NetCare
Life & Health Insurance

424 West O'Brien Drive, Julale Center, Suite 200, Hagatna, Guam 96910
Tel: (671) 472-3610 Fax: (671) 472-3615
Website: www.netcarelifeandhealth.com

PARTICIPATING PROVIDER
APPLICATION & PROFILE

Provider / Medical Group Name: _____

Date of Submission: _____

Dear Provider,

Thank you for your interest in joining the NetCare Life and Health Insurance Participating Provider Network.

Please complete the Participating Provider Application & Profile and submit required documents.

Please prepare an electronic copy of your proposed fee schedule in MS Excel format and send to: providers@netcarelifeandhealth.com upon request.

Visit our website: www.netcarelifeandhealth.com for more information on our services. NetCare Health Insurance encourages electronic claims submission.

Please note that NetCare Health Insurance requires Prior Authorization on certain services. A listing of services that require a PA is listed on our website.

Once all documents are received and reviewed, our Provider Relations Staff will contact you.

Kind Regards,

Provider Relations

NetCare Life & Health Insurance

Participating Provider Application

Please type or print using a ball point pen.

Note: This information will be used to develop the Provider Directory

⬭MD ⬭DO ⬭DDS ⬭OD ⬭RPT ⬭RPH

⬭OTHER (Please Specify)_____

PIN_____
Network_____
Netcode_____

Provider Name: _____
Last Name First M.I. Degree

☐ Professional Corp ☐ Partnership ☐ IPA ☐ Solo Practice ☐ Other

Medical/Dental Group or IPA Affiliation _____

Group Tax Identification No. (If applicable)_____ Will you bill under this number? ☐ Yes ☐ No

Medical/Ancillary/Dental Specialty (Primary)_____

Specialty Board Certification ☐Yes ☐No ☐N/A (If Yes, Year _____)

Medical/Ancillary/Dental Specialty (Secondary)_____

Specialty Board Certification ☐Yes ☐No ☐N/A (If Yes, Year _____)

Are you an Active Candidate for Board Certification? ☐Yes ☐No

Boards for which you are Qualified by Completion of Residency Training Program

_____

_____

If you are not Board Certified in your Primary or Secondary Specialty (listed above) and not eligible to take either examination, please attach an explanation of any relevant training experience.

Date of Birth_____ National Provider Identifier (NPI) _____

Social Security Number_____ Will you bill under this number? ☐Yes ☐No

Do you have a current Federal DEA Narcotics License? ☐Yes ☐No

DEA# _____ DEA Exp. Date: _____

Name of Professional Liability Insurance Carrier_____

Limits of Professional Liability Insurance Policy_____

Limits of Professional Liability Insurance Policy _____ / _____
Per Occurance Aggregate

Policy Renewal Date _____

For information purposes only, please indicate whether you accept Medicare Assignment ☐Yes ☐No

State License Numbers (List all active license numbers)

License Number State Expiration Date

License Number State Expiration Date

License Number State Expiration Date

NetCare Life & Health Insurance

Participating Provider Application (Continued)

Primary Office Address

Office Manager

Street

City State Zip Code

Phone Number Fax Number

Email Address

Primary Billing Address

Billing Manager

Street

City State Zip Code

Phone Number Fax Number

Email Addres

Average lead time needed to schedule appointment for non-urgent care_____

Number of patients seen on an average day _____ Percent of increase in patients that can be handled_____

Tax Identification No. Ownership (required) _____

Office Hours:

Monday	—	Wednesday	—	Friday	—
Tuesday	—	Thursday	—	Saturday	—

Hospital Affiliations

List all Hospitals at which you currently have clinical privileges

Name of Place City State Zip Code

Name of Place City State Zip Code

List all previous Hospital affiliations

Name of Place City State Zip Code

Name of Place City State Zip Code

Are you able to provide all treatment services at a participating hospital/facility? ☐Yes ☐No
If NO, please name procedure and facility below:

Educational Background

Medical School and/or applicable graduate and clinical education_____

City_____ State_____ Year Graduated_____

Type of Internship_____ ☐ N/A Dates (From/To)_____

Name of Institution_____ City_____ State_____

Type of Residency_____ ☐ N/A Dates (From/To)_____

Name of Institution_____ City_____ State_____

Type of Fellowship_____ ☐ N/A Dates (From/To)_____

Name of Institution_____ City_____ State_____

NetCare Life & Health Insurance

Confidential Information

			NONE	YES	NO	N/A
1.	A.	Are you or have you ever been involved in any malpractice suit, including Arbitration? (If none, please state "None")	☐	☐	☐	☐
	B.	Has any malpractice claim settlement, not involving litigation or arbitration, ever been paid by you or paid on your behalf?		☐	☐	☐
	C.	Have you ever had a civil suit brought against you related to your professional work or is any such action pending?		☐	☐	☐
		If the answer to either of the above questions is yes, please attach the following information for each action, suit or settlement whether open or closed, and regardless of whether or not payment was made:		☐	☐	☐

