FIRST MCO/ACTIVE CARE

Application for Provider Participation in First Managed Care Option
GENERAL INSTRUCTIONS

Please include the following with submission of your application (check if complete):

__Copy of current State Medical License
__Copy of additional current license(s)
__Copy of current DEA Registration Certificate
__Copy of current CDS; Controlled Dangerous Substances Registration Certificate (if applicable)
__Copy of malpractice coverage showing amount of coverage, company name, and renewal date (face sheet)
__The signed copy of each Provider Agreement/signed application
__Copy of curriculum vitae

Last Name	First	Middle	Degree

A. Applying as

Applying as:

- ❑ **Primary Care Physician** (Primary Care Physicians must practice in Family Practice, General Practice, Internal Medicine, Pediatrics)
- ❑ **Referral Specialist** (Orthopedist, Neurologist, etc.) Specify:_____

Allied Health Professional (Licensed, certified, registered, or otherwise authorized non-physician providers of direct care services)
Specify:_____

B. General Information

Please indicate which number should be used for tax reporting (IRS 1099) purposes.

Individual Tax Identification # ❑ IRS 1099	Group Tax I.D.# NPI #:	Social Security # ❑ IRS 1099	Date of Birth	Medicare UPIN	Gender ❑ Male ❑ Female

Primary Office Address: Group Name (if applicable) :

Street _____ Suite # _____

City _____ State _____ Zip Code _____

Telephone # _____ Fax # _____

Name of Office Manager/Contact _____

Secondary Office Address: Group Name (if applicable)

Street _____ Suite # _____

City _____ State _____ Zip Code _____

Telephone # _____ Fax # _____

Billing Name and Billing office Address:

Street _____ Suite# _____

City _____ State _____ Zip Code _____

Telephone # _____ Fax # _____

*** Please attach a list of additional office addresses for inclusion in the Directory**

C. Education and Training

A curriculum vitae may be attached in lieu of completing this section if all requested information is included.

Medical School or Professional Training	Complete Name of Institution	
	Mailing Address, City, State and Country	
	Degree/Year Graduated	
Internship	Complete Name of Institution	
	Mailing Address, City, State and Country	
	Specialty	From (month/year) to (month/year)
Residency	Complete Name of Institution	
	Mailing Address, City, State and Country	
	Specialty	From (month/year) to (month/year)
Second Residency	Complete Name of Institution	
	Mailing Address, City, State and Country	
	Specialty	From (month/year) to (month/year)
Fellowship	Complete Name of Institution	
	Mailing Address, City, State and Country	
	Specialty	From (month/year) to (month/year)

D. Certification

Please indicate the Boards or Certifications (*e.g., American Board of Medical Specialties, American Osteopathic Association, American Board of Oral and Maxillofacial Surgery, American Board of Podiatric Surgery, American College of Social Workers, American Speech-Language-Hearing Association*) in which you are certified in your specialty(ies) or profession, the date(s) of certification and the expiration date on the certificate(s).

Name of Board	Specialty	Certification Date	Expiration Date
Name of Board	Specialty	Certification Date	Expiration Date
Name of Board	Specialty	Certification Date	Expiration Date

If Certification has not been achieved yet, please submit a copy of your certificate of completion of a residency program. In addition, please document your status in the certifying process.

Name of Board	Specialty	Date(s) examination was taken/retaken	OR	Date examination is scheduled
☐ Not eligible to take boards		☐ Not Planning to take specialty boards		

E. State License(s)

Please provide the information requested below regarding your **State License** or other authorization to practice.

Profession	State and Authorizing Agency	License Number	Expiration Date
Profession	State and Authorizing Agency	License Number	Expiration Date

F. DEA Certificate

Please provide the information requested below regarding your **federal DEA Certificate** and any required **state DEA/CDS Certificate**.

Federal Certificate Number	Expiration Date	State Certificate Number	State	Expiration Date

G. Malpractice Insurance

Insurance Carrier		
Policy Number	Expiration Date	Amount of Coverage $ per occurrence/ $ aggregate

H. Work History

Please present your professional work history, starting with the present, including: office practice, teaching appointments, employment and former hospital privileges. Use an additional page, if needed. You may send a curriculum vitae in lieu of completion of Work History.

1. Name of Organization or Office Practice	City/State
Position	From (mo/yr) To (mo/yr)
2. Name of Organization or Office Practice	City/State
Position	From (mo/yr) To (mo/yr)
3. Name of Organization or Office Practice	City/State
Position	From (mo/yr) To (mo/yr)
4. Name of Organization or Office Practice	City/State
Position	From (mo/yr) To (mo/yr)
5. Name of Organization or Office Practice	City/State
Position	From (mo/yr) To (mo/yr)

First MCO/Active Care

I. General Practice Information

Languages Spoken (Including English and foreign languages)

Fluently by self	Fluently by staff members

Scheduled Office Hours: Please list hours for additional office locations on a separate page.

