Credentialing Application for Participation with Humana Health Plans

Return to:

Humana

Please check the networks for which you are applying:

HUMANA:	☐ HMO	☐ PPO	☐ Medicare	☐ Medicaid

Provider Type (select one):

☐ MD ☐ DO ☐ DPM ☐ DC ☐ DDS ☐ DMD ☐ Other (specify)

Are services provided in a home or mobile setting in lieu of office ☐ Yes ☐ No

Last Name:	First Name:	Middle Name:	Other Names Used:

Social Security Number:	List all non-english languages you speak, including American Sign Language:

Date of Birth:	Place of Birth:	Citizenship:	Federal Tax ID Number:

Humana is required by law to report the ethnicity and gender of providers who serve enrollees in order to demonstrate non-discriminatory practices. In order to comply with this reporting requirement, please provide the information below:

Gender: ☐ Female ☐ Male	Ethnicity:

Primary Practicing Specialty:	Secondary Practicing Specialty:	PCP or Specialist?:

Primary Service Address

Legal Practice Name/Name Associated with Federal Tax ID#:

Address:	City:	State:	Zip Code:

Office Phone Number:	Office Fax Number:	Alternate Phone Number:
( )	( )	( )

Email Address:	TTD Number:

Office Hours	Mon	Tue	Wed	Thu	Fri	Sat	Sun

List all non-english languages spoken by office personnel, including American Sign Lanaguage:

Interpreters available? ☐ Yes ☐ No	Languages Interpreted:

Accessibilities

Does this office meet ADA accessibility requirements?	☐ Yes	☐ No
Does this site offer handicapped access for the following:		
Building?	☐ Yes	☐ No
Parking?	☐ Yes	☐ No
Restroom?	☐ Yes	☐ No

Other handicapped access:

Accessibilities continued		
Does this site offer other services for the disabled?	☐ Yes	☐ No
Text telephony (TTY)?	☐ Yes	☐ No
American Sign Language?	☐ Yes	☐ No
Mental/Physical Impairment Services?	☐ Yes	☐ No
Other disability services:		
Accessible by public transportation?	☐ Yes	☐ No
Bus?	☐ Yes	☐ No
Subway?	☐ Yes	☐ No
Regional train?	☐ Yes	☐ No
Other transportation access:		

Secondary Service Address			
Legal Practice Name/Name Associated with Federal Tax ID#:			
Address:	City:	State:	Zip Code:
Office Phone Number: ( )	Office Fax Number: ( )	Alternate Phone Number: ( )	
Email Address:	TTD Number:		

Group Information			
Group Name	Group Federal Tax ID Number:	Start date with group:	
Address:	City:	State:	Zip Code:
Group Phone Number: ( )	Group Fax Number: ( )	Alternate Phone Number: ( )	

Billing/Pay To Address (if different from your Primary Service Address)			
Address:	City:	State:	Zip Code:
Office Phone Number: ( )	Office Fax Number: ( )	Contact Name:	

Correspondence Address (if different from your Primary Service Address)			
Location Name:	Contact Name:		
Address:	City:	State:	Zip Code:
Office Phone Number: ( )	Office Fax Number: ( )	Contact Name:	

Medical/Professional School			
School Name:	Graduation Date:	Degree received:	ECFMG Number:
Address:	City:	State:	Zip Code:

Internship (if applicable, please attach additional Internships on a separate sheet)		
Institution Name:	Location (City and State)	Dates Attended (Month/Year) to
Program Type:	Did you complete the program? ☐ Yes ☐ No	

Residency (if applicable, please attach additional Residencies on a separate sheet)		
Institution Name:	Location (City and State)	Dates Attended (Month/Year) to
Program Type:	Did you complete the program? ☐ Yes ☐ No	

Fellowship (if applicable, please attach additional Fellowships on a separate sheet)		
Institution Name:	Location (City and State)	Dates Attended (Month/Year) to
Program Type:	Did you complete the program? ☐ Yes ☐ No	

Board Certification			
Specialty:	Certifying Board:	Expiration Date:	Last Recertification Date:
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Professional License Information			
State:	License or Certificate Number:	Date of Expiration:	Date License was originally issued:
State:	License or Certificate Number:	Date of Expiration:	Date License was originally issued:

Federal DEA Certificate and State Narcotics Registration			
State	Certificate number:	Expiration date:	Please list schedules held: ☐ 2 ☐ 2N ☐ 3 ☐ 3N ☐ 4 ☐ 5
State	Certificate number:	Expiration date:	Please list schedules held: ☐ 2 ☐ 2N ☐ 3 ☐ 3N ☐ 4 ☐ 5

Medicare/Medicaid Numbers		
NPI Number:	Medicare Number (if applicable):	Medicaid Number and State (if applicable):

Professional Liability Insurance			
Carrier Name:	Policy Number:	Effective date:	Expiration date:
Address:	City:	State:	Zip code:
Type of policy: ☐ Claims Made ☐ Occurrence	Retroactive Date:	Occurrence/Claim limit:	Aggregate limit:

