MercyCare

PROVIDER PARTICIPATION REQUEST FORM

Thank you for your interest in becoming a participating provider with MercyCare Health Plans. Your request will be evaluated for participation in all MercyCare-affiliated networks. In order to expedite the processing of your application:

1. Complete the application in full. Please print clearly or fill out electronically and attach any additional information or brochures that may help in our evaluation of your facility and the services you provide.

2. Attach a copy of your W-9 form and provide the requested information specific to all facilities, practitioners and services (a W-9 form is attached for your convenience.)

3. If applicable, provide: 1) evidence that you are Medicare- and Medicaid-eligible; and 2) evidence of licensure to operate according to state and federal regulations.

PLEASE RETURN VIA:

Email: contracting.mercycarehealthplans@mhemail.org

Fax: (608) 752-3751

Mail: MercyCare Health Plans
PO Box 550
580 N. Washington St.
Janesville, WI 53547-0550

SECTION I: BILLING INFORMATION	
Legal Entity Name: *(include d/b/a if applicable)*	
Ownership Type: *(Sole Proprietor, LLC, SC, etc.)*	
Tax ID Number:	
Mailing Street address:	
Mailing City, State and ZIP:	
Billing Payable to Address:	
Billing Payable to City, State and ZIP:	
Phone Number:	
2nd Phone Number:	
Fax Number:	
Facility's Website Address:	
Facility's NPI:	

CONTACT INFORMATION	
Contract Contact Person: (Person filling out paper)	
Phone:	
Fax:	
Email:	

	SECTION II: GENERAL INFORMATION	
1.	Have you ever applied for or had a contract with MercyCare Health Plans? If yes, under what name or group?	☐ Yes ☐ No
2.	Covered service area (cities and counties):	
3.	Please list any MercyCare Health Plans network providers that currently refer to your office:	
4.	Please provide a brief description of your facility and the services you currently provide:	
5.	Is public transportation accessible to and from your facility?	☐ Yes ☐ No
6.	Does your facility accommodate people with physical disabilities (including exam rooms, equipment, restrooms, handicap entrance and parking)?	☐ Yes ☐ No
7.	Describe how you meet the needs of members with physical disabilities and limited mobility:	
8.	Describe how you meet the needs of non-English speaking patients:	
9.	Please list the number of hours per week your facility is open for appointments:	
10	Please list the hours staff are available (include evening/weekend hours):	
11	Please describe your process for handling calls after hours for urgent and emergent patient situations:	
12	Does your organization allow mid-level practitioners (e.g., nurse practitioners and/or physician assistants) to be selected by patients as a primary care provider?	☐ Yes ☐ No
13	Does your facility provide e-visits, virtual visits or telehealth services? Comments:	☐ Yes ☐ No
14	a. Does your facility use restraint measures, such as restraints or seclusion? b. Do you have a policy* to support the use of restrictive measures? c. If you do not use restrictive measures, do you have a policy* to support your patients' right to be free from any form of restraint or seclusion? **Policy must be available upon request.*	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Providers Employed by Facility: **Practitioner Name**	**Degree**	**License State/Number**	**Date License Issued**	**NPI #**

Providers Employed by Facility: Practitioner Name	Hospital Affiliation

SECTION IV: BEHAVIORAL HEALTH PROVIDER INFORMATION

A. Practice Type

	Group		Individual

B. Treatment Information

1.	Area(s) of specialization/interest (include special populations):	
2.	Conditions treated:	
3.	Methods/approaches used in treatment:	
4.	Does the practice have a psychiatrist consulting on staff or referral arrangements with a psychiatrist at another location?	☐ Yes ☐ No
5.	What are these arrangements and, if there aren't any, what are the means for getting patients psychiatric care?	
6.	Will your facility be providing medication assisted treatment (MAT)? Buprenorphine: ☐ Yes ☐ No Vivitrol: ☐ Yes ☐ No Methadone: ☐ Yes ☐ No • If yes, please describe your process for providing or arranging counseling with a therapist for primary substance use disorder: • If services are not provided by you, list the providers that you have agreements with to provide therapy and describe how patients are referred: • List the medical specialty of providers prescribing MAT: Comments:	

SECTION V: FACILITY CREDENTIALING FORM

License/Accrediting Body	Indicate Yes or No or N/A	Number	Effective Date	Expiration Date
Facility Type: ☐ Hospital ☐ Clinic ☐ Nursing Home ☐ Surgery Center ☐ Behavioral Health				
Facility State License, Wisconsin	☐ Yes ☐ No ☐ N/A			
Facility State License, Illinois	☐ Yes ☐ No ☐ N/A			
Medicare Certification	☐ Yes ☐ No ☐ N/A			
Medicaid Certification	☐ Yes ☐ No ☐ N/A			
The Joint Commission	☐ Yes ☐ No ☐ N/A			
AAAHC - Accreditation Association for Ambulatory Health Care	☐ Yes ☐ No ☐ N/A			
AAAASF - American Association for Accreditation of Ambulatory Surgical Facilities	☐ Yes ☐ No ☐ N/A			
ACHC - Accreditation Commission for Health Care	☐ Yes ☐ No ☐ N/A			
CARF - Commission on Accreditation of Rehabilitation Facilities	☐ Yes ☐ No ☐ N/A			
CHAP - Community Health Accreditation Program	☐ Yes ☐ No ☐ N/A			
COA - Council on Accreditation	☐ Yes ☐ No ☐ N/A			
DNV Healthcare - Det Norske Veritas Healthcare, Inc.	☐ Yes ☐ No ☐ N/A			
HFAP - Healthcare Facilities Accreditation Program	☐ Yes ☐ No ☐ N/A			
CLIA – Clinical Laboratory Improvement Amendments	☐ Yes ☐ No ☐ N/A			

***Please attach copies of the following documents*:**

☑ Copy of the facility's state license
☑ Most recent State/CMS survey results and the cover letter stating acceptance of the plan of correction, if applicable
☑ Explanation regarding any loss or change of certification or accreditation status within the past three years
☑ Written procedure for credentialing your providers

For facilities without accreditation, MercyCare reserves the right to conduct an onsite visit to your facility.

SECTION VI: SERVICES

Please review each service listed and indicate the services provided by your facility.

BEHAVIORAL HEALTH SERVICES		BILLING NPI
☐	Mental Illness Adult – Inpatient Treatment	
☐	Mental Illness Child/Adolescent – Inpatient Treatment	
☐	Mental Illness Adult – Outpatient Treatment	
☐	Mental Illness Child/Adolescent – Outpatient Treatment	
☐	AODA Adult – Inpatient Treatment	
☐	AODA Adolescent – Inpatient Treatment	
☐	AODA Adult – Outpatient Treatment	
☐	AODA Adolescent – Outpatient Treatment	
☐	Other:	
EYE CLINICS SERVICES		**BILLING NPI**
☐	Ophthalmology Services	
☐	Optometry Services	
☐	Vision Care/Screening	
☐	Vision Supplies (Eye Glasses and Contacts)	
☐	Other:	
DIALYSIS		**BILLING NPI**
☐	Inpatient	
☐	Outpatient	
☐	Other:	
DURABLE MEDICAL EQUIPMENT SERVICES		**BILLING NPI**
☐	Apnea Monitors	
☐	BI-Pap	
☐	Bone Growth Stimulator	
☐	CPAP	
☐	DME/HME (standard wheelchair, hospital bed, etc.)	
☐	Oxygen Concentrator	
☐	Oxygen-Liquid	
☐	Photo Therapy	
☐	Respiratory DME	
☐	TENS Unit	
☐	Ventilators	
☐	Wound Vac	
☐	Other Specialty DME Items:	
HOME HEALTH SERVICES		**BILLING NPI**
☐	Durable Medical Equipment	
☐	Home Infusion	
☐	Home Health Services – Skilled	
☐	Home Health Services – Aid	
☐	Occupational Therapy	
☐	Physical Therapy	
☐	Speech Therapy	
☐	Other:	

NURSING HOME SERVICES	BILLING NPI
☐ Skilled Nursing Services	
☐ Other:	
PATHOLOGY SERVICES	**BILLING NPI**
☐ Pathology Services (Professional)	
☐ Pathology Services (Technical)	
☐ Other:	
PODIATRIC SERVICES	**BILLING NPI**
☐ Radiology – Diagnostic & Therapeutic	
☐ Podiatric Services	
☐ Other:	
PROSTHETICS/ORTHOTIC SERVICES	**BIILLING NPI**
☐ Mastectomy Supplies	
☐ Orthotic Supplies	
☐ Prosthetic Supplies	
☐ Other:	
RADIOLOGY SERVICES	**BILLING NPI**
☐ Bone Density Measurement	
☐ CT (Professional)	
☐ MRI (Professional)	
☐ MRI (Technical)	
☐ Nuclear Medicine	
☐ Nuclear Medicine (Professional)	
☐ Open MRI	
☐ Radiation Oncology	
☐ Radiation	
☐ Radiology – General Services (Technical)	
☐ Radiology Services – Diagnostic & Therapeutic	
☐ Radiology Services – Mammography	
☐ Ultrasound	
☐ Vascular and Interventional Radiology	
☐ Other:	
SPORTS MEDICINE SERVICES	**BILLING NPI**
☐ Durable Medical Equipment (Dispensed In-house)	
☐ Occupational Therapy (Outpatient)	
☐ Physical Therapy (Outpatient)	
☐ Orthotic Supplies	
☐ Prosthetic Supplies	
☐ Radiology – Diagnostic & Therapeutic (In-house)	
☐ Orthopedic Surgery (Adult)	
☐ Orthopedic Surgery (Pediatric)	
☐ Other:	

OTHER SERVICES	BILLING NPI
☐ Anti-Hemophiliac Factor	
☐ Anesthetists	
☐ ECG Interpretation	
☐ Insulin Pump Therapy	
☐ Cardiac Outpatient Telemetry	
☐ Specialty Clinic	
☐ Urgent Care Services	
☐ Other:	

CLINIC SERVICES	BILLING NPI
☐ Allergy Services	
☐ Audiology – Hearing Screening	
☐ Audiology – Hearing Aids	
Behavioral Health:	
☐ • Mental Illness Adult – Outpatient Treatment	
☐ • Mental Illness Child/Adolescent – Outpatient Treatment	
☐ • Alcoholism/Chemical Dependency Adult – Outpatient	
☐ • Alcoholism/Chemical Dependency Adolescent – Outpatient	
☐ Cardiology Services	
☐ Dental Services	
☐ Dermatology Services	
☐ Durable Medical Equipment	
☐ Endocrinology Services	
☐ Eye Glasses & Contacts	
☐ Family Practice	
☐ Gastroenterology Services	
☐ Hematology/Oncology Services	
☐ Infectious Disease Services	
☐ Internal Medicine Services	
☐ Laboratory Services	
☐ Nephrology Services	
☐ Neurology Services	
☐ Neurosurgery	
☐ Obstetrics & Gynecology	
☐ Occupational Health Services	
☐ Occupational Therapy (Outpatient)	
☐ Opthalmology Services	
☐ Optometry Services	
☐ Oral/Maxillofacial Surgery	
☐ Orthopedics Services	
☐ Otolaryngology (ENT)	
☐ Pediatric Services	
☐ Physical Medicine & Rehabilitation	
☐ Physical Therapy (Outpatient)	

☐	Plastic & Reconstructive Surgery – General
☐	Podiatric Services
☐	Orthotic Supplies
☐	Prosthetic Supplies
☐	Pulmonary Medicine Services
☐	Radiation Therapy
☐	Radiology Services – Diagnostic & Therapeutic
☐	Radiology Services – Mammography
☐	Renal Dialysis
☐	Rheumatology Services
☐	Speech Therapy
☐	Sports Medicine Services
☐	Surgery – Outpatient or Ambulatory
☐	Urgent Care Services
☐	Urology Services
☐	Other:
HOSPITAL SERVICES	**BILLING NPI**
☐	Acute Inpatient Hospital Care
	Behavioral Health:
☐	• Mental Illness Adult– Inpatient Treatment
☐	• Mental Illness Child/Adolescent–Inpatient Treatment
☐	• Mental Illness Adult – Outpatient Treatment
☐	• Mental Illness Child/Adolescent – Outpatient Treatment
☐	• Alcoholism/Chemical Dependency Adult – Inpatient
☐	• Alcoholism/Chemical Dependency Adolescent – Inpatient
☐	• Alcoholism/Chemical Dependency Adult – Outpatient
☐	• Alcoholism/Chemical Dependency Adolescent – Outpatient
☐	Cardiology Services
☐	Cardiac Surgery Program
☐	Cardiac Catheterization Services
☐	Critical Care Services – Intensive Care Units (ICU)
☐	Durable Medical Equipment
☐	Emergency & Trauma Center
☐	Endocrinology Services
☐	Gastroenterology Services
☐	Hematology/Oncology Services
☐	Home Health
☐	Infectious Disease Services
☐	Laboratory Services
☐	Neonatal Intensive Care Unit
☐	Neurology Services
☐	Neurosurgery
☐	Occupational Health Services
☐	Occupational Therapy (Inpatient)

☐	Occupational Therapy (Outpatient)
☐	Orthopedic Surgery (Adult)
☐	Orthopedic Surgery (Pediatric)
☐	Otolaryngology (ENT)
☐	Outpatient Infusion/Chemotherapy
☐	Pediatric Services
☐	Physical Medicine & Rehabilitation
☐	Physical Therapy (Inpatient)
☐	Physical Therapy (Outpatient)
☐	Plastic & Reconstructive Surgery - General
☐	Pulmonary Medicine Services
☐	Radiation Oncology Services
☐	Radiology Services – Diagnostic & Therapeutic
☐	Radiology Services - Mammography
☐	Rheumatology Services
☐	Speech Therapy (Outpatient)
☐	Surgery – Outpatient or Ambulatory
☐	Surgery (General)
	Transplant Program:
☐	• Heart Transplant
☐	• Heart/Lung Transplant
☐	• Kidney Transplant
☐	• Liver Transplant
☐	• Lung Transplant
☐	• Pancreas Transplant
☐	Swing Bed – (Skilled Nursing Services)
☐	Urgent Care Services
☐	Urology
☐	Vascular Surgery
☐	Other:

SECTION VII: LANGUAGES (REQUIRED)

Please list below all languages spoken by the practitioners and employees of your facility.

☐ English ☐ Spanish ☐ American Sign Language ☐ Arabic

☐ Chinese ☐ Farsi ☐ French ☐ German ☐ Greek

☐ Italian ☐ Mandarin ☐ Hindi ☐ Russian ☐ Urdu

☐ Other: _____

SECTION VIII: ATTESTATION

I hereby verify that the information provided herein is current, correct and complete as of the date of my signature below and that, at a minimum, the staff are legally and professionally qualified for the positions they hold and that there are no state or federal sanctions against this facility. As an administrative representative of this facility, I have the authority to sign on behalf of the organization.

_____

Signature Date

_____(Print Name) _____(Phone Number)

MERCYCARE CONTRACT IMPLEMENTATION FORM

Billing and Facility Information

Contact Information (for information regarding claims, address changes, and/or practitioner changes):

Contact Name:			
Contact Address:			
Contact Telephone Number:		Contact Fax Number:	
Contact Email Address:			

Credentialing Recipient:

Contact Name:			
Contact Address:			
Contact Telephone Number:		Contact Fax Number:	
Contact Email Address:			

Service Site Locations:

1.	Location/Clinic:							
	Street Address:		City:		State:		Zip + 4:	
	Billing Address:		City:		State:		Zip + 4:	
	County:		Phone Number:		Fax Number:			
	Billing National Provider Identification (NPI) Number:							
	Tax Identification Number:							
	Swing Bed Facility?	☐ Yes ☐ No	Essential Community Provider Type:					
	Total # of Beds:		☐	Federally Qualified Health Center Provider	☐	Ryan White Provider		
	# of Certified Medicare Beds:		☐	Indian Health Provider	☐	Other ECP Provider		
	# of ICU/CCU Beds:		☐	Family Planning Provider	☐	Hospital Provider		
	On-Call/After Hours Coverage? ☐ Yes ☐ No		Regular Office Hours:					

2.	Location/Clinic:							
	Street Address:		City:		State:		Zip + 4:	
	Billing Address:		City:		State:		Zip + 4:	
	County:		Phone Number:		Fax Number:			
	Billing National Provider Identification (NPI) Number:							
	Tax Identification Number:							
	Swing Bed Facility?	☐ Yes ☐ No	Essential Community Provider Type:					
	Total # of Beds:		☐	Federally Qualified Health Center Provider	☐	Ryan White Provider		
	# of Certified Medicare Beds:		☐	Indian Health Provider	☐	Other ECP Provider		
	# of ICU/CCU Beds:		☐	Family Planning Provider	☐	Hospital Provider		
	On-Call/After Hours Coverage? ☐ Yes ☐ No		Regular Office Hours:					

MERCYCARE CONTRACT IMPLEMENTATION FORM

Billing and Facility Information

Service Site Locations Continued:

3.	Location/Clinic:							
	Street Address:		City:		State:		Zip + 4:	
	Billing Address:		City:		State:		Zip + 4:	
	County:		Phone Number:		Fax Number:			
	Billing National Provider Identification (NPI) Number:							
	Tax Identification Number:							
	Swing Bed Facility?	☐ Yes ☐ No	Essential Community Provider Type:					
	Total # of Beds:		☐	Federally Qualified Health Center Provider		☐	Ryan White Provider	
	# of Certified Medicare Beds:		☐	Indian Health Provider		☐	Other ECP Provider	
	# of ICU/CCU Beds:		☐	Family Planning Provider		☐	Hospital Provider	
	On-Call/After Hours Coverage? ☐ Yes ☐ No		Regular Office Hours:					

4.	Location/Clinic:							
	Street Address:		City:		State:		Zip + 4:	
	Billing Address:		City:		State:		Zip + 4:	
	County:		Phone Number:		Fax Number:			
	Billing National Provider Identification (NPI) Number:							
	Tax Identification Number:							
	Swing Bed Facility?	☐ Yes ☐ No	Essential Community Provider Type:					
	Total # of Beds:		☐	Federally Qualified Health Center Provider		☐	Ryan White Provider	
	# of Certified Medicare Beds:		☐	Indian Health Provider		☐	Other ECP Provider	
	# of ICU/CCU Beds:		☐	Family Planning Provider		☐	Hospital Provider	
	On-Call/After Hours Coverage? ☐ Yes ☐ No		Regular Office Hours:					

5.	Location/Clinic:							
	Street Address:		City:		State:		Zip + 4:	
	Billing Address:		City:		State:		Zip + 4:	
	County:		Phone Number:		Fax Number:			
	Billing National Provider Identification (NPI) Number:							
	Tax Identification Number:							
	Swing Bed Facility?	☐ Yes ☐ No	Essential Community Provider Type:					
	Total # of Beds:		☐	Federally Qualified Health Center Provider		☐	Ryan White Provider	
	# of Certified Medicare Beds:		☐	Indian Health Provider		☐	Other ECP Provider	
	# of ICU/CCU Beds:		☐	Family Planning Provider		☐	Hospital Provider	
	On-Call/After Hours Coverage? ☐ Yes ☐ No		Regular Office Hours:					

MercyCare Provider Participation Request Form

MERCYCARE CONTRACT IMPLEMENTATION FORM

Practitioner Information

Practitioner Name (First, MI, Last):		DOB:	
Credentials/Degree:		License State/Number:	
Individual NPI:		Accepting New Patients? ☐ Yes ☐ No	Taxonomy:
Tax Identification #:		DEA License # & Exp. Date:	
Has Practitioner completed Cultural Competency Training? ☐ Yes ☐ No		Practitioner E-mail:	
Available for patients to choose as their PCP? ☐ Yes ☐ No		Is provider employed by your facility? ☐ Yes ☐ No	
Gender	☐ Male ☐ Female	Area(s) of Specialty:	
Race:	☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Other:		
In-Training/Non-Licensed? ☐ Yes ☐ No		Languages Spoken:	American Sign Language: ☐ Yes ☐ No
Number of hours in practice each week:		Please List Hospital Affiliations:	
Medicare #:		Participating? ☐ Yes ☐ No	Accepting Assignment? ☐ Yes ☐ No
Medicaid #:		Certified? ☐ Yes ☐ No	
Comments:			
Please list the Service Site numbers for this practitioner (from the previous page(s)) and answer the following for each site:			
Service Site #:	Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:	Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:	Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:	Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No

