PROVIDER ENROLLMENT APPLICATION

1) Please return your signed *agreement* with this *application* and all listed credentials to follow: Current Attestation, Joinder, Ownership, W9, HIPAA, and 2 Peer reviews
2) Update your CAQH ProView Account by uploading copies of the following required items: *License certificate, Insurance certificate, and Board certificate(s)*
3) *Authorize CAQH to allow **all carriers** to review your profile and **re-attest***

Last Name		Professional Title	
First Name, Middle		Gender	
Practice Name		DOB*	
Corporate (if Differs)		SSN*	
Primary Office Street Address		Name of School	
City State		Address	
9 Digit Zip Code		City State & Zip	
Office Email		Mo/Yr & Degree	
County		Board Cert(s) & Year	
Phone #		Malpractice Carrier	
Fax #		Street Address	
Location NPI #		City, State & Zip	
Prior Sir Name(s)		Policy Limits & ID #	
Home Address		Expiration mm/dd/yy	
City, State & Zip		W-9 Tax ID #	
CAQH ProView #		W-9 Billing Address	
Individual NPI #		W-9 City State & Zip	
State / License # (s)		Administrator	
Medicare PTAN #		Admin Phone #	
Medicaid ID #		Admin Email	
Annual Fraud, Waste & Abuse Training Date		Languages Spoken by Participating Provider	
Annual Cultural Competency Training Date		Languages Spoken by Office Staff	

To join, e-mail: credentials@2020hearingnetwork.com

If you are new to CAQH or AHCA - we can help you get started

☐ **Yes,** please set up a new CAQH Profile for my review

☐ **Yes,** please complete a new AHCA Application on my behalf

*Required to meet NCQA Standards and complete enrollment

(August 2018)

2900 W Cypress Creek Rd, Ste 4
Fort Lauderdale, FL 33309
(844) 575-4327 ***(HEAR)***
info@2020HearingNetwork.com
www.2020HearingNetwork.com

PROVIDER APPLICATION (Page 2)

Please return your signed *provider agreement* with your *application* and *all credentials* to: credentials@2020hearingnetwork.com

Any Additional Office Locations

Office Address		
City & 9 Digit Zip		
County		
Phone #		
Location NPI #		

Office Address		
City & 9 Digit Zip		
County		
Phone #		
Location NPI #		

5 Year Employment History* (Required information to meet NQQA Standards)

Company Name		
Office Address		
City & 9 Digit Zip		
County		
Phone #		
Dates Mo/Year		

Company Name		
Office Address		
City & 9 Digit Zip		
County		
Phone #		
Dates Mo/Year		

	6 Month Gaps require an Explanation	**Reason for Gap**
Gap Dates		

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

3094

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

NETWORK PROVIDER JOINDER TO THE
SPECIALTY NETWORK AGREEMENT BETWEEN

By signing below, the parties to this Joinder agree to comply with, be bound by and subject to the terms and conditions set forth in the Specialty Network Agreement (the "Agreement") addendum or amendment by and between Network and Provider (as defined in the Agreement) to the same extent as the undersigned were Provider under the Agreement. This Joinder is effective this_____ day of _____, 20____.

PLEASE COMPLETE THE INFORMATION BELOW AND RETURN WITH YOUR CREDENTIAL APPLICATION					
PRINT PROVIDER NAME	**SIGNATURE X**	**MEDICARE NUMBER**	**MEDICAID NUMBER**	**PROVIDER CAQH #**	**DATE**

ALL CREDENTAILED PROVIDERS MUST
HAVE A SIGNED JOINDER PAGE

HIPAA WORKFORCE CONFIDENTIALITY AGREEMENT

I understand that 2020 Eye Care Network, Inc dba 2020 Hearing Care Network (2020) has a legal and ethical responsibility to maintain patient privacy, including obligations to protect the confidentiality of patient information and to safeguard the privacy of patient information. Recording of PHI information is prohibited in office and premises, unless prior authorization is obtained. In addition, I understand that during the course of my employment/assignment/affiliation at 2020. I may see or hear other Confidential Information such as financial data and operational information pertaining to the practice that 2020 is obligated to maintain as confidential.

As a condition of my employment/assignment/affiliation with 2020. I understand that I must sign and comply with this agreement within 30 days of employment and annual. By signing this document I understand and agree that:

1. I will disclose Patient Information and/or Confidential Information only if such disclosure complies with 2020 policies, and is required for the performance of my job.
2. My personal access code(s), user ID(s), access key(s) and password(s) used to access computer systems or other equipment are to be kept confidential at all times.
3. I will not access or view any information other than what is required to do my job. If I have any question about whether access to certain information is required for me to do my job, I will immediately ask my supervisor for clarification.
4. I will not discuss any information pertaining to the practice in an area where unauthorized individuals may hear such information (for example, in hallways, on elevators, in the cafeteria, on public transportation, at restaurants, and at social events). I understand that is not acceptable to discuss any Practice information in public areas even if specifics such as a patients name are not used.
5. I will not make inquiries about any practice information for any individual or party who does not have proper authorization to access such information.
6. I will not make any unauthorized transmissions, copies, disclosures, inquiries, modifications, or purging of Patient Information or Confidential Information. Such unauthorized transmissions include, but are not limited to, removing and/or transferring Patient information or Confidential Information from 2020 computer system to unauthorized locations (for instance, home).
7. I agree that my obligations under this agreement regarding Patient Information will continue after the termination of my employment/assignment/affiliation with 2020.
8. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of my employment/assignment/affiliation and/or suspension, restriction or loss of privileges, in accordance with 2020 policies, as well as potential personal civil and criminal legal penalties.
9. I understand that any Confidential Information or Patient information that I access or view at 2020 does not belong to me.
10. I have read the above agreement and agree to comply with all the terms as a condition of continuing employment.

_____ _____

Signature of employee/physician/student/volunteer Date

_____

Printed Name

2900 W Cypress Creek Rd, Ste 4
Fort Lauderdale, FL 33309

(914) 510-7300 | *Provider Relations*

info@2020HearingNetwork.com

www.2020HearingNetwork.com