KERN HEALTH SYSTEMS
ADDENDUM A
HEALTH PLANS AND IPA'S/MEDICAL GROUPS

This application is submitted to**:** **Kern Health Systems** , herein, this Healthcare Organization[1]

I. TYPE OF ENTITY (check all that apply)

☐ Solo Practice ☐ Group Practice ☐ Single Specialty ☐ Multi Specialty

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Medical Group(s)/IPA(s) Affiliation:		

Do you intend to serve as a primary care provider? ☐ Yes ☐ No

So you intend to serve as a specialist? ☐ Yes ☐ No

If yes, please list specialty(s):

III. BILLING INFORMATION

Billing Company Name:

Mailing Address:	City:	
	State:	ZIP:
Contact Person:	Telephone Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

IV. PRACTICE INFORMATION

So you employ any allied health professionals (AHP) (e.g. nurse practitioners, psychologists, etc.)? ☐ Yes ☐ No

If yes, please list all AHP(s) below:

STAFF MEMBER NAME	TYPE OF PROVIDER	LICENSE NUMBER

If you are a Physician Assistant Supervisor, please include State License Number:

[1] As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

Applicant Name: _____

Do you personally employ any physicians? ☐ Yes ☐ No

If yes, please list all AHP(s) below:

STAFF MEMBER NAME	CALIFORNIA MEDICAL LICENSE NUMBER

Please list any clinical services you perform that are not typically associated with your specialty:

Please list any clinical services **you do not** perform that are typically associated with your specialty:

Is your practice limited to certain age groups? If yes, specify limitations:	☐ Yes	☐ No
Are you a Certified Qualified Medical Examiner (QME) of the Sate Industrial Medical Council?	☐ Yes	☐ No
Do you participate in electronic data interchange (EDI)? If yes, which Network?	☐ Yes	☐ No
Do you use practice management systems/software? If yes, which system/software?	☐ Yes	☐ No

What type of anesthesia do you provide in your group/office?

☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other (please specify)

Has your office received any of the following accreditations, certifications or licensures?

☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
☐ California Department of Health Services Licensure
☐ Institute for Medical Quality – Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
☐ Medicare Certification
☐ The Medical Quality Commission (TMQC)
☐ Other

V. OFFICE HOURS (please indicate the hours your office is open)

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Please indicate which Holidays your office is closed or have fluctuating hours:

VI. COVERAGE OF PRACTICE – List your answering service and covering physicians by name. (Attach additional sheets if necessary)

Answering Service Company:	Phone Number:	Fax Number:

Mailing Address:

Applicant Name: _____

City:	State:	ZIP:

COVERING PHYSICIAN'S NAME	CONTACT NUMBER

If you do not have hospital privileges, please provide written plan for continuity of care:

VII. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:	Fluently by Staff:

VIII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Applicants must **submit legible copies** of CLIA certificate or waiver, if applicable.

Tax ID#:	Billing Name:	Type of Service Provided:

Do you have a CLIA certificate? ☐ Yes ☐ No

CLIA Certificate Number:	CLIA Expiration Date:

IX. PROFESSIONAL ORGANIZATIONS

Please list county, state or national medical societies or other professional organizations or societies of which you are a member or applicant.

ORGANIZATION NAME	APPLICANT	MEMBER
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

I certify that the information in this document and any attached documents is true and correct

Print Name Here _____

Physician Signature_____ Date_____
(Stamped Signature Is Not Acceptable)

Applicant Name: _____

ADDITIONAL INFORMATION for _____

PRIMARY **Payment Address** *(if different from practice location)*

Practice Name		**Name***	
Address		**Address**	
Suite		**Suite**	
City/State/Zip		**City/State/Zip**	
Phone No.		**Phone No.**	
Fax No.		**Contact Person**	
Office Day/Hours		**Name Affiliated with Tax ID Number**	
Contact Person		**Tax ID Number**	

FTE Percentage of a forty-hour workweek this provider is available to see patients at this location	☐ **100%** ☐ **80%** ☐ **75%** ☐ **60%** ☐ **50%**	☐ **40%** ☐ **30%** ☐ **25%** ☐ **20%** ☐ **Other _____**	**The sum of percentages for one provider located at different sites should not exceed 100%.**