Primary Admitting Hospital In-Network (if applicable)			
Primary Admitting Hospital Name:	Department:	Current or pending privileges?	
Address:	City:	State:	Zip code:
Does this hospital receive the greatest number of your admissions? ☐ Yes ☐ No			

Additional Hospital Privileges (if applicable)			
Additional Admitting Hospital Name:	Department:		Current or pending privileges?
Address:	City:	State:	Zip code:

If you do not have admitting privileges at an in-network hospital, please indicate who will admit on your behalf.		
Physician Name:	Office Phone Number: ( )	Practicing specialty:
Physician Name:	Office Phone Number: ( )	Practicing specialty:

If you utilize a hospitalist group please provide the following information:		
Hospitalist group name:	Name of hospital:	Phone number of hospitalist group:

Practice History for the past five (5) years		
For any gaps in practice history greater than six (6) months, an explanation must be attached.		
Practice/Facility Name:	Location (City and State)	Practice dates (Month/Year) to
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Please answer each question completely and accurately. If the answer to any of the below questions "yes", please attach documentation explaining the response.

Disciplinary Actions

1. Have any of the following been, or are currently in the process of being, investigated, suspended, reduced, limited, placed on probation, not renewed, voluntarily relinquished, revoked, canceled, denied or granted with stated limitations (either temporarily or permanently):

Medical license in any state?	☐ Yes ☐ **No**
DEA registration?	☐ Yes ☐ **No**
Other professional registration?	☐ Yes ☐ **No**
Board certification?	☐ Yes ☐ **No**
Academic appointment?	☐ Yes ☐ **No**
Clinical privileges?	☐ Yes ☐ **No**
Membership on any hospital or other medical staff?	☐ Yes ☐ **No**
Participation in any federal or state health program? e.g. Medicare/Medicaid	☐ Yes ☐ **No**
Professional organization membership?	☐ Yes ☐ **No**
Professional liability insurance?	☐ Yes ☐ **No**

2. Have you been convicted of a felony or misdemeanor other than traffic minor traffic violations? ☐ Yes ☐ **No**

Insurance Information	
1. Have any professional liability suits, actions or claims alleging malpractice been filed against you?	☐ Yes ☐ **No**
2. Have any professional liability suits, actions or claims been filed against you that are presently pending?	☐ Yes ☐ **No**
3. Have any judgments been made against you in professional liability cases or claims, or have you entered into any settlements?	☐ Yes ☐ **No**
Health Status	
1. Is there any reason that you are not able to perform the essential functions of your position, with or without accommodation?	☐ Yes ☐ **No**
2. Are you currently engaged in the unlawful use of drugs?	☐ Yes ☐ **No**

Professional Liability Action Explanation Form

Please complete a separate form for each pending or closed professional liability action, whether or not any payment was made on your behalf. All questions must be answered completely. If additional sheets are required, photocopy this sheet prior to completing.

Please return to: _____

_____

_____

Provider's Name:	Specialty:		
Social Security Number:	Date of birth:		
Date of occurrence or alleged incident:	Date claim or suit filed:		
Patient Name:	Location of incident:		
Your relationship to patient (attending physician, surgeon, assistant surgeon, consultant, etc.):			
Allegation or description of claim:			
Liability carrier when incident occurred:			
Additional named defendant(s):			
Name of Court in Which the Suit was filed:	Name of Defending Attorney:		
Address of Defending Attorney:	City:	State:	Zip code:

CLAIM STATUS

If open, amount being sought	*If closed, indicate method of closing*	*Amount of settlement*	*Date of settlement*

Please summarize the circumstances giving rise to the action. If the action involves patient care, please provide a narrative which describes your care and treatment of the patient. If additional space is necessary, attach adequate clinical detail to allow proper evaluation by a committee of peers. Include 1.) condition and diagnosis at time of incident, 2.) dates and description of treatment rendered, and 3.) condition of patient subsequent to treatment.

_____

_____

_____

_____

_____

_____

_____ _____

Provider Signature Date

DISCLOSURE OF OWNERSHIP, BUSINESS TRANSACTIONS & EXCLUSIONS STATEMENT FOR PROVIDERS

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to managed care organizations that contract with the Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. **This statement must be completed whether or not you have any information to report.**

OWNERSHIP &CONTROL INTERESTS (42 CFR 455.104)

A. Please provide the following information for each Person with an Ownership or Control Interest in you as a Provider, or in any Subcontractor in which you, as a Provider, have direct or indirect ownership of 5% or more. If no such ownership exists, please indicate this with an "N/A."

	Full Legal Name	Address	% Owner	Interest	SSN or FEIN	Relationship
1						
2						
3						

B. If any Person with an Ownership or Control Interest listed in subsection IV (A) is related to another Person with an Ownership or Control Interest listed in section A as a spouse, parent, child or sibling, please complete the following section. If no such relationship exists, please indicate this with an "N/A."

