

Application Request for PPLLC Participation – single provider

Name of requester: _____ Phone: _____

Email: _____

Practice Name: _____

Office Contact Name and number:

Primary Practice Address: _____ Secondary Practice Address: _____

Check if practice is: PCP _____ Specialist _____ both _____

Practice Specialty _____ NPI _____

Current Practice Affiliation(s): _____

PPLLC must be your primary affiliation. Are you going to maintain your current affiliation? Yes No

If no - Term date _____

TAX ID that will be specific to your PPLLC membership: _____

(Tax ID will be assigned to only PPLLC for all contracting purposes)

Is the TIN actively enrolled in: Medicare Yes No Medicaid Yes No

Group Medicare # _____ Group Medicaid # _____

If yes, please provide us with a copy of your PECOS screenshot and/or Medicare and Medicaid welcome letter. Participation is required for membership in PPLLC

Hospital privileges at:

- | | | | | |
|--|--------------------------------------|-------------------------------------|--|--|
| <input type="checkbox"/> BIDMC | <input type="checkbox"/> BID-Needham | <input type="checkbox"/> BID-Milton | <input type="checkbox"/> BID-Plymouth | <input type="checkbox"/> Anna Jaques |
| <input type="checkbox"/> Cambridge Health Alliance | <input type="checkbox"/> Lahey | <input type="checkbox"/> Mt. Auburn | <input type="checkbox"/> New England Baptist | <input type="checkbox"/> Addison Gilbert |
| <input type="checkbox"/> Beverly | <input type="checkbox"/> Winchester | | | |

At which of the above hospitals do you take call? _____

Please provide the following annualized information on claims billed by your office.

Payor Mix	Medicare	Medicaid	BCBS/HPHC/Tufts	Other commercial	Free Care
% of annual revenue					
% of total patients					

Five Most Frequent E&M/Procedures	Number of visits
1.	
2.	
3.	
4.	
5.	
Total Visits	

1. Where are you currently referring/providing the following services?

Type of Service	Primary referral facility/practice	Secondary referral facility/practice
Radiology		
Laboratory		
Other Diagnostics		
Surgery		
Other		

What percentage of your patients are currently part of the PPLLC network? _____%

Do you already have existing relationships with any PPLLC primary care physicians?

Yes No

(If Yes, please list the names of the top referring PCP's or groups below or on a separate sheet)

_____	_____
_____	_____
_____	_____

What is the 3rd next available appointment (or equivalent access measure)?

_____ 2 weeks _____ 4 weeks _____ > 4 weeks _____ Other

Please describe any mechanisms to prioritize PPLLC patients if the wait is more than 30 days.

My office hours will be:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM						
PM						

I have included my current CV

I have included information on any malpractice cases in the last five years or

I have no malpractice cases in the last five years

A. PLEASE PROVIDE AN EXPLANATION ON A SEPARATE SHEET IF ANY OF THE FOLLOWING 3 QUESTIONS BELOW ARE ANSWERED "YES."

1. Are you a director, officer, member, or participant in, or affiliated in any way with, any other physician organization, IPA (independent practice association), physician-hospital organization, Accountable Care Organization (ACO) or other entity or network (apart from your own practice) that contracts with payors? Yes No
2. Are you employed by, medical director/administrator of, or affiliated in any other way (other than as a participating provider) with a payor? Yes No
3. At present, or during the last five years, have you been party to a professional malpractice lawsuit? Yes No
4. I have read and agree to the BILHPN EHR policy terms. Yes No
5. Do you participate, and meet the conditions of participation, in Medicare and have a valid and active Medicare PTAN number?
If yes, please indicate PTAN number: _____ Yes No
6. Do you participate, and meet the conditions of participation, in MA Medicaid and have a valid and active MA PIDSL number?
If yes, please indicate PIDSL number: _____ Yes No

B. Do you as a PCP/Spec or Specialist attest that you have no other contractual obligations that require you to be an exclusive participating provider with another organization and thus prohibits you from fully participating in the BILHPN contracts? Yes No

C. Will you be performing any services not currently offered by your hiring practice or not in the current scope of services of this practice? Service(s): Yes No

D. **Are you currently board certified in a recognized ABMS member specialty board or other recognized American specialty board?** Yes No

IF YES: Board Name _____ Year Certified ____ Exp. Date

Board Name _____ Year Certified ____ Exp. Date

IF NO: Are you qualified to take a board exam? Yes No

Board Name _____ Year Eligible _____

Do you have a scheduled exam date? Yes No (DATE)