ALTERNATE (2nd Location) **Payment Address** *(if different from practice location)*

Practice Name		**Name***	
Address		**Address**	
Suite		**Suite**	
City/State/Zip		**City/State/Zip**	
Phone No.		**Phone No.**	
Fax No.		**Contact Person**	
Office Day/Hours		**Name Affiliated with Tax ID Number**	
Contact Person		**Tax ID Number**	

FTE Percentage of a forty-hour workweek this provider is available to see patients at this location	☐ **100%** ☐ **80%** ☐ **75%** ☐ **60%** ☐ **50%**	☐ **40%** ☐ **30%** ☐ **25%** ☐ **20%** ☐ **Other _____**	**The sum of percentages for one provider located at different sites should not exceed 100%.**

ADDITIONAL INFORMATION for _____

ALTERNATE (3rd Location) **Payment Address** *(if different from practice location)*

Practice Name		**Name***	
Address		**Address**	
Suite		**Suite**	
City/State/Zip		**City/State/Zip**	
Phone No.		**Phone No.**	
Fax No.		**Contact Person**	
Office Day/Hours		**Name Affiliated with Tax ID Number**	
Contact Person		**Tax ID Number**	

FTE Percentage of a forty-hour workweek this provider is available to see patients at this location	☐ **100%** ☐ **80%** ☐ **75%** ☐ **60%** ☐ **50%**	☐ **40%** ☐ **30%** ☐ **25%** ☐ **20%** ☐ **Other _____**	**The sum of percentages for one provider located at different sites should not exceed 100%.**

ALTERNATE (4th Location) **Payment Address** *(if different from practice location)*

Practice Name		**Name***	
Address		**Address**	
Suite		**Suite**	
City/State/Zip		**City/State/Zip**	
Phone No.		**Phone No.**	
Fax No.		**Contact Person**	
Office Day/Hours		**Name Affiliated with Tax ID Number**	
Contact Person		**Tax ID Number**	

FTE Percentage of a forty-hour workweek this provider is available to see patients at this location	☐ **100%** ☐ **80%** ☐ **75%** ☐ **60%** ☐ **50%**	☐ **40%** ☐ **30%** ☐ **25%** ☐ **20%** ☐ **Other _____**	**The sum of percentages for one provider located at different sites should not exceed 100%.**

Attachment D

ATTENTION PROVIDERS

Provider Name:_____

If you are performing or would like to perform antenatal services to Kern Family Health Care members, you must provide documentation of adequate training and experience. See Policy 4.24 in you Provider Manual.

A provider may be credentialed to perform antenatal services if they can provide documented training in one of the following:

☐ Obstetrics through a certified Obstetrical Residency Program

☐ Family Practice through a certified Family Practice Residency Program

☐ Qualified training and experience, as well as, a sponsor to help supervise the clinical practice. A sponsor must be either an Obstetrician or Family Practice Provider who has completed an Obstetrical Residency Program or a Family Practice Program.

All antenatal providers must provide documentation that their malpractice insurance carrier is aware that they are providing such services.

☐ **I do not offer antenatal services**

If you have any questions, please contact the Credentialing Dept at (661) 664-5147

Physician and Staff Language Capabilities Form

Provider/Clinic Name:____

Site Address:____

If English is the only language spoken by you and your staff, please check this box: ☐ **English only**

STAFF NAME	POSITION	LANGUAGE(S)	SPEAKING	READING	WRITING
	☐ Physician ☐ RN/NP ☐ Staff	1. 2. 3.	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5
	☐ Physician ☐ RN/NP ☐ Staff	1. 2. 3.	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5
	☐ Physician ☐ RN/NP ☐ Staff	1. 2. 3.	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5
	☐ Physician ☐ RN/NP ☐ Staff	1. 2. 3.	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5
	☐ Physician ☐ RN/NP ☐ Staff	1. 2. 3.	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5

If you need additional pages, please photocopy this form.

Evaluation Guidelines

(1) Poor — Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry level questions. May require slow speech and repetition.

(2) Fair — Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar.

(3) Good — Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics.

(4) Very Good — Able to use the language fluently and accurately on all levels related to work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.

(5) Excellent — Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialism, and pertinent cultural preferences. Usually has received formal education in target language.