Thank you for your interest in becoming a Consociate Care Network Provider.

In addition to the completed application, we will need the following:

- Copy of CV
- Copy of medical license
- Copy of DEA license
- Proof of malpractice coverage
- Copy of W-9 form for your clinic

Please mail the completed application along with copies of the items listed above to:

Consociate Care PPO
Provider Services
P.O. Box 1068
Decatur, IL 62525-1068

CONSOCIATE CARE

Physician/Practitioner Application

Please complete ONE application for each Provider

Last Name	First Name	M.I.	Jr., Sr., as applicable

Birth Date (mm/dd/yy)	Professional Degree	Social Security Number (Billing Purposes ☐ Yes ☐ No)

Clinical Name or D.B.A. Name	Tax I.D. Number (Billing Purposes ☐ Yes ☐ No)

Office Locations

Office Location #1	Street Address for PPO Directory		Phone	Fax
City	State	Zip	E-mail	
Office Location #2	Street Address For PPO Directory		Phone	Fax
City	State	Zip	E-mail	

Billing Location

Billing Address (if different from above)			Phone	Fax
City	State	Zip	E-mail	

Availability/Accessibility of Service/Office Hours

Monday	Hours		a.m.		p.m.
Tuesday	Hours		a.m.		p.m.
Wednesday	Hours		a.m.		p.m.
Thursday	Hours		a.m.		p.m.
Friday	Hours		a.m.		p.m.
Saturday	Hours		a.m.		p.m.
Sunday	Hours		a.m.		p.m.

Do you accept walk-in patients? (Check one) ☐ Yes ☐ No

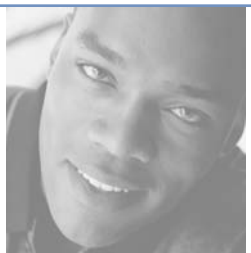
Do you accept new patients? (Check one) ☐ Yes ☐ No

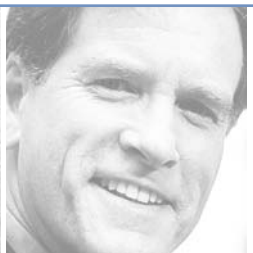
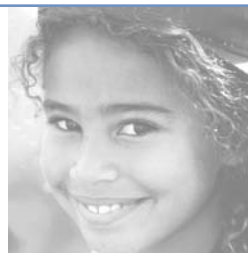
Is your office bilingual? (Check one) ☐ Yes ☐ No	If yes, please identify secondary language:

Worker's Injury/Illness

Does provider agree to participate in the Workers' Injury(s)? (Check one) ☐ Yes ☐ No

CONSOCIATE CARE



Hospital/Surgicenter Staff Privileges

Facility #1 Address	Type of Privileges:	City	State	Zip Code	Telephone
Facility #2 Address	Type of Privileges:	City	State	Zip Code	Telephone
Facility #3 Address	Type of Privileges:	City	State	Zip Code	Telephone
Facility #4 Address	Type of Privileges:	City	State	Zip Code	Telephone
Facility #5 Address	Type of Privileges:	City	State	Zip Code	Telephone

Licensure

State Licensed	License Number	Effective Date	Expiration Date
State Licensed	License Number	Effective Date	Expiration Date
Medicaid Provider Number	Medicare Provider Number		UPIN / NPI
Federal DEA Certificate	Registration Number	Date Issued	Expiration Date
State CDS Certificate	Registration Number	Effective Date	Expiration Date

If you answer "Yes" to any of the following questions, please provide a full narrative description of the circumstance. Your application will not be considered complete without this information.

Have your licenses to provide medical services in any state ever been or are they currently restricted, modified, challenged, suspended, or revoked?	☐ Yes	☐ No
Have you ever been the defendant in any criminal proceedings other than minor traffic offenses?	☐ Yes	☐ No
Have your DEA licenses ever been or are they currently challenged, restricted, modified, suspended, revoked, or has your application ever been denied?	☐ Yes	☐ No
Have you been a defendant in a medical malpractice action including out of court settlements or dropped/closed cases in the past 5 years?	☐ Yes	☐ No
Have your staff privileges ever been suspended, restricted or otherwise modified in the past 5 years?	☐ Yes	☐ No
Have you ever been involved with a voluntary or involuntary termination of professional or medical staff membership or limitation, reduction, or loss of clinical privileges at a hospital or other health care delivery setting?	☐ Yes	☐ No
Have you ever been involved in any disciplinary action by any hospital, medical society or state licensing agency, including, but not limited to, letters of concern, admonition or censure?	☐ Yes	☐ No

