auxilio salud plus
El plan que trabaja contigo

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PROVIDER NETWORK CREDENTIAING /CONTRACT APPLICATION FORM

The information contained here is privileged and confidential.

This document must be completed in all its parts, the boxes that do not apply please write N/A. If you need additional space, please include additional sheet with this application.

Provider Name: _____ Billing Name: _____

Rendering NPI: _____ Billing NPI: _____

Specialty: _____ Specialty: _____

Email: _____ Tax ID: _____

For a Primary Care Physicians (PCP) contract, please include the Group Name and any Intention Letter, if apply:

Group Name: _____ _____

Group Administrator Signature

Contract Request Type

☐ Corporate Contract	☐ Individual Contract	☐ Group Contract	☐ Vendor Change	☐ Add to Group	☐ Add to Specialty	☐ Add Services	☐ Demographic Information Change
☐ Rate Change	☐ Service Change	☐ Specialty Change		☐ Other:		Explain:	

	Address (To be included in the Provider Directory):	Address:
Primary Location Address		**Billing Address**
	Phone:	Phone:
	Fax:	Fax:

Names of Hospital Privileges	1			2			
Business Hours	Monday	Tuesday	Wenesday	Thursday	Friday	Saturday	Sunday

Additional Comments:

_____

Professional Liability Policy	
Carrier Name	
Policy Number	
Policy Limit by Claim	$
Policy Limit by Aggregate	$
Effective Date (mm/dd/yyyy)	/ /
Expiration Date (mm/dd/yyyy)	/ /

Final Adverse Legal Actions/Convictions: Information on persons convicted of crimes-This section includes adverse final-ACTIONS OF INFORMATION persons convicted of offenses-APPLICANT. Answer the following questions by selecting "Yes" or "No". If any of the questions you select "Yes", indicate which was the event in the space provided. This section collects information on adverse final actions, such as convictions, exclusions, revocations and suspensions. All applicable definitive legal actions must be reported, even if the records were deleted or appeals are pending.

Has any individual (s) or organizations listed in this application, under any current or former name or business identity, within ten years from the date of this statement, ever:

Questions	Yes	No
A. Had a final adverse action, conviction, exclusion, revocation or suspension by any state, including the federal, state or local government program or agency?		
B. Been convicted of any felony or misdemeanor involving fraud or abuse in any federal, state or local government program or agency		
C. Found liable of fraud or abuse involving any federal, state or local government program or agency in any civil proceeding?		
D. Entered into a settlement in lieu of conviction for fraud or abuse involving any federal, state or local government program or agency		
E. Had your license, certificate or other approval to provide health care ever been excluded, revoked or suspended, from a federal, state or local government program or agency?		
F. Ever lost or surrendered your license, certificate, or other approval to provide health care, while a disciplinary hearing was pending?		
G. Ever been convicted of any crime (excluding traffic or parking violations) or pending any litigation for an alleged crime?		
H. Ever been convicted of a crime under the Criminal Control Act or are you currently under indictment for an alleged crime?		
I. Has your license, certificate, or other approval to provide health care, ever been disciplined by any licensing authority?		
J. Do you now or have you ever had a chemical dependency, substance abuse, alcohol or drug problem, treated or untreated, which in any way impairs your ability to practice to the fullest extent of your licensure and qualifications or in any way poses a risk of harm to your patients?		
K. Do you have any ongoing physical or mental health impairment or condition, which would make you unable, with or without accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?		
l. Do you have any Conflict of Interest with Auxilio Salud Plus or any affiliated entitiy with Auxilio Salud Plus?		

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

Consent and Release

1. I acknowledge and agree Auxilio Salud Plus has a valid interest and legal requirement to obtain and verify information concerning the professional competence, therefore:

2. I authorize Auxilio Salud Plus to consult with malpractice carriers and other persons or entities to obtain and verify information concerning the facilities professional competence, character, moral and ethical qualifications.

3. I release Auxilio Salud Plus and its employees, managers, agents, and consulting committees from any and all liability for their acts performed in good faith and without malice in obtaining, verifying and evaluating such information.

4. I consent to and authorize the release by any person or entity to Auxilio Salud Plus of all information and documents that may be relevant to an evaluation of the facilities professional competence, character, morality and ethical qualification, including any information or material relating to any disciplinary or criminal action, professional competence, suspension or curtailment (including malpractice claims and/or coverage).

5. I consent and authorize that Auxilio Salud Plus to verify with The Office of the Inspector General (O.I.G) established in 42 CFR 1001.1901 and Opt-Out Providers List established in 42 CFR 405.440 any sanction or exclusion that avoid the applicant to participate in any Federal Program including Medicare and Medicaid.

6. I hereby release any such person or entity providing such information from any and all liability for doing so. If I have contracted with a medical group, Individual Physician Association or similar entity as a participating provider with Auxilio Salud Plus or such other health plans, they may also receive the credentialing information or quality assurance data relating to this facility.

7. I understand that I have the burden and legal responsibility of providing adequate information to Auxilio Salud Plus to demonstrate professional competence, character, moral ethics and other qualifications. If any material changes occur affecting the professional status, I agree to notify Auxilio Salud Plus within 30 days.

Provider Attestation and Certification Statement

I attest that the information submitted by me in this document is true, correct, and complete to the best of my knowledge. I fully understand that misstatement in, or omission from this application may constitute cause of denial of participation or be subject to applicable state or federal penalties for perjury.

By signing this application I certify:

1. By his/her signature(s), the applicant binds the provider to all of the requirements listed in the Certification Statement and acknowledges that the provider may be denied entry to or revoked from the Auxilio Salud Plus if any requirements are not met.

2. By signing this application, the applicant agrees to immediately notify to Auxilio Plus Salud if any information furnished on this application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify Auxilio Salud Plus of any future changes to the information contained in this form, after the provider is enrolled in Auxilio Plus Salud, in accordance with the timeframes established in 42 C.F.R. § 424.520 (b) &/or 42 C.F.R § 424.516 (e).

3. I agree to notify Auxilio Plus Salud any future changes to the information contained in this application in accordance.

Applicant Signature

Date (M/D/Y)

Please remit filled form to the email address: jgonzalez06@auxiliomutuo.com.

***In case of group corporation contract, please complete this form for the group corporation and one individual form for each provider in the group corporation.**

Rev. 05/2020