing and recredentialing process, I accept the following conditions:

I have the responsibility to keep this application current by informing EVOLUTIONS HEALTHCARE SYSTEMS, INC., through the Credentialing Manager or his/her designee, of any changes, including, but not limited to: Any change in my professional liability insurance coverage, the filing of a lawsuit against me, any change in status of my hospital medical staff membership, voluntary or involuntary limitation, reduction, or loss of privileges in any health care organization or managed care organization, any medical license or DEA/CDS limitation, reduction, or restriction (including both current and pending investigations and challenges), any changes in my physical or mental condition that could affect my ability to exercise the participation privileges requested or require an accommodation in order for me to exercise the privileges requested safely and competently, and restrictions or sanctions imposed by Medicare or Medicaid. Failure to provide and update required information shall be grounds for termination of privileges to participate in the EVOLUTIONS HEALTHCARE SYSTEMS, INC. Preferred Provider Network.Reappointment and continued participating privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of EVOLUTIONS HEALTHCARE SYSTEMS, INC. Preferred Provider Network, and acceptable performance of all related responsibilities, as well as the other factors deemed relevant by EVOLUTIONS HEALTHCARE SYSTEMS, INC.

I extend absolute immunity to, and release from any and all liability, EVOLUTIONS HEALTHCARE SYSTEMS, INC., its authorized representatives and any third parties, for any acts performed in good faith and without malice, communications, reports, records, statements, documents, recommendations or disclosures involving me; performed, made, requested, or received by EVOLUTIONS HEALTHCARE SYSTEMS, INC., and its authorized representatives to, from, or by any third party, including otherwise privileged or confidential information, relating, but not limited to the following: Application for participation with EVOLUTIONS HEALTHCARE SYSTEMS, INC.; periodic reappraisals undertaken for recredentialing; proceedings for suspension or reduction of clinical privileges; or denial or revocation of participation or any other disciplinary action; medical care evaluations; utilization reviews; any other EVOLUTIONS HEALTHCARE SYSTEMS, INC. service or committee activities; matters concerning my professional qualifications, credentials, clinical competence, character, ethics or behavior; matters of inquiries concerning my mental or emotional stability, or physical condition; and any other matter which might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of a health care facility.

The foregoing shall be privileged to the fullest extent permitted by law. My release and immunity shall extend to EVOLUTIONS HEALTHCARE SYSTEMS, INC., its authorized representatives, and to any third party, regardless of whether my application is accepted; and if accepted, regardless of whether my membership and privileges as hereafter aforementioned are terminated, either voluntarily or involuntarily. I specifically authorize EVOLUTIONS HEALTHCARE SYSTEMS, INC. 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, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my satisfaction of the criteria for initial or continued participation with EVOLUTIONS HEALTHCARE SYSTEMS, INC. relating to such questions. I also specifically authorize said third parties to release said information to EVOLUTIONS HEALTHCARE SYSTEMS, INC. and its authorized representatives upon request and receipt of a copy of the consent and release form.

The term EVOLUTIONS HEALTHCARE SYSTEMS, INC. and its authorized representatives means the corporation (s) with which I have applied for participation, and any of the following individuals who may have any responsibility for obtaining or evaluating my credentials, or acting upon my application: the members of EVOLUTIONS HEALTHCARE SYSTEMS, INC. Board and their appointed representatives, the Chief Executive Officer or his designees, the Credentials Committee members, other EVOLUTIONS HEALTHCARE SYSTEMS, INC. employees, consultants to EVOLUTIONS HEALTHCARE SYSTEMS, INC., EVOLUTIONS HEALTHCARE SYSTEMS, INC. attorney and his/her partners, associates or designees. The term third parties means all individuals, including appointees to EVOLUTIONS HEALTHCARE SYSTEMS, INC. medical staffs or hospital or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested by EVOLUTIONS HEALTHCARE SYSTEMS, INC. or its authorized representatives or who have requested such information from EVOLUTIONS HEALTHCARE SYSTEMS, INC. and its authorized representatives.

_____

Applicant's Signature

_____ ____/____/_____

Print Applicant's Name Date

Explanation of Claims, Suits, or Judgments

(complete one sheet for each case)

1. Name of the individual involved in the claim: _____
2. Name of the Claimant: _____

   Sex: _____ Age: _____

3. Was claim or suit:
   _____ Merely threatened, or
   _____ Limited to Claimant's attorney contact (e.g. request of medical records), or
   _____ Actually filed against you?
4. Date of the alleged error: _____ / _____ / _____
5. Date of the claim: _____ / _____ / _____
6. Additional defendants: _____

   _____

   _____
7. Disposition of claim:
   _____ DISMISSED
   _____ ABANDONED (no activity for over 3 years)
   _____ WON by defense
   _____ WON by claimant
   Total paid..... $_____
   Amount paid on your behalf..... $_____
   Indicate whether: Court judgment _____, or out of court settlement _____
   _____ OPEN – Provide the following information:
   Claimant's settlement demand?..... $_____
   Defendant's offer for settlement?..... $_____
   Insurer's loss reserve..... $_____
8. Name of the insurer: _____
9. Description of claim (provide enough information to allow appropriate evaluation):

- Describe the alleged act, error, or omission upon which Claimant bases claim: _____

  _____

  _____
- Description of the case and events: _____

  _____

  _____

  _____
- Type of injury claimed:

  _____ Emotional only _____ Temporary disability _____ Death
  _____ Cosmetic _____ Permanent Disability _____ Other (describe)

  _____

  _____

Physician's Name: _____ Date: _____ / _____ / _____

Signature: