Application For Membership

Please read the following prior to completing and returning this application. This application is a required part of the contracting process for Majoris Health Systems.

INSTRUCTIONS

- **Complete this application in its entirety for *each Tax ID number* applying for panel membership. Please keep a copy on file.**
- **The term "Provider" in this application refers to the entity that holds the Tax ID number for which the application is being submitted.**
- **Please sign and date the Authorization and Release of Information Form on pages 6. We cannot process an application dated over 180 days from the date we receive it.**
- **Attach all supporting documents when submitting the application. Applications received unsigned or missing any required supporting documents will not be processed.**

    - Accreditation documentation (if applicable)
    - Face Sheet of Professional Liability Policy or Certificate
    - Currently signed W-9
    - Provider Roster (for those providers who will see work comp patients; each provider seeking panel membership under this provider contract will need to submit an Montana Practitioner Credentialing Application)

- **If a section does not apply to you, please check the provided box at the top of the section indicating DOES NOT APPLY.**
- **You can mail, fax, or email this application, along with all supporting documents.**

    - **Mail:** Majoris Health Systems, Inc.
      Attention: Provider Relations
      PO Box 1728
      Lake Oswego, OR 97035

    - **Fax:** 503-601-8438

    - **Email providerrelations@majorishealthsystems.com**

I. PROVIDER IDENTIFICATION

A. Corporate Identification Information

Furnish the provider's legal business name (as reported to the IRS) "doing business as" name (name provider generally known by to the public), and the various operating dates and places of formal business registration and/or incorporation. All payments will be issued in the provider's legal business name in compliance with IRS regulations.

1. Legal Business Name as Reported to the IRS (claims will be paid to this name)

2. "Doing Business As" (DBA) Name (if applicable)

3. Billing Address:	**4**. Tax Identification Number:

B. Current Practice Location(s) – please submit a separate page 2 for each practice address that bills under the Tax Identification number stated in box 4 above

Practice Location Name:	NPI #:

Practice Location Address Line 1:

City:	State:	Zip:	County:

Phone: ( )	Fax: ( )	E-mail:

Office Manager:

Phone: ( )	Fax: ( )	E-mail:

Work Comp Contact:

Phone: ( )	Fax: ( )	E-mail:

C. Mailing/Correspondence Address

This must be an address where provider can be contacted directly.

Check here ❑ if all correspondence can be directed to the practice location in Section B.

Mailing Address Line 1:

City:	State:	Zip:	County:

D. Type of Provider – check all that apply below AND complete attachment B "MCO Specialty List"

Provider Type (*check all boxes that apply)*: ❑ Acupuncture ❑ Chiropractic ❑ Dental Practice ❑ Free Standing Surgical Center ❑ Free Standing Laboratory ❑ Hospital (attach a list of services provided) ❑ Medical Practice	❑ Naturopathic Practice ❑ Optometry/Ophthalmology ❑ Physical/Occupational Therapy ❑ Podiatric Practice ❑ Psychology/Psychiatry Practice ❑ Skilled Nursing/Rehab Facility	❑ Other (explain):

Physical Therapy/Occupational Therapy Providers: **Services Provided** (*check all boxes that apply)*

❑ Pool Therapy
❑ Physical Capacity Evaluations
❑ Work Capacity Evaluations
❑ Work Hardening
❑ Other (explain):

Does this facility currently treat worker's compensation patients? **Yes** ☐ **No** ☐

If YES, are you currently accepting new worker's compensation patients? **Yes** ☐ **No** ☐

If you are NOT accepting new worker's compensation patients, do you treat existing patients that sustain a work related injury? **Yes** ☐ **No** ☐

II. CERTIFICATION AND ACCREDITATION ☐ DOES NOT APPLY

A. Accreditation

1. Is this provider accredited by a national accreditation organization? ❑ Yes ❑ No ❑ Pending
If Yes, please complete the following & submit a copy of current Accreditation Certificate:

2. Check One:	❑ JHACO	❑ URAC	❑ NCQA	❑ CLIA	❑ Other _____

3. Date of last survey (MM/DD/YYYY): _____
4. Name of Accreditation Organization: _____
6. Has this provider ever been denied accreditation by any accrediting body? ❑ Yes ❑ No
7. **If Yes,** please provide details below.

