



Professional PPO Application

MultiPlan/WPPN, Inc.
PO Box 6090
De Pere WI 54115-6090
Telephone: 920-337-6550
Fax: 920-337-6594

PROVIDER INFORMATION (please type or print)

Last Name	First Name	Professional Degree
Date of Birth	Social Security #	Group Affiliation

PROVIDER IDENTIFICATION NUMBERS

Federal DEA#	State CDS/DEA#	UPN#
Exp. Date	Exp. Date	Medicare#

OFFICE #1 Practice Name _____

Street _____

City _____ County _____ State _____ Zip _____

Phone () _____ Fax () _____ email _____

Type of office Service Billing Mailing

List all TINs associated with this office _____

OFFICE #2 Practice Name _____

Street _____

City _____ County _____ State _____ Zip _____

Phone () _____ Fax () _____ email _____

Type of office Service Billing Mailing

List all TINs associated with this office _____

OFFICE #3 Practice Name _____

Street _____

City _____ County _____ State _____ Zip _____

Phone () _____ Fax () _____ email _____

Type of office Service Billing Mailing

List all TINs associated with this office _____

LICENSURE (Attach copy of medical license for each state)

State	License Type	License #	Year Obtained	Exp. Date / /
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HOSPITAL AFFILIATION

Please list each hospital/facility with which you are affiliated, using boxes below in the order in which you most frequently admit patients. List additional affiliations on a separate attached sheet.

1 Hospital Name _____

City _____ State _____

Telephone () _____ Status _____

2 Hospital Name _____

City _____ State _____

Telephone () _____ Status _____

3 Hospital Name _____

City _____ State _____

Telephone () _____ Status _____

PROFESSIONAL LIABILITY INSURANCE

Attach copy of face sheet of current liability insurance policy.

Current Carrier _____ Policy # _____ Exp. Date ___/___/___

Address _____ Initial Coverage Date ___/___/___

City _____ State _____ Zip _____ Policy Limits _____

Other accredited (NCQA, JCAHO, URAC) health plans/networks of which you are a member. (OPTIONAL)

1. Name of Plan/Network _____ Active/Unrestricted
Address _____ Restrictions

2. Name of Plan/Network _____ Active/Unrestricted
Address _____ Restrictions

3. Name of Plan/Network _____ Active/Unrestricted
Address _____ Restrictions

SPECIALTY/SUB-SPECIALTY CERTIFICATION & DIRECTORY LISTING

Specialty	Board Certified by ABMS/AOA only		Certification Active		List in MultiPlan Directory	
	Yes	No	Yes	No	Yes	No
1. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Yes No

If you are not Board Certified, have you completed the training requirements for your specialty within the past five (5) years?

If you practice Internal Medicine, Obstetrics and Gynecology, Family Practice or Pediatrics, do you accept patients for primary care services?

Are you interested in participating in clinical trials?

EDUCATION & TRAINING (Medical/Graduate School)

Name _____
 City _____ State _____
 From ___/___/___ To ___/___/___ Degree _____

Yes No

If foreign medical school, are you certified by the Educational Council for Foreign Graduates?

If yes, indicate the ECFMG # _____

INTERNSHIP

Program/Hospital Name _____
 City _____ State _____
 From ___/___/___ To ___/___/___ Specialty _____

RESIDENCY

Program/Hospital Name _____
 City _____ State _____
 From ___/___/___ To ___/___/___ Specialty _____

PROFESSIONAL AND HEALTH STATUS INFORMATION

	Yes	No
1. Has your DEA/CDS registration or any license to practice medicine and/or perform surgery in any Jurisdiction been restricted, suspended, placed under probation, revoked, or surrendered involuntarily?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been denied membership, or been subject to disciplinary proceedings, in any medical organization?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has any disciplinary action been taken against you or your license by any state licensing Board and/or is any such action pending and/or is any investigation of you by such a Board underway?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have your privileges been restricted, refused, suspended, revoked, or dropped involuntarily from any Hospital, other health care institution, or health plan/network?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any ongoing physical and/or mental impairment or condition, or substance abuse problem which would make you unable with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice? If you require reasonable accommodation, what reasonable accommodation is necessary?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you been named, or are you currently named in any malpractice action, including cases which may have been dismissed with no cash payment?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you been excluded or suspended from participation in any governmental health program (e.g. Medicare, Medicaid, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has your professional liability coverage been restricted, suspended, refused, revoked, or denied?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you been convicted of a felony or any other criminal charge (excluding minor traffic violations)?	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: If you answer YES to any of the above questions, please explain on a separate sheet.

I represent and warrant that the information contained in the foregoing application is true and complete to the best of my knowledge and belief, and I agree to inform MPWPPNI within five (5) business days if any material change in such information occurs. I hereby authorize release to MPWPPNI or its designated agents information to verify the above. I release MPWPPNI from any liability in connection with any request for information hereunder.

The Applicant, and only the Applicant, is responsible for the accuracy and completeness of the information provided on, and in support of, this Application including any attached sheet or photocopy which is part of this application. THE SUPPLYING OF INACCURATE, MISLEADING, AND/OR INCOMPLETE INFORMATION ON OR IN SUPPORT OF THIS APPLICATION MAY SUBJECT THE APPLICANT TO CIVIL AND/OR CRIMINAL PENALTIES UNDER STATE AND/OR FEDERAL LAW, AND MAY SUBJECT THE APPLICANT TO LICENSE REVOCATION AS WELL.

Signature _____ Date _____

Name (Please print) _____



Malpractice History

Complete this form in detail for any **malpractice action (open, closed, settled, litigated, or dismissed)** that occurred. Information provided is **confidential**. Complete clinical details and settlement amounts are required on all cases regardless of status or date of occurrence. If more than one case, please photocopy this form for each case. **Incomplete forms will delay your application process!**

I do not have any malpractice action. (Please sign and date below).

Patient's Name: _____

Date of Occurrence: / / Carrier Name: _____

Were you the attending physician? Yes No

If no, describe your role: _____

What was the condition of the patient leading up to the occurrence? What were the specifics in reference to the malpractice action? What is/was your role in this event?

Was the occurrence documented in the medical record? Yes No

If so, by whom?: _____

Describe your actions subsequent to the occurrence:

What is/was your status in the action?: Primary defendant Co-defendant Other

Status of case: Open Dropped Dismissed
If open, amount reserved by carrier: \$ _____
If settled, settlement amount: \$ _____ Date: ____/____/____
Your share of settlement amount: \$ _____

Practitioner's Name: _____

Practitioner's Signature: _____ Date: ____/____/____



Authorization to Release Information

I, _____, authorize the release to MultiPlan/WPPN
(name of applicant)
information necessary to certify or verify the current validity of my license,
certification and/or hospital privileges.

I release from liability, any organization or individual that provides in good
faith such information to MultiPlan/WPPN.

A photocopy of this form shall be as effective as an original.

Signature of applicant: _____

Date: ____/____/____

MultiPlan/WPPN
PO Box 6090
De Pere WI 54115-6090
800-279-9776

Reminder

Please attach copies of your...

Professional Liability
Insurance face sheet

Current state licensure