Application Request for PPLLC Participation – OBGYN

Name of requester:_____Phone:_____

Email:_____

Practice Name: _____

Office Contact Name and number:

_____

Primary Practice Address:

_____

_____

_____

Secondary Practice Address:

_____

_____

_____

Check if the practice is: PCP☐ Specialist☐ Both☐

Are you board certified by the American Board of Obstetrics and Gynecology Yes ◯ No ◯

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:

☐	BIDMC	BID-Needham	☐	BID-Plymouth	☐	BID Milton	☐
☐	Cambridge Health Alliance	New England Baptist	☐	Addison Gilbert	☐	Anna Jacques	☐
☐	Mt. Auburn	Beverly	☐	Winchester	☐	Lahey	☐

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

Check off EHR used:

☐ eClinical Works (must convert to BIDCO-Hosted)	GE Centricity ☐
☐ AthenaClinicals	NextGen ☐
☐ Epic	Other ☐

Why do you want to join PPLLC (attach separate sheet if necessary)?

# of Providers in the practice?_____# of Mid-level providers? _____

If there are NP's or PA's in the practice, please confirm a Board certified physician is physicallyon site where the NP/PA is working. Yes ◯ No ◯

List all providers in the practice. If more room is needed, please add an additional page.

Provider Name	NPI	Medicare ID	MassHealth ID	Specialty	Board Certified?	Year Certified	Participate in MOC?

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					

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

Five Most Frequent E&M/Procedures	Number of visits
1. E&M	
2. GYN Procedure	
3. Obstetrics	
4. Other (please specify)	
5.	
Total Visits	

How many of your patients are admitted for care, and to what institution?

	Number of admissions	Hospital
Obstetrics/Deliveries		
Gynecological Care		

Where are you currently referring/providing the following services?

Type of Service	Primary referral facility/practice	Secondary referral facility/practice
Gynecology Oncology		
Maternal-Fetal Medicine		
Endocrine and Infertility		
Urogynecology		
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.

What is your protocol for call coverage?

☐ Associate(s) in the practice ☐ Colleague(s) in another practice ☐ Refer to ED

My current office hours are:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM						
PM						

Requirements for PPLLC Membership include:

- All providers must have privileges at a BILHPN hospital and must use BIDMC as their primary hospital for tertiary and quaternary patients.
- Providers must have a certified electronic medical record in accordance with the BILHPN EHR policy.
- Whole TAX ID participation is required (if you have multiple providers in your group, all that bill with the TAX ID you are providing in this application must join PPLLC or obtain a separate TAX ID number)
- Providers must participate in all BIDCO and BILHPN risk contracts (currently UHC Medicare Advantage, BCBS, Tufts, HPHC, MSSP, MA Health ACO/THPP)
- Providers must participate in all clinical quality initiatives and allow access to Medical Records to BILHPN and PPLLC staff to obtain clinical quality data and to operationalize patient care management programs.
- Provider must have a valid license, malpractice, DEA and Controlled Substance, or in application 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 TIN APPLICANT

I hereby apply to become a Participating Practitioner Group 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 Group, 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 the professional competence, character, health status, ethical qualifications, and ability to work cooperatively with others of my Group.

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 the credentials and other qualifications for membership of my Group in PPLLC.

I hereby authorize any hospital, health care institution, health insurer, managed care company, or third-party payor with which I or other participants of my Group 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 andquality 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 or my Group's 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 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.

(Signature page follows)

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.

Federal Tax ID

Practice Legal Name

If applicable Parent Organization Tax ID

If applicable Parent Organization Legal Name

Practice Authorized Representative Signature

Date

Alexa Kimball, MD, MPH, President

Date