Physician Performance LLC (PPLLC) Participating Provider Questionnaire

Practice Name: _____

Physician **Office contact**

Name:_____ Name:_____

Phone: _____ Phone: _____

Email:_____Email: _____

Primary Practice Address: _____

I want to be listed in plan directories as:

◯ PCP ◯ Specialist ◯ PCP/Specialist

Provider Specialties _____

Hospital privileges at:

☐ BIDMC ☐ BID-Needham ☐ BID-Milton ☐ BID-Plymouth ☐ Anna Jaques

☐ Cambridge Health Alliance ☐ Lahey ☐ Mt. Auburn ☐ New England Baptist ☐ Addison Gilbert

☐ Beverly ☐ Winchester

At which hospitals do you take call?_____

If you will not use BIDMC as your primary hospital for tertiary and quaternary care of your patients,

please explain: _____

For specialists, do you have existing relationships with any BIDCO/BILHPN PCPs? Yes ◯ No ◯

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

_____ _____

_____ _____

What is your protocol for call coverage?

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

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 5 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? ◯Yes ◯No
   If yes, please indicate PTAN number:_____

6. Do you participate, and meet the conditions of participation, in MA Medicaid and have a valid and active MA PIDSL number? ◯Yes ◯No
   If yes, please indicate PIDSL number:_____

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?

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):

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

◯ Yes ◯ No

◯ 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 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.

This application does not guarantee membership in API, PPLLC or BILHPN. The committee takes many criteria into account when considering membership, including but not limited to, clinical need in the geographic area, insurances accepted, additional affiliations, etc.

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 any 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 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.

_____ _____

Applicant's 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:_____