Insurance

Malpractice/Professional Liability Insurance Company	Policy Number:	Expiration Date:

Limits of Liability

Each Medical Incident:	Annual Aggregate:

Education/Training/Certification

American Board Certified (Please refer to the Minimum Standards for Provider Participation for recognized boards.) ☐ Yes ☐ No

Primary/Main Medical Specialty:	Subspecialty:

American Board Eligible (Please refer to the Minimum Standards for Provider Participation for recognized boards.) ☐ Yes ☐ No

Primary/Main Medical Specialty:	Subspecialty:

Medical School Name (Please print school's full name)	Contact Name

Address	Telephone	Year Graduated

Place of Internship/1st Year Residency	Contact Name

Address	Telephone	Year Completed

Place of Residency	Contact Name

Address	Telephone	Year Completed	Specialty

Place of Fellowship	Contact Name

Address	Telephone	Year Completed	Specialty

Undergraduate Program School Name	Contact Name

Address	Telephone	Year Graduated	Specialty Certified

Graduate Program School Name	Contact Name

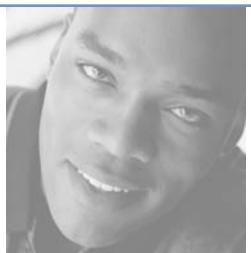
Address	Telephone	Year Graduated	Specialty	Special Training

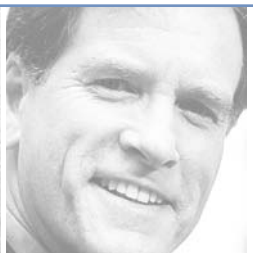
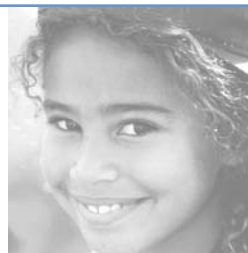
Chiropractic Graduate Program School Name	Contact Name

Address	Telephone	Year Graduated	Special Training

Accreditation/State Certifications	Contact Name

Address	Telephone	Year Certified	Special Training



Clinical Competence

(This section applies to non-medical allied health professionals, including chiropractors and physical therapists, and those physicians without clinical privileges. Refer to the Minimum Standards for Provider Participation for recognized specialties.)

List two names of "authoritative personnel", not currently in practice with you, who are personally acquainted with your professional and clinical performance, either in teaching facilities or in other health care settings. For example, training program's personnel (director), and associates from professional school and residency/postdoctoral programs.

Name			Company Name
City	State	Zip	Telephone
Name			Company Name
City	State	Zip	Telephone

Submit, along with your completed application, one letter from each person listed above, describing their opinions of your scope and level of clinical performance, satisfactory fulfillment of professional obligations, clinical judgement, technical skills, and ethical performance, etc. Each letter must be signed by the authoritative personnel. Primary source verification will be performed during the credentialing process.

Practice Type

Type of Practice: ☐ Solo ☐ Single Specialty Group ☐ Multi-Specialty Group ☐ Hospital Based ☐ Rehabilitation Hospital

General Practitioner

Choose One:

☐ Primary Care Including Pediatrics ☐ Specialty Care Including Pediatrics ☐ Primary Care Including OB & Pediatrics ☐ Specialty Care Only
☐ Primary Care - Adult Only ☐ Both Primary Care & Specialty Care including Pediatrics ☐ Both Primary Care & Specialty Care - Adult Only ☐ Other_____

Patient Type

Choose the boxes that apply to the types of patients you accept. Select as many as are pertinent.

☐ General/Family Medicine
☐ Specialty medicine
Type of Specialty _____
☐ General Surgery
☐ Specialty Surgery
Type of Specialty _____
☐ General/Diagnostic Radiology
☐ Therapeutic Radiology
☐ Specialty Pediatrics
Type of Specialty _____

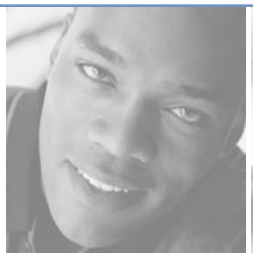
☐ Gynecology Only
☐ Podiatry
☐ Occupational Medicine
☐ Occupational Therapy
☐ Sports Medicine
☐ Physical Therapy
☐ Work Hardening
☐ Pain Management