Practitioner Name (First, MI, Last):		DOB:	
Credentials/Degree:		License State/Number:	
Individual NPI:		Accepting New Patients? ☐ Yes ☐ No	Taxonomy:
Tax Identification # :		DEA License # & Exp. Date:	
Has Practitioner completed Cultural Competency Training?	☐ Yes ☐ No	Practitioner E-mail:	
Available for patients to choose as their PCP? ☐ Yes ☐ No		Is provider employed by your facility? ☐ Yes ☐ No	
Gender	☐ Male ☐ Female	Area(s) of Specialty:	
Race:	☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Other:		
In-Training/Non-Licensed?	☐ Yes ☐ No	Languages Spoken:	American Sign Language: ☐ Yes ☐ No
Number of hours in practice each week:		Please List Hospital Affiliations:	
Medicare #:		Participating? ☐ Yes ☐ No	Accepting Assignment? ☐ Yes ☐ No
Medicaid #:		Certified? ☐ Yes ☐ No	
Comments:			
Please list the Service Site numbers for this practitioner (from the previous page(s)) and answer the following for each site:			
Service Site #:	Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:	Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:	Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:	Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No

MercyCare Provider Participation Request

Practitioner Name (First, MI, Last):			DOB:	
Credentials/Degree:		License State/Number:		
Individual NPI:		Accepting New Patients? ☐ Yes ☐ No	Taxonomy:	
Tax Identification #:		DEA License # & Exp. Date:		
Has Practitioner completed Cultural Competency Training?	☐ Yes ☐ No	Practitioner E-mail:		
Available for patients to choose as their PCP? ☐ Yes ☐ No		Is provider employed by your facility? ☐ Yes ☐ No		
Gender	☐ Male ☐ Female	Area(s) of Specialty:		
Race:	☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Other:			
In-Training/Non-Licensed?	☐ Yes ☐ No	Languages Spoken:	American Sign Language: ☐ Yes ☐ No	
Number of hours in practice each week:		Please List Hospital Affiliations:		
Medicare #:		Participating? ☐ Yes ☐ No	Accepting Assignment? ☐ Yes ☐ No	
Medicaid #:		Certified? ☐ Yes ☐ No		
Comments:				
Please list the Service Site numbers for this practitioner (from the previous page(s)) and answer the following for each site:				

Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No

Practitioner Name (First, MI, Last):			DOB:	
Credentials/Degree:		License State/Number:		
Individual NPI:		Accepting New Patients? ☐ Yes ☐ No	Taxonomy:	
Tax Identification #:		DEA License # & Exp. Date:		
Has Practitioner completed Cultural Competency Training?	☐ Yes ☐ No	Practitioner E-mail:		
Available for patients to choose as their PCP? ☐ Yes ☐ No		Is provider employed by your facility? ☐ Yes ☐ No		
Gender	☐ Male ☐ Female	Area(s) of Specialty:		
Race:	☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Other:			
In-Training/Non-Licensed?	☐ Yes ☐ No	Languages Spoken:	American Sign Language: ☐ Yes ☐ No	
Number of hours in practice each week:		Please List Hospital Affiliations:		
Medicare #:		Participating? ☐ Yes ☐ No	Accepting Assignment? ☐ Yes ☐ No	
Medicaid #:		Certified? ☐ Yes ☐ No		
Comments:				
Please list the Service Site numbers for this practitioner (from the previous page(s)) and answer the following for each site:				

Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No
Service Site #:		Hospitalist? ☐ Yes ☐ No	Can this Practitioner be selected as a PCP **at this location**: ☐ Yes ☐ No	Can an appointment be scheduled at this location on a regular basis? ☐ Yes ☐ No