Details:

III. HEALTHCARE LICENSURE, REGISTRATION, CERTIFICATES, AND ID NUMBERS ☐ DOES NOT APPLY				
	License #	**Issue Date**	**Expiration Date**	**Licensing Agency**
State/City/County License:				
FDA:				
Hospital License:				
Other:				
DEA Number (if applicable)	Expiration Date:			Medicare Number:

IV. LIABILITY INSURANCE

This section is to be completed with information about the provider's professional liability and/or medical malpractice insurance including, but not limited to General Liability, Excess Liability, Umbrella and/or Reinsurance policies. If there is more than one carrier, copy and complete this section for each.

A copy of all face sheets showing current coverage amounts and expiration dates must be attached.

A. Current Coverage

Current Carrier Name:		Policy #:
Carrier Address:		Coverage Type: ❑ Occurrence Based ❑ Claims Based
City:	State:	Zip:
Effective Date:		Expiration Date:
Aggregate: $		Per Incident: $

VII. SITE REVIEW (as required)

I hereby grant permission for Montana Health Systems or its designated agent to conduct on-site and/or medical record reviews as necessary. I further agree that this provider will participate in, and support Montana Health Systems' Credentialing, Quality Improvement and Utilization Review Programs.

AUTHORIZATION AND RELEASE OF INFORMATION FORM

By submitting this application, it is agreed and understood that:

1. As a representative of the health care provider(s)/supplier(s) listed on this application, I understand that, as a contracted facility, the burden of producing adequate information for proper evaluation of licensure, accreditation, malpractice insurance, malpractice history and sanctions indicated in this application is upon the contracted provider or its representative.

2. I further understand and acknowledge that Montana Health Systems or designated agent will investigate the information in this application. By submitting this application, the provider(s)/supplier(s) agree to such investigation required as a part of the verification and credentialing process.

3. I authorize all individuals, institutions, entities of other hospitals or institutions with which the provider(s)/supplier(s) have been associated and all professional liability insurers with which the provider(s)/supplier(s) have had or currently have professional liability insurance, who may have information bearing on the provider(s)/supplier(s) licensure, accreditation, Medicare certification, malpractice or sanctions to consult with Montana Health Systems or designated agent.

4. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating the provider(s)/supplier(s) application, and waive all legal claims against any representative of Montana Health Systems its respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

5. I understand and agree that the authorizations and releases given by me herein shall be valid for three years according to Montana Health Systems cycle of recredentialing provided the provider(s)/supplier(s) is actively pursuing or holds an active contract with Montana Health Systems

6. The provider(s)/supplier(s) agree to exhaust all available procedures and remedies as outlined in the rules, regulations, and policies, and/or contractual agreements of Montana Health Systems or its respective agent(s) before initiating judicial action.

7. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

8. I further acknowledge that failure to communicate any relevant information or to release any and all required documentation and authorizations in support of this application may be considered a request to withdraw from the credentialing process and participation with Montana Health Systems.

I, the undersigned authorized agent, hereby attest and certify that all statements on this application are true, accurate, and correct to the best of my knowledge. I fully understand that any falsification of information or omissions from this application may be grounds for denial of this application.

Further, I understand that acceptance of this application does not constitute approval or acceptance or participating status with Montana Health Systems and grants this provider no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this provider by Montana Health Systems.

I acknowledge that action on this application will be delayed until all required information is received and/or verified.

Print Name _____ _____ **Title:** _____

Signature: _____ **Date:** _____

MCO SPECIALTY LIST

Please check all that apply. Specialties will be listed in the MHS directory.