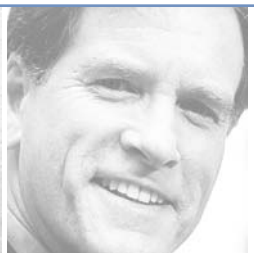
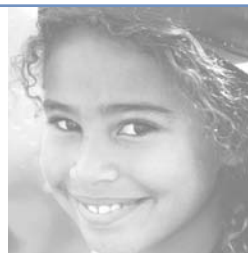
Mental Health Providers
☐ Chemical Dependency
☐ Individual Therapy
☐ General Practice
☐ Child/Adolescent Disorders
☐ Marital/Family
☐ Other _____

Work History (At a minimum, past 5 years must be included)

Employer Name	Contact Name	From/To		Position
Address	City	State	Zip	Telephone
Employer Name	Contact Name	From/To		Position
Address	City	State	Zip	Telephone
Employer Name	Contact Name	From/To		Position
Address	City	State	Zip	Telephone

CONSOCIATE CARE



Consent/Representations and Warranties

I consent to the inspection of my records and documents pertinent to the consideration of my application and continued participation as a provider in the Consociate Care PPO Network. In addition, I consent to the performance of site evaluations performed by Consociate Care and/or its affiliates and/or agents.

I am able to perform all of my professional activities without impediment or constraint and meet the minimum standards for provider participation. In the past five years, I have had no physical, mental or chemical dependency condition(s), loss or limitation of licenses and/or felony convictions, loss or limitation of privileges or disciplinary activity that affect, or have affected my ability to perform all of my professional activities. I agree to practice within the scope of my licensure.

The undersigned represents, warrants and certifies that the information provided herein is true, correct and complete. The undersigned agrees to notify Consociate Care immediately and in writing of any change in name, address or ownership possession and of any material adverse change in any of the information contained in this statement or in the ability of the undersigned to perform its (or their) obligations. In the absence of such notice, the information provided herein should be considered as a continuing statement and substantially correct. If the undersigned fails to notify CONSOCIATE CARE as required above, or if any of the information herein should prove to be inaccurate or incomplete in any material respect, CONSOCIATE CARE shall immediately decline the application for participation or immediately terminate the provider's participation.

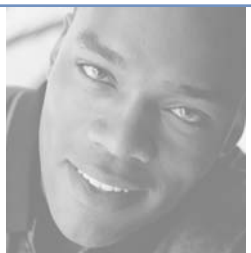
I authorize CONSOCIATE CARE to consult with hospital administrators, members of medical staffs, malpractice carriers and other persons to obtain and verify my credentials and qualifications as a provider. I release CONSOCIATE CARE and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

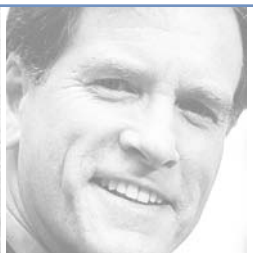
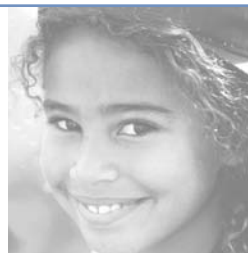
IF YOU DO NOT COMPLETE THIS APPLICATION IN ITS ENTIRETY INCLUDING ANSWERING ALL APPLICABLE QUESTIONS, THE ENTIRE PACKET WILL BE RETURNED FOR COMPLETION.

Applicant's Printed Name	Date
Applicant Signature	

A photocopy of this consent shall be as effective as the original when so presented.

CONSOCIATE CARE



Consociate Care P.P.O. (Narrative of Malpractice Suit)

Provider's Name	Date

Please provide detailed information regarding any and all malpractice suits. Your narrative should include at a minimum:

1.) Patient's name: _____

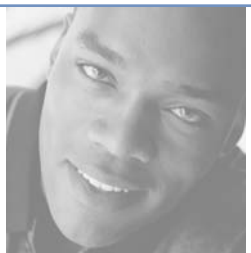
2.) Insurance Carrier at the time of suit: _____

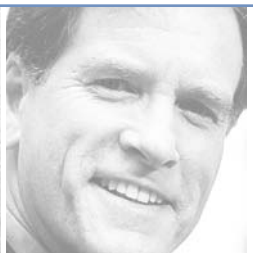
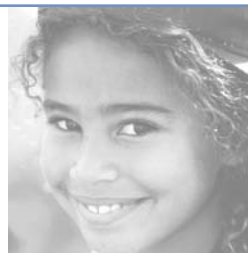
3.) Description of allegations: _____

