Membership Application

Please Note: Majoris is a Worker's Compensation Managed Care Organization and completing a membership application is not a guarantee of participation. If a contract is extended, a completed Credentialing Application will be required for each provider agreeing to treat our Work Comp clients.

Instructions

- **Majoris requires the following malpractice requirements; each provider practicing in the states of Montana, Oregon and Wyoming must provide proof of coverage of a minimum of $1,000,000/occurrence and $3,000,000 aggregate; each provider practicing in the state of Texas must provide proof of coverage of a minimum of $100,000/occurrence and $300,000 aggregate.**
- **The term "Provider" in this application refers to the entity that holds the Tax ID number for which the application is being submitted.**
- **Applications received unsigned or missing any required documents will not be processed.**

Please include the following documents when submitting your Membership Application:

- ***Provider Roster for all providers who will treat work comp patients***
- ***Accreditation documentation (if applicable)***
- ***Current Copy of Professional Liability Policy or Certificate***
- ***Currently signed W-9 for each Tax ID number***
- ***Current copy of business license for the facility***
- ***3 full case examples (from start to finish) of each provider on your roster treating an injured worker***

Please mail, fax, or email this application along with all requested documents to:

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. **Business identification information**			
Please list the provider's legal business name (as reported to the IRS) and "doing business as" name (if applicable),			
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.**Tax Identification Number:
4. Billing Address:			
City:	State:	Zip:	County:
Phone:	Fax:		E-mail:
B. Practice Location(s) – Please submit a separate page for each practice address that bills under the Tax Identification number stated in box 3 above. If there is more than one TIN# used, please photocopy this page for each TIN# used at each of your locations. (This is important for data integrity)			
Practice Location Name:			NPI #:
Practice Address:			
City:	State:	Zip:	County:
Phone:	Fax:		E-mail:
Office Manager:			
Phone:	Fax:		E-mail:
Work Comp Contact:			
Phone:	Fax:		E-mail:
C.1. Mailing/Correspondence Address (if different than Practice Location)			
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:			
City:	State:	Zip:	County:
Phone:	Fax:		Email:
C. 2. Have you previously treated Workers' Compensation patients?			
No: Yes: If Yes, which States(s)?			
If Yes, please estimate how many: a. Years b. Injured Workers			

D. **Type of Practice – Please check all that apply**

❑ Solo Private Practice Provider	❑ Hospital	❑ Other (explain):
❑ Medical Group – single location	❑ Ambulatory Surgical Center	
❑ Medical Group – multiple locations	❑ Rehabilitation Facility	
❑ Independent Physician Association	❑ Skilled Nursing Facility	
❑ Imaging Center	❑ Home Health	
❑ Free Standing Laboratory	❑ DME/Medical Supplies	

II. CERTIFICATION AND ACCREDITATION ☐ DOES NOT APPLY

A. Accreditation

1. Is this Facility 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:	❑ JCAHO	❑ 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.

IV. INTEREST IN JOINING MAJORIS' PROVIDER NETWORK

In order to help us make the best decision when processing your membership application, please review the below questions. Should you need additional room, writing a cover letter to accompany your membership application is also accepted.

A. Community Partners

Do you currently work with Majoris panel providers? If so, who and in what capacity?

B. Reason for Application

Why are you now applying to be on panel with Majoris?

AUTHORIZATION AND RELEASE OF INFORMATION

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 Majoris 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 Majoris 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 Majoris 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 Majoris Health Systems cycle of recredentialing provided the provider(s)/supplier(s) is actively pursuing or holds an active contract with Majoris 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 Majoris 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 Majoris Health Systems.

9. I hereby grant permission for Majoris 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 Majoris Health Systems' Credentialing, Quality Improvement and Utilization Review Programs.**

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 Majoris 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 Majoris Health Systems.

Provider's Signature certifies they have submitted the required financial disclosure forms to the Department of Insurance, if applicable.

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

Print Name _____ **Title:** _____

Signature: _____ **Date:** _____

Roster List

Name____**Specialty**____

Admitting Privileges (If Applicable) ____

****

Name____**Specialty**____

Admitting Privileges (If Applicable) ____

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Name____**Specialty**____

Admitting Privileges (If Applicable) ____

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Name____**Specialty**____

Admitting Privileges (If Applicable) ____

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Name____**Specialty**____

Admitting Privileges (If Applicable) ____

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Name____**Specialty**____

Admitting Privileges (If Applicable) ____

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Name____**Specialty**____

Admitting Privileges (If Applicable) ____

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Name____**Specialty**____

Admitting Privileges (If Applicable) ____

****

Name____**Specialty**____

Admitting Privileges (If Applicable) ____

Specialty List

~Please carefully review our specialty list. Check ALL THAT APPLY. ~

Note: If you check a specialty with an asterisk (*), please also check which 900 codes apply.