Location	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Primary Office							
Secondary Office							

Coverage of Practice: 24-hour, 7 day-a-week coverage for Primary Care is required. Please describe after-hours arrangements and list your covering physicians by name. Covering physicians should be participating providers in the FMCO Network. If not – participating physician must agree to the fees and administrative procedures of the FMCO Network.

Covering Physician Name	Address	City, State, Zip	Phone	❑ FMCO Par
Covering Physician Name	Address	City, State, Zip	Phone	❑ FMCO Par
Covering Physician Name	Address	City, State, Zip	Phone	❑ FMCO Par

Are you accepting new patients? ☐Yes ☐No

Are all your office locations handicap accessible? ☐Yes ☐No

Please identify the laboratory and radiology services in your office. Also, describe usual referral patterns for the provision of these services outside your office. Laboratory CLIA Certified? ☐Yes ☐No CLIA#_____

Group Practice or Partnership Affiliation: All Physicians should be participating providers in the FMCO Network. Use a separate page to list additional names.

Partnership or Group Practice Name

Name	Specialty
Name	Specialty
Name	Specialty

Independent Practice Information (IPA) Membership/Physician Hospital Organization (PHO)

IPA Name/PHO Name	Affiliated Hospital	Member Since
IPA Name/PHO Name	Affiliated Hospital	Member Since

J. Hospital Practice Information

Please list, in order of descending frequency of admissions, all hospitals where you have medical staff privileges and the membership category (e.g., Active, Associates, Courtesy).

Primary Admitting Hospital/Surgery Center	City & State	% of Admissions	Membership Category
Name of Hospital/Surgery Center	City & State	% of Admissions	Membership Category
Name of Hospital/Surgery Center	City & State	% of Admissions	Membership Category
Name of Hospital/Surgery Center	City & State	% of Admissions	Membership Category

K. Confidential Information

1. Have you ever been refused hospital privileges or have your hospital privileges ever been revoked, suspended or reduced? ☐Yes ☐No

2. Have you ever been disciplined by any state licensing or other authorizing agency, or by and Professional Conduct Board, or have you ever been reprimanded, or fined by any state agency that disciplines physicians or allied health professionals? ☐Yes ☐No

3. Have you ever been reprimanded, censured, excluded, suspended, or disqualified by the Medicare, Medicaid, or CLIA programs? ☐Yes ☐No

4. Has your DEA certificate ever been suspended or otherwise limited? ☐Yes ☐No

5. Has your authorization to practice in any jurisdiction (state or county) ever been revoked, suspended, or subject to probation or any conditions or limitations? ☐Yes ☐No

6. Have you ever been convicted of a felony or are you presently under indictment for a felony? ☐Yes ☐No

7. To your knowledge, has any information pertaining to you ever been reported to the National Practitioner Data Bank? ☐Yes ☐No

8. Has any malpractice suits, arbitrations or other proceedings ever been instituted against you? If **"Yes",** details provided should include when each action or proceeding was instituted and the status or outcome of each including the date and amount of any judgement, adverse decision or settlement, together with copies of the same. ☐Yes ☐No

9. Have you any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede your ability to provide care according to accepted standards or professional performance or pose a threat to the health or safety of patients? ☐Yes ☐No

Note: If you answered "Yes" to any of the preceding questions, please provide details on a separate sheet of paper. Include a copy of any order or settlement where applicable.

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Conditions of Appointment:

By making this application, I hereby

- Understand and agree that I, was an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.
- Signify my willingness to appear for interviews in regard to my application.
- Authorize the FMCO committees and their representative to consult with the administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character, and ethical qualifications.
- Consent to the inspection by FMCO, its committees, and its representatives of all records and documents including hospital medical records that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for membership in FMCO Provider Network.
- Release from liability all representatives of FMCO and its committees and their staff for acts performed in good faith and without malice in connection with evaluating my application, my credentials, and qualifications.
- Release from liability any or all individuals or organizations who provide information to FMCO or its committees in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges, and I hereby consent to release of such information.
- Attest to the correctness and competence of all information furnished and acknowledge that any significant misstatements in, or omissions from, this application constitutes cause for summary dismissal from the FMCO Provider Network. All information submitted by me in this application is true to my best knowledge and belief.
- Agree to immediately notify the President of FMCO of any change, made or proposed, in the status of my professional license to practice; DEA or other controlled substance registration; professional liability coverage.
- Authorize FMCO and its committees, to collect any information necessary to verify the information in the credentialing application.

Signature	Date

Please Provide the following with the submission of your application:

- Copy of all current Medical Licensing as required by state
- Copy of current DEA Registration Certificate
- Copy of current CDS (if applicable)
- Copy of malpractice coverage showing amount of coverage, company name, and renewal date (face sheet)
- Copy of curriculum vitae
- The signed copy of each Physician Agreement

If you are interested in participating on our New Jersey Medical Review Organization (MRO) panel, please check the appropriate box if you are an active New Jersey practitioner; deriving 50% of income from practicing medicine.

☐ Yes ☐ No

PLEASE FAX COMPLETED APPLICATION TO 973-257-5329 Attn: Tony Alvarez