4.) Dates of treatment and/or surgery and narrative defense of your activity: _____

5.) If filed, specify disposition or current status of claim or suit: _____

6. Date and dollar amount of settlement (if applicable): _____



Practitioner Site Questionnaire

Check all that apply to this site

Setting/Type

- ☐ Ambulatory
- ☐ Free Standing Building
- ☐ Mobile Unit
- ☐ Home Care
- ☐ Hospice
- ☐ Hospital
- ☐ Long Term Care
- ☐ Mental Health
- ☐ Inpatient
- ☐ Residential
- ☐ Supervised Living
- ☐ Partial Hospitalization
- ☐ Outpatient

- ☐ POS
- ☐ HMO
- ☐ IPA
- ☐ PPO
- ☐ Practitioner Office
- ☐ Laboratory

High Risk Services

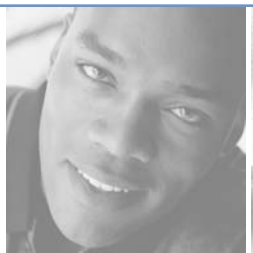
- ☐ Anesthesia
- ☐ Average LOS greater than 24 hours
- ☐ Birthing Center
- ☐ Chronic Dialysis
- ☐ Contrast Imaging
- ☐ Infusion Therapy
- ☐ Radiation Oncology
- ☐ Ventilator Care
- ☐ 23-hour Recovery Center
- ☐ Emergency/Urgent Care Center

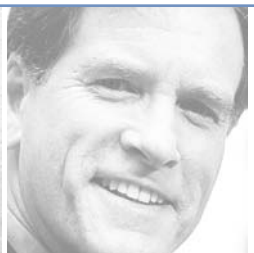
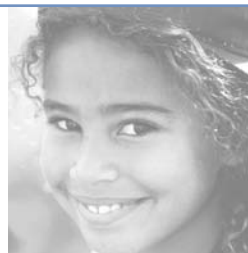
Other Services

- ☐ Acute Inpatient
- ☐ Acquired Brain Injury
- ☐ Alcohol/Drug Rehab Svc
- ☐ Chemical Dependency
  - ☐ Adult
  - ☐ Child/Adolescent
- ☐ Dementia/Alzheimer's
- ☐ Durable Medical Equip.
- ☐ General Long Term _____
- ☐ Home Healthcare
- ☐ Imaging Services _____
- ☐ Laboratory Services
- ☐ Mental Health Services _____
  - ☐ Adult
  - ☐ Child/Adolescent
- ☐ MR/DD Services
- ☐ Pharmaceutical Services
- ☐ Physical Rehab Services
- ☐ Primary Care Services
- ☐ Subacute Services
- ☐ Other _____

Please list the education and training of all management, clinical personnel and equipment technicians including title of position and degree(s) and/or certification held.

Title	Degree/Training/Certification



Practitioner Site Questionnaire (Continued)

Availability of Services: (check those that apply)

Average length of office visit:
- ☐ 5-10 min.
- ☐ 10-20 min.
- ☐ 20-30 min.
- ☐ 30+ min.

Average length of waiting time:
- ☐ 5-10 min.
- ☐ 10-20 min.
- ☐ 20-30 min.
- ☐ 30+ min.

Average wait time for appointment:
- ☐ 0-7 days
- ☐ 7-14 days
- ☐ 14+ days

Does the practitioner site have specific policies regarding patient record security and confidentiality? ☐ Yes ☐ No

Does the practitioner site use a standard Patient Assessment form for all patients seen? ☐ Yes ☐ No

Does the practitioner site have specific policies for scheduling appointments based on the needs of the patient? ☐ Yes ☐ No

Does the practitioner site have procedures in place to assist patients that need referrals to other facilities or for additional treatments? ☐ Yes ☐ No

Is the practitioner site accredited? ☐ Yes ☐ No

If yes, provide the following:

	ID #	Award Date	Exp. Date
☐ Joint Commission			
☐ Other, (Identify) _____			

How do you communicate self-care, health promotion and disease prevention to your patients?

☐ Newsletters ☐ Brochures ☐ Pamphlets ☐ Other _____

General Comments: Please provide comments on how CONSOCIATE CARE could serve you and your patients more effectively.

CONSOCIATE CARE