**This page may be copied if you have additional practitioner information to provide.*

MercyCare (HMO) FDR Annual Compliance Attestation

1. **Compliance & Fraud, Waste and Abuse (FWA) Training:**
   My organization provided General Compliance Training to all applicable employees (including temporary employees and volunteers), governing board members, and contractors within 90 days of hire or contracting and annually thereafter. (§50.3.1)
   ☐ Yes ☐ No

   My organization provided FWA Training to all applicable employees (including temporary employees and volunteers), governing board members, and contractors within 90 days of hire or contracting and annually thereafter **or** has been deemed to have met the FWA certification requirements through enrollment in the Medicare program or accreditation as a supplier of Durable Medical Equipment, Prosthesis, Orthotics, and Supplies (DMEPOS). (§50.3.2)
   ☐ Yes ☐ No

2. **Code of Conduct and/or Compliance Program Policies**
   My organization has a Code of Conduct and/or Compliance Program policies that explain its commitment to comply with federal and state laws, ethical behavior and compliance program operations, which are distributed to all employees, (including temporary employees and volunteers), governing board members, and contractors within 90 days of hire or contracting, upon revision, and annually thereafter. (§50.1.3)
   ☐ Yes ☐ N o

3. **US Department of Health & Human Services Office of Inspector General (OIG) and General Services Administration's System for Award Management (SAM) Exclusion Screenings**
   My organization screens the OIG and SAM exclusion lists prior to hire or contracting and monthly thereafter, to ensure none of our employees (including temporary employees and volunteers), governing board members, contractors, and Downstream Entities are the exclusion lists, and immediately removes any person or entity from working on business if found on either of the exclusion lists. (§50.6.8)

   OIG ☐ Yes ☐ No

   GSA ☐ Yes ☐ No

4. **Reporting Mechanisms**
   My organization has communicated to employees how to report any suspected or detected non-compliance or potential fraud, waste, or abuse, and that it is their obligation to report without fear of retaliation or intimidation against anyone who reports in good faith. My organization either requests employees report concerns or maintains confidential and anonymous mechanisms for employees to report internally, and we will report these concerns to MercyCare as they occur. (§50.4.2)
   ☐ Yes ☐ N o

5. Offshore Operations

My organization and/or our Downstream Entities engage in offshore operations that involve the receipt, processing, transferring, handling, storing or accessing of Protected Health Information (PHI).

☐ Yes ☐ No

If yes, you are required to complete MercyCare's "Offshore Subcontractor Attestation" for each entity, and submit along with your completed FDR Annual Compliance Attestation. This attestation can be found under "Resources" at SeniorPreferred.org.

6. Downstream Entity Oversight

My organization uses Downstream Entities for business.

☐ Yes ☐ N o

If yes, my organization conducts oversight (e.g., monitoring/auditing, obtains annual attestations) to ensure that they comply with all applicable Medicare laws, rules, and regulations that apply to me as a First Tier Entity, and communicates and requires compliance with Medicare compliance program requirements described in this attestation. (§50.6.6)

☐ Yes ☐ No

7. Record Retention

My organization agrees to maintain documentation supporting the statements made above (e.g., training materials/logs, exclusion screening checks, dissemination of COC and/or compliance program policies, reporting mechanisms, etc.) and will maintain this documentation in accordance with federal regulations and your contract, which is no less than ten (10) years. (§50.3.2)

☐ Yes ☐ No

Attestation Authorization

I certify, as an authorized representative of my organization, that the statements made above are true and correct to the best of my knowledge. In addition, my organization will furnish evidence, upon request, and understands that the inability to provide this evidence may result in a request for a Corrective Action Plan (CAP) or other contractual remedies such as contract termination.

Printed Name of Provider/Organization:	**Date of Attestation:**
Printed Name of First Tier Organization's Authorized Representative:	**Signature of First Tier Organization's Authorized Representative:**
First Tier Organization's Authorized Representative's Title:	**First Tier Authorized Representative's Email Address:**

SUBMIT