	Full Legal Name	Address	% Owner	Interest	SSN or FEIN	Relationship
1						
2						
3						

C. For each Person with an Ownership or Control Interest listed in subsection IV (A) who also has an ownership or control interest in an organization other than those indicated in section A, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

	Full Name of Business	Name of Other	Address	SSN or FEIN	% Ownership of
1					
2					
3					

SIGNIFICANT BUSINESS TRANSACTIONS (42 CFR 455.105)

A. Please report your ownership of any Subcontractor with whom you as a Provider have had business transactions totaling more than twenty five thousand dollars ($25,000.00) during the previous twelve (12) month period ending on the date of this request. If no such ownership exists please indicate this with an "N/A."

	Full Legal Name	Address	SSN or FEIN	% of Owner
1				
2				
3				

B. Please report any Significant Business Transactions between you as a Provider and any Wholly Owned Supplier, or between you as a Provider and any Subcontractor, during the previous five (5) year period ending on the date of this request. If no such business transactions exist, please indicate this with an "N/A."

	Name of Wholly Owned	Address	SSN or FEIN	Nature of Business
1				
2				
3				

EXCLUDED INDIVIDUALS OR ENTITIES (42 CFR 455.106)

A. Are there any Persons with an Ownership or Control Interest in you as a Provider, or any type of your managing Employees, Agents or Subcontractors who have ever:

Been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 and 1128A of the Social Security Act?

☐ Yes ☐ No

Been excluded from participation in Medicare, Medicaid, or other federally funded governmen health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?

☐ Yes ☐ No

B. Do you as a Provider have any agreements for the provisions of items or services related to the health plan's obligations under its contract with the Department of Human Services or the Centers for Medicare and Medicaid Services with an individual or entity who has been excluded from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?

☐ Yes ☐ No

If you answered "Yes" to any of the above questions, list the name and social security number or Tax ID of the individual or entity and reason for answering "Yes" (i.e. conviction of a criminal offense related to involvement in or exclusion from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act).

	Full Legal name	Address	SSN or FEIN	Reason
1				
2				
3				

CONSENT AND RELEASE FORM WITH ATTESTATION

I hereby apply/reapply for participation in those Humana offered or administered health benefit plans and products covered under the separate participation agreement executed or to be executed by and between myself and identified Humana licensed health maintenance organization(s) and/or Humana insurance companies and/or the Choice Care Network (hereafter severally and collectively as the "Plan") as requested in this application and I am willing to make myself available for interviews in regard to said applications.

I acknowledge and agree that: (a) Privileges to participate as a provider with the Plan is not a right; and (b) By applying for privileges with the Plan I am agreeing to comply with the terms and conditions of the Participation Agreement ("Agreement"), whether signed by me or not, pursuant to which I am rendering services to Plan Members either as a direct contractor, subcontractor, independent contractor, or covering physician.

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 participation with the Plan.

For the purpose of obtaining and maintaining credentialing or privileges with the Plan, I agree to hold harmless and from any and all liability, the Plan, 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, otherwise privileged or confidential information. Such information may relate to, but not be limited to information sharing on my professional qualifications, credentials, clinical competence 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 on an ongoing basis.

It is understood by both parties hereto that any and all information obtained by the Plan shall be confidential to the fullest extent permitted by law, regardless of whether my membership and privileges are approved or subsequently terminated, except as otherwise provided herein or in the separate participation agreement under which I will provide services to Plan members.

The term "Plan 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 the Plan's Board and their appointed representatives, the Chief Executive Officer or his designees, other Plan employees, consultants to the Plan, delegated credentialing entities, the Plan's attorney and his/her partners, associates or designees. The term "third parties" means all individuals, including appointees to the Plan's medical staffs, hospitals, other physicians or health practitioners, nurses, government agencies, organizations, professional liability insurance carriers, associations, partnerships, and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the Plan or its authorized representatives or who have requested such information from the Plan and its authorized representatives.

As a condition of the Plan's acceptance of my application for participation privileges and in support of the Plan's commitment to continuous quality improvement and peer review, I hereby authorize the Plan and its authorized representatives to disclose and communicate with my employer, partners or affiliates, as applicable in relation to my provision of medical and related health care services to Plan members, regarding actions or information relating to the Plan credentialing, re-credentialing and/or quality management programs.

As an applicant, I agree to produce adequate information for proper evaluation of my professional qualifications. I also agree to update the Plan with current information regarding all responses and/or questions contained in this application and/or information obtained through the credentialing process as such information becomes available and any additional information as requested by the Plan or its authorized representatives. Failure to produce such information will prevent my application from being evaluated and acted upon, and may affect any existing privileges I have with the Plan

I further acknowledge and agree that communications and/or documents which are required in writing in order to comply with applicable laws and regulations shall be considered to be in compliance with any such laws and requlations, if transmitted, acknowledged and/or executed through the use of mail (e-mail), electronic data interface, (EDI), internet or other electronic transmission.

I hereby acknowledge that this Consent and Release Form will be valid for a period of three (3) years from the date it is signed by me, and that a photocopy or fax will serve as an original.

Applicant's Signature:_____ Date: _____