√	MHS Code	Specialty Description	√	MHS Code	Specialty Description	√	MHS Code	Specialty Description
	001	Aerospace Medicine		055	Hand Surgery/Orthopedic		200	Impairment Rating
	002	Acupuncture		056	Orthopedics		201	Designated Doctor
	003	Allergy		057	Otolaryngology		900	Spine Surgery
	004	Allergy And Asthma		058	Pain Centers		901	Biofeedback
	005	Allergy/ Immunology		061	Pain Mgt./ Anesthesiology		903	Backs, Non-Surgical
	006	Anesthesiology		062	Pathology		904	Backs, Surgical
	007	Assistants		063	PCE Preferred Provider		905	Upper Extremities
	008	Audiology		065	Pediatrics		906	Shoulders
	009	Cardiology		066	Pharmacy		907	Elbows
	010	Chiropractic		068	Physical Medicine & Rehab		908	Hands
	011	Clinics		071	Physical Therapy		909	Lower Extremities
	012	Dentistry		072	Plastic Surgery		910	Hips
	013	Dermatology		074	Podiatry		911	Knees
	014	Emergency Medicine		075	Preventative Medicine		912	Ankles And Feet
	015	Endocrinology		076	Psychiatry		913	Joint Reconst/Replace
	016	Dermatopathology		077	Psychology			Others (Please List)
	017	Gastroenterology		078	Radiation Oncology			
	018	General & Family Prac.		079	Pulmonary Disease			
	019	General Surgery		080	Radiology			
	021	Geriatrics		081	Rheumatology			
	022	Hand/Plastic Surgery		082	Speech & Hearing			
	023	Hematology/ Oncology		084	Surgical Centers			
	024	Home Health Care Serv.		085	Sports Medicine			
	025	Hospitals		086	Thoracic/ Vascular Surgery			
	026	IME		087	Urology			
	027	Infectious Disease		089	Work Hardening /Rehab.			
	028	Internal Medicine		091	Vestibular Rehabilitation			
	029	Laboratory Services		092	Urgent Care			
	030	MRI/CT		093	Cardiothoracic Surgery			
	031	Maternal-Fetal Medicine		094	Brain Injury Rehabilitation			
	032	Naturopathic		095	Dietary			
	033	Neonatalogy		096	Counseling			
	034	Nephrology		097	Hospitalist			
	035	Nerve Conduction		098	Bariatrics			
	036	Neurosurgery		099	Durable Medical Equip.			
	040	Neurology		100	Wound Care			
	041	Neuropsychology		101	Addictionology			
	043	Nurse Prac./ Phys. Asst.		102	Chemical Dependency			
	044	OB/GYN		103	Hyperbaric Medicine			
	045	Occupational Medicine		105	Registered Dietician			
	046	Occupational Therapy		106	Pool Therapy			
	047	Oncology		107	Genetics			
	048	Ophthalmology		108	Lic. Massage Therapist			
	052	Optometry		143	Nursing Home			
	053	Oral Surgery		145	EMG			
	054	Orthodontics		146	FCE			

Addendum to Credentialing

Provider Info:

Applicant's Last: _____ First: _____ Middle I: _____Title_____

Languages spoken: _____

Are you accepting new **work comp** patients? Yes _____ No _____

Will you see **work comp** patients for second opinions? Yes _____ No _____

Will you act as attending physician for patients? Yes_____ No_____

Are you able to perform closing examinations? Yes _____ No _____

Practice Information:

Medical Records Contact Information:

Name: _____Phone: _____Fax: _____Email:_____

Pre-Auth Contact Information:

Name: _____Phone: _____Fax: _____Email:_____

Credentialing Contact:

Name: _____Phone: _____Fax: _____Email:_____

Please provide copies of the following supporting documents when submitting a credentialing application:

- ***License***
- ***DEA License***
- ***Current Malpractice Insurance***
- ***W-9***

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Majoris Health Systems Corporate Office
P.O. Box 1728, Lake Oswego, OR 97035
Phone (503) 639-6080 • Toll Free (800) 525-0394 • Credentialing Fax: (503) 601-8438
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