✓	CODE	Specialty Description	✓	CODE	Specialty Description	✓	CODE	Specialty Description
	001	Acupuncture		039	* Orthopedics (see right)		077	Perform Closing Examination
	002	Allergy		040	Otolaryngology		078	Perform 2nd Opinions
	003	Allergy & Asthma		041	Pain Centers		079	Burn Unit
	004	Allergy/Immunology		042	Pain Management		080	Nursing Home
	005	Anesthesiology		043	PCE/WCE Reporting		081	EMG
	005	Audiology		044	Pharmacy		082	F C E
	006	Cardiology		045	Phys Medicine & Rehab		083	Osteopath
	017	Chiropractic		046	Physical Therapy		084	PET
	008	Dentistry		047	Plastic Surgery		085	Sonography
	009	Dermatology		048	Podiatry		086	Inpatient Rehab
	010	Emergency Medicine		049	Preventative Medicine		087	Outpatient Rehab
	011	Endocrinology		050	Psychiatry		088	Biofeedback
	012	Dermatopathology		051	Psychology		089	Behavioral Health
	013	Gastroenterology		052	Pulmonary Disease		090	Multi-Disciplinary Pain Evaluations (Clinic)
	014	General & Family Practice		053	Radiology			
	015	General Surgery		054	Rheumatology			
	016	Hand/Plastic Surgery		055	Speech & Hearing			
	017	Home Health Care		056	Ambulatory Surgical Center			
	018	Hospital		057	Sports Medicine			
	019	IME		058	Thoracic/Vascular Surgery			
	020	Infectious Disease		059	Urology			
	021	Internal Medicine		060	Work Hardening/Rehab			
	022	Laboratory Services		031	Vestibular Rehabilitation			
	023	MRI/CT		062	Urgent Care			
	024	Naturopathic		063	Cardiothoracic Surgery			
	025	Nephrology		064	Brain Injury Rehab			
	026	Nerve Conduction Studies		065	Counseling			
	027	Neurosurgery		066	Hospitalist			
	028	Neurology		067	Bariatric Surgery			
	029	Neuropsychology		068	DME			
	030	Nurse Practitioner		169	Wound Care Clinic			
	031	Physician Assistant		070	Addictionology			
	032	Occupational Medicine		071	Chemical Dependency			
	033	Occupational Therapy		072	Hyperbaric Medicine			
	034	Ophthalmology		073	Pool Therapy			
	035	Optometry		074	License Massage Therapy			
	036	Oral Surgery		075	Social Worker			
	037	Orthodontics		076	Perform Impairment Rating			
	038	Hand Surgery/Orthopedic						

***Orthopedics**
SPECIFIC Area of Expertise

✓	CODE	Specialty Description
	901	Biofeedback
	903	Backs, Non-Surgical
	904	Backs, Surgical
	905	Upper Extremities
	906	Shoulders
	907	Elbows
	908	Hands
	909	Lower Extremities
	910	Hips
	911	Knees
	912	Ankles & Feet
	913	Joint Reconstructive Replacement
	914	Non-Surgical
	933	Cervical Disc Replacement
	934	Lumbar Disc Replacement

Please note if your specialty is not listed above, it is likely not a specialty used in workers' compensation. As Majoris is exclusive to workers' compensation, if you still wish to apply for membership, please explain how your specialty fits in workers' compensation medicine.

Addendum to Credentialing

Provider Info:

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

Languages spoken: _____

Are you accepting new **work comp** patients? Yes ☐ No ☐ Established Patients Only ☐

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

Will you act as attending physician for **work comp** patients? Yes ☐ No ☐ Established Patients Only ☐

Will you perform closing examinations? Yes No Established Patients Only

Practitioner Signature:_____Date:_____

MDs, DOs, DCs & NDs:

Are you willing and qualified to perform closing examinations for Oregon workers compensation claims?

(Please note, it is a closing exam only, and does not require an impairment rating).

Yes _____ No _____ Practitioner Initials (if applicable) _____

(***If 'no'***, please provide on a separate sheet your process to ensure timely claim closure.)

NPs:

Are you willing to act as the attending physician as allowed under OAR guidelines?

Yes _____ No _____ Practitioner Initials (if applicable) _____

If 'yes', please understand that you will not be able to perform a closing examination if the worker has, or may have, permanent impairment. Please provide on a separate sheet your process to ensure timely claim closure in the event this occurs. Please also provide a transfer of care plan, NPs are eligible to be the attending only for 180 days.

Practice Information:

Work Comp Contact:

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***

Majoris Health Systems Oregon, Inc.
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