California Participating Physician Application

Addendum A

Health Plans and IPA's/Medical groups

This application is submitted to: _____, herein, this Healthcare Organization

I. IDENTIFYING INFORMATION		
Last Name:	**First:**	**Middle:**
Medical Group (s) /IPA (s) Affiliation:		
Do you intend to serve as a primary care provider? ☐ **Yes** ☐ **No** **Do you intend to serve as a specialist?** ☐ **Yes** ☐ **No** **(If yes, please list specialty (s))**		
Please check all that apply: ☐ **Solo Practice** ☐ **Single Specialty** ☐ **Group Practice** ☐ **Multi Specialty**		

II. BILLING INFORMATION		
Billing Company:		
Street Address:	**City:**	
	State:	**ZIP:**
Contact:	**Telephone Number: ( )**	
Name Affiliated with Tax ID Number:	**Federal Tax ID Number:**	

III. PRACTICE INFORMATION

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? If so, please list ☐ **Yes** ☐ **No**

Name	Type of provider	License number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Do you personally employ any physicians? (do not include physicians that are employed by the medical group)? ☐ **Yes** ☐ **No**
If so, please list:

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?	☐ **Yes**	☐**No**
If yes, specify limitations:_____		
Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council?	☐ **Yes**	☐ **No**
Do you participate in EDI (electronic data interchange)?	☐ **Yes**	☐ **No**
If so, which Network?_____		
Do you use practice management systems/software?	☐ **Yes**	☐ **No**
If 'Yes', which one_____		

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

☐**Local**	☐**Regional**	☐**Conscious Sedation**	☐**General**	☐**None**	☐**Other (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**_____

IV. OFFICE HOURS- Please indicate the hours your office is open:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holidays

V. 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:	**City:**	
	State:	**ZIP:**
Covering Physician's Name	**Telephone Number: ( )**	
Covering Physician's Name	**Telephone Number: ( )**	
Covering Physician's Name	**Telephone Number: ( )**	
Covering Physician's Name	**Telephone Number: ( )**	

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

VI. FOREIGN LANGUAGES SPOKEN	
Fluently by Physician:	**Fluently by Staff:**

VII. LABORATORY SERVICES		
If you provide direct laboratory services, please indicate the TIN **utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.**		
Tax ID #:	**Billing name:**	**Type of service provided:**
Do you have a CLIA certificate?	☐ **Yes**	☐ **No**
Do you have a CLIA waiver?	☐ **Yes**	☐ **No**
Certificate number:	**Certificate expiration date:**	

VIII. 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)