Requirements for PPLLC Membership include:

- All providers must have privileges at a BILHPN hospital.
- Providers must have a certified electronic medical record in accordance with the BILHPN EHR policy.
- Whole TIN participation is required (if you have multiple providers in your group, all that bill with the TIN you are providing in this application must be listed and join or obtain a separate TIN number)
- Providers must participate in all BIDCO and BILHPN Risk contracts (currently UHC Medicare Advantage, BCBS, Tufts, HPHC, MA Health ACO/THPP, Medicare Shared Savings Program)
- Providers must participate in all clinical quality initiatives and allow access to Medical Records to BILHPN staff to obtain clinical quality data and to operationalize patient care management programs.
- Provider must have a valid medical license, malpractice insurance, DEA and Controlled Substance licenses, or an application in process.
- Provider must disclose any open or settled malpractice cases.
- Provider must disclose any pending or active claim or allegation of malpractice, professional misconduct, or grounds for licensure or clinical privilege revocation, suspension, or restriction raised against him/her by any governmental agency, professional organization, health care facility, health care practice setting or person. This disclosure requirement applies both during the application phase and at any time after membership approval.
- Provider must be board certified in declared specialty or have equivalent foreign training. Note that some plans, including BCBS and UHC, will not enroll physicians who are not board certified.
- Practice must pay annual dues for each physician linked to their TIN.

The PPLLC Credentials and Membership Committee considers a variety of criteria, including but not limited to a clinical need in the geographic area, insurance accepted, and additional affiliations, when making membership determinations. If your application request is approved, you have ninety (90) days from the date of Credentialing and Membership Committee decision to return your provider survey to PPLLC and enrollment paperwork to BILHPN.

STATEMENT OF APPLICANT

I hereby apply to become a Participating Practitioner in BIDCO Physician, LLC d/b/a Physician Performance LLC ("PPLLC"). If my application is approved, I understand that I will not become a Participating Practitioner unless and until I am approved by the PPLLC Board of Managers and have signed the appropriate documents with my Participating Group.

By applying to become a PPLLC Participating Practitioner, I hereby signify my willingness to appear for one or more interviews with regard to my application. I hereby authorize PPLLC and its representatives to consult my associates and any others who have information bearing on my professional competence, character, health status, ethical qualifications, and ability to work cooperatively with others.

I hereby release from liability all representatives of PPLLC, including its directors, officers, committee members, and all individuals and organizations who or which provide information to PPLLC, in connection with the evaluation of my credentials and other qualifications for membership in PPLLC.

I hereby authorize any hospital, health care institution, health insurer, managed care company, or third-party payor with which I have privileges, affiliations, or contractual or employment relationships to release and transmit to PPLLC such information as is requested by PPLLC, including reproducing pertinent portions of any records as are maintained by any of the foregoing, including but not limited to individual physician credentialing, utilization review and quality assurance files and all other available records and information.

I understand and agree that I have the burden and am responsible for producing adequate information to permit sufficient evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I hereby also authorize PPLLC to share any and/or all of the information referenced above to BILHPN and/or the Participating Organizations of BILHPN.

I acknowledge that my employer has signed a joinder to the PPLLC Participation Agreement on my behalf, and I agree to be bound by all terms and conditions of such Participation Agreement.

I understand that acceptance or rejection of this application is solely within the discretion of the PPLLC Board of Managers in accordance with such standards, criteria and procedures as may be established from time to time in the policies, rules and regulations of PPLLC. I represent and warrant to the best of my knowledge that all information furnished herein and hereafter to PPLLC is accurate and complete.

By my electronic signature below, I attest that my response to this application are true and complete to the best of my knowledge. I further understand that this application does not guarantee membership in PPLLC.

I acknowledge that my electronic (typed) signature below is intended to authenticate this writing and to have the same force and effect as manual signature pursuant to the Massachusetts Uniform Electronic Transactions Act (M.G.L. ch. 1 et seq) as amended from time to time.

(Signature page follows)

Federal Tax ID

Practice Legal Name

Practice Authorized Representative Signature

Date

Alexa Kimball, MD, MPH, President

Date

The following sections for PPLLC use only:

Approved by Member	Yes	No
Recommended by Credentials Committee	Yes	No
Approved by Board of Managers	Yes	No
Conditions:		