

**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:

	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>	<b>Saturday</b>
<b>AM</b>						
<b>PM</b>						

I have included my current CV

I have included information on any malpractice cases in the last 5 years

I have no 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? \_\_\_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 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 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

Physician 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:		