- ► Date and details of the incident(s) leading to the action, suit or settlement
- ► Date of filing and settlement or award
- ► Your role in the incident(s)
- ► Your status in any suit or other legal action (Primary Defendant, Co-Defendant, Other)
- ► Subsequent events, including patient outcome
- ► Current status of suit or other legal action
- ► Amount paid as an out-of-court settlement or amount of jury award or court award (Please obtain this information from your insurer if necessary)

		YES	NO	N/A
2.	Has your professional liability insurance ever been denied, suspended, cancelled, or not renewed? (If the answer is yes, please explain in an attachment)	☐	☐	☐

		YES	NO	N/A
3.	Do you now have or within the last five years have you had any physical condition, mental condition or chemical dependency condition (alcohol or other substance dependency) that does or has interfered with your ability to practice medicine or perform appropriate clinical duties?	☐	☐	☐

		YES	NO	N/A
4.	Have you ever had any of the following items involuntarily denied, revoked, suspended, not renewed, placed under probation, subjected to disciplinary action, or otherwise limited or curtailed; or have your voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items?	☐	☐	☐
	► State License	☐	☐	☐
	► Federal DEA Registration or other applicable narcotic registration	☐	☐	☐
	► Hospital or other Health Care Facility staff membership or privileges	☐	☐	☐
	► Professional organization membership	☐	☐	☐
	► Medicare, Medicaid, or other government program participation	☐	☐	☐
	► HMO, PPO, or other prepaid health plan participation	☐	☐	☐

If the answer to any of the above items is yes, please explain in an attachment

NetCare Life & Health Insurance

Confidential Information (Continued)

			YES	NO	N/A
5.	A.	If you have previously been employed as a physician or other provider by a military service, a hospital, an HMO, or any other health care organization, were you ever terminated by your employer?"	☐	☐	☐
	B.	Have you ever participated in a managed care plan that you no longer participate?	☐	☐	☐
6.		Have you ever been convicted of a crime (other than a traffic offense) or are you currently under indictment for an alleged crime? If the answer is yes, please explain in an attachment.	☐	☐	☐
7.	A.	Has disciplinary action of any sort ever been taken against you by an ethics committee, licensing board, professional association or educational/training institution?	☐	☐	☐
	B.	Have you ever been the object of a complaint or inquiry regarding sexual contact, harassment or exploitation?	☐	☐	☐
8	A.	NetCare is committed to going green for the environment. Is your practice/clinic capable of submitting claims electronically?	☐	☐	☐
	B.	Does your practice/clinic submit claims electronically? If so, please provide the name of your clearinghouse vendor. _____	☐	☐	☐

NetCare Life & Health Insurance

Confidential Information

PLEASE BE SURE TO ENCLOSE WITH THE APPLICATION THE FOLLOWING:

- Copy of current local/state business registration certificate
- Copy of current local/state board license
- Copy of board certification status (i.e. board eligible or board certified)
- Copy of medical degree/diploma
- Copy of current local/state and Federal Drug Enforcement Agency registration certificate
- Completed IRS Form W9: Request for Taxpayor ID Number and Certification (attached)
- Copy of Proposed Fee Schedule. Electronic copy on MS Excel format to be submitted at a later date
- Copy of your current professional liability insurance certificate of coverage and name and address of agent
- Any explanatory statements requested related to confidential questions 1 - 7

RELEASE

I authorize NetCare Life & Health Insurance, its affiliates and successors to consult with members of hospital medical staffs, professional liability carriers, and other persons or entities to obtain information concerning my professional qualifications, including competence, ethics, and other qualifications.

I release NetCare, its affiliates and successors and their employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my applications.

I consent to the release, by any person to NetCare or its affiliates or successors, of all information that may be relevant to an evaluation of any qualifications, including information about disciplinary actions or other confidential or priviledged information.

I release all from any and all liability to anyone providing this information in good faith and without malice. I understand that I have the burden of proving adequate information to NetCare, its affiliates or successors to demonstrate my qualifications. I understand that any misstatement in this application may constitute ground for denial of this application or for summary dismissal as a participating NetCare provider.

If any material changes occur affecting my professional status, it is my obligation to notify NetCare or the appropriate affiliate or successor as soon as possible. I consent to the release of this information, as well as other quality assurance data relating to me, to health benefit plans owned, managed or administered by NetCare, its affiliates or successors, and to medical groups, IPA's and other similar entities contracting with those plans.

Name (Please Print) _____

Signature _____ Date _____

Form **W-9**
(Rev. November 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ---------- ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
			–			–		

or

Employer identification number
			–					

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here Signature of U.S. person ▶ Date ▶

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,