GLOBAL HEALTH CLAIM SERVICES, INC.

13399 SW 131 St. Miami, FL 33186
Tel: 305.278.2853 Fax: 305.251.2967

APPLICATION FOR PREFERRED PROVIDER ORGANIZATION

PERSONAL (please print)

Last Name	First Name	Middle Initial	Generation (I.e, Sr., Jr., III)
Date of Birth	Birth Place	Male________ Female________	
Social Security Number	Medicare Number	Medicaid Number	
UPIN Number		NPI Number	

Optional: This section for state reporting purposes only.
Race: White _______ Black _______ Latin _______ Asian _______ Other (Please specify)____________________________

PROFESSIONAL

Office/Group Name			
Primary Office Address			
City	State	Zip Code	County
Tax ID Number	Phone Number	Fax Number	
Office E-mail			
Office Hours/Contact			

Additional Office/Group Name			
Additional Office Address			
City	State	Zip Code	County
Tax ID Number	Phone Number	Fax Number	
Office E-mail			
Office Hours/Contact			

PLEASE ATTACH ANY OTHER LOCATIONS AND ADDITIONAL TAX ID PER LOCATION

BILLING ADDRESS (if different from primary office)

Name		
Address		
City	State	Zip Code
Phone Number	Fax Number	Office Hours

ADDITIONAL INFORMATION

Language(s) Spoken by Provider	Language(s) Spoken by Staff
English____ Spanish____ Other______________	English____ Spanish____ Other______________
Office Manager E-mail	
Doctor E-mail	

LICENSURE & CERTIFICATION

License Number (Attach copy)	Expiration Date
DEA Number (Attach copy)	Expiration Date

EDUCATION & TRAINING

Pre Medical Education: College or University	
City/State/County	
Degree	Date of Graduation
Medical School	
City/State/Country	
Degree	Attended Dates (mm/yyyy to mm/yyyy)
Internship (Institution)	
City/State/Country	
Type (straight, Rotation)	Attended Dates (mm/yyyy to mm/yyyy)
Residency (Institution)	
City/State/Country	
Number of Years	Attended Dates (mm/yyyy to mm/yyyy)
Fellowship (Institution)	
City/State/Country	
Number of Years	Attended Dates (mm/yyyy to mm/yyyy)

SPECIALTY

Primary Care Physician

Family Medical________ Internal Medicine________ Pediatrics________ OB/GYN________ GYN________

. . . . **or** . . . .

SPECIALTY CARE PHYSICIAN

Please Specify Specialty

CERTIFICATION

American Board Certification (Attach Copy)	
Date of Certification	Date of Recertification (If Applicable)
American Board eligibility (Attach Copy of Document of Eligibility)	
Other Specialty Board(s), Name of Board(s)(e.g. Osteopathy, Podiatry, etc.) (Attach Copy)	

HOSPITAL PRIVILEGES

Primary Hospital
Member Category
Other Hospitals

WORK HISTORY: Please enclose a copy of the Curriculum Vitae

PRACTICE INFORMATION if yes has been answered, please enclose details.

A. Yes_______ No_______ Have you ever resigned your staff or clinical privileges or have such privileges ever been limited, revoked, suspended, not renewed, reduce or subjected to probationary conditions, or have proceedings towards any of these ends ever been instituted or recommended by a Medical Staff committee or governing board at any hospital or similar Institution, or are proceedings towards any of those ends presently pending?

B. Yes_______ No_______ Has your membership in any local, state, or national professional society or organization ever been revoked, suspended, not renewed or are revocation or suspension proceedings presently pending?

C. Yes_______ No_______ Has your license and authority to practice any profession in any jurisdiction ever been revoked, suspended, denied, voluntarily relinquished or subjected to probationary conditions, or have proceeding towards any of these ends ever been instituted, or are proceedings towards any of these ends presently pending?

D. Yes_______ No_______ Have you ever been convicted of a felony, or are felony proceedings, indictments, or information presently pending?

E. Yes_______ No_______ Have you ever been or are you presently the subject of an investigation by any state or federal agency or body, including Medicare and Medicaid, regarding your professional activities?

F. Yes_______ No_______ Has your Drug Enforcement Agency controlled substances authorization or other authorization ever been denied, revoked, suspended, or voluntarily or otherwise relinquished, reduced or not renewed, or are proceedings towards any of those ends presently pending?

G. Yes_______ No_______ Have you ever been terminated from a managed care plan?

I. Yes_______ No_______ Are you currently engaged in the illegal use of drugs?

J. Yes_______ No_______ Have you ever been denied professional malpractice or liability insurance or have you ever had a professional malpractice or liability policy cancelled?

PROFESSIONAL LIABILITY PROTECTION

I Maintain (Check One):

________ Professional liability coverage of at least $250,000 per claim and $750,000 per aggregate. Please enclose a copy of the policy face sheet.

________ Irrevocable letter of credit for at least $250,000 per claim and $750,000 per aggregate. Please enclose a copy of the document establishing the Escrow Account.

________ Escrow Account for at least $250,000 per claim and $750,000 per aggregate. Please enclose copy of the document establishing the Escrow Account.

________ I have agreed to be personally responsible for the payment of any settlement or final judgment up to $250,000 including all court fees an accrued interest for which the physician is responsible.

________ Please enclose a copy of the notarized Financial Responsibility filed with the Department of Professional Regulation of your state.

Please sign ______________________________ Date ______________________________

MALPRACTICE ACTIVITY

Yes_______ No_______ Are you now or have you ever been during the past five years a defendant in an alleged malpractice suit?

If the answer is yes, please answer the following:

A. Yes_______ No_______ Were any judgments entered against you for an amount exceeding $10,000?

B. Yes_______ No_______ Were any suits settled for an amount exceeding $10,000?

C. Yes_______ No_______ During the past five years have you settled any alleged medical malpractice claims not involving litigation for an amount in excess of $10,000?

If yes has been answered please provide a brief summary of each suit or claim including a summary of the occurrence which created the claim and a description of each judgment or settlement agreement.

CREDENTIALING

If you are participating with any credentialing agency and wish for us to obtain your credentials from them, please provide us with the following:
Name:
Address:
Phone Number:
E-MAIL:

ATTESTATION STATEMENT

I certify that all information provided on this application is complete and accurate. I authorize Global Health Claim Services, to consult with and inspect any documents from individuals and organizations having information bearing on my qualifications and credentials. I understand that if false information is provided on this application it may be grounds for termination by Global Health Claim Services.

Signature of Dr. ______________________________ Date ______________________________

Please mail Letter of Agreement and Application with original signatures along with copy of the following documents:

IMPORTANT:

COPIES OF THE FOLLOWING MUST ACCOMPANY THIS APPLICATION FOR CREDENTIALING:

- ☐ Current Medical License
- ☐ Current DEA License
- ☐ Diploma
- ☐ Educational Commission For Foreign Medical Graduates Certification (ECFMG if Applicable)
- ☐ American Board Certification (ABMS Certification, Other Specialty Board)
- ☐ Board Eligibility (Certification of Fellowship Or Residency)
- ☐ Current Malpractice Face Sheet or Declaration Page (If non insured, Please provide copy of "Notice to Patients")
- ☐ Summary of Any Malpractice Suits or Settlements
- ☐ Curriculum Vitae