

# Rehab Net of Arkansas

## Provider Application

Discipline     P.T.         O.T.         S.L.P.

### FACILITY DATA

(1) Business Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

(2) Billing Address \_\_\_\_\_  
\_\_\_\_\_

(3) Owner/Contact Person \_\_\_\_\_

(4) Type of Ownership     Sole Proprietor     Partnership         Corporation

(please complete attached Statement of Ownership)

(5) Date practice started \_\_\_\_\_ Tax ID number \_\_\_\_\_

(6) Owner's therapist license number \_\_\_\_\_ State AR Effective Date \_\_\_\_\_  
Medicare Provider Number \_\_\_\_\_ Medicaid Provider Number \_\_\_\_\_  
Clinic NPI # \_\_\_\_\_ Owner's Individual NPI # \_\_\_\_\_  
Owner's Soc. Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Owner's CEU's for last 2 years \_\_\_\_\_  
Member of APTA         Yes         No  
Member of APTA sections-please list \_\_\_\_\_

(7) Type of practice \_\_\_\_\_  
(i.e. ortho, pediatric, neuro, home health, etc.)

(8) Do you use an ECS system (electronic claims submission)?  No  Yes. If yes, do you electronically submit all claims possible  or just Medicare/BCBS  What software or clearinghouse do you use? \_\_\_\_\_

(9) Do you bill under your own tax ID number?  No         Yes. If no, please explain.  
\_\_\_\_\_

- (10) Do you lease your equipment?  No  Yes. If yes, from whom do you lease it?  
\_\_\_\_\_
- (11) Do you have a system for tracking outcomes?  No  Yes. If yes, what system?  
\_\_\_\_\_
- (12) Do you use a computerized office management system?  No  Yes, if yes, what system? \_\_\_\_\_
- (13) Do you have internet access?  Yes  No  
If yes, e-mail address: \_\_\_\_\_
- (14) Does your practice have any physician ownership or do you provide monetary or material incentives for physicians to make referrals to you?  No  Yes. If yes, please provide details \_\_\_\_\_  
\_\_\_\_\_
- (15) Are you Medicare certified?  No  Yes  
As an independent practice  Rehab  CARF/CORF
- (16) Do you have more than one office location?  No  Yes. Please provide the business name and address of other affiliating facilities. Please attach list of locations with address, telephone numbers, fax numbers and tax ID numbers. Do you wish for this membership to cover all of your locations and if so please indicate which ones?
- (17) Have you or your facility's malpractice insurance ever been canceled, or has renewal ever been refused because of claims or liability risk?  No  Yes. If yes, please explain on a separate enclosure.
- (18) Are you currently a member or are you currently being considered for membership in another network, PPO, IPO, or other contracting entity?  No  Yes. If yes, please provide details \_\_\_\_\_  
\_\_\_\_\_
- (19) Please describe; list any specialty services that you provide at your facility. (Functional capacity, pain mgmt, biofeedback, etc.) \_\_\_\_\_  
\_\_\_\_\_
- (20) What is the average number of patients seen in your office per day? \_\_\_\_\_
- (21) What is the waiting time to obtain an appointment in your office for:  
Elective visits: \_\_\_\_\_ Urgent Problems: \_\_\_\_\_
- (22) Please list your office hours:  
Mon. \_\_\_\_\_ to \_\_\_\_\_  
Tue. \_\_\_\_\_ to \_\_\_\_\_  
Wed. \_\_\_\_\_ to \_\_\_\_\_  
Thu. \_\_\_\_\_ to \_\_\_\_\_  
Fri. \_\_\_\_\_ to \_\_\_\_\_





**(Complete for Each Additional Licensed Staff Member)**

Name: \_\_\_\_\_ Soc. Security # \_\_\_\_\_

License #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

NPI #: \_\_\_\_\_

**HEALTH STATUS**

Do you presently have or have had a physical or mental condition, that has affected or could affect your ability to perform professional or medical staff duties appropriately (i.e., if you are a surgeon, do you have a seizure disorder)?

Yes     No    If yes, please provide a full explanation on a separate sheet.

**DISCIPLINARY ACTIONS**

All providers please answer all questions in this section completely. No application will be processed until complete. If you answer yes to any questions, please provide full explanation on a separate sheet.

Have any of the following ever been, or are currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished?

Yes	No	
		Medical license in any state
		Other professional registration/license
		Academic appointment
		Terminated from any rehabilitation employment on any medical/hospital staff
		Professional society membership
		Professional liability insurance

Please answer yes or no to the following questions.

Yes	No	
		Have any Government or third party payer sanctions ever been imposed upon you or any practice you engaged in?
		Have you or any owners ever been convicted of a felony?
		Is there now, or has there ever been, any action pending against you arising from an investigation conducted by, or complaint filed with, the State Board of Healing Arts, Medicare, or other state or federal regulatory body?
		Are you now, or have you ever been, subject to an investigation conducted by any of the aforementioned regulatory bodies?
		Have you ever been named in, or been the subject of, in whole or in part, a lawsuit or claim alleging professional liability within the last 5 years? (If so, please provide the following information on a separate sheet: Name of the parties of the case, date case was filed if applicable, name of the court in which the case was filed if applicable, case number, current status or resolutions of the claim or lawsuit (i.e., pending, settled, judgement for plaintiffs/defendants, etc.) and a brief description of the allegations of the claim or lawsuit. If a claim was settled or judgement, please forward copy of court documentation.)
		Are you currently engaged in the use of illegal drugs?

Malpractice Action: Number of pending claims: \_\_\_\_\_ Number of prior judgements or settlements since licensure: \_\_\_\_\_ (If none, please write "none".)

\_\_\_\_\_  
Signature of Staff Member

\_\_\_\_\_  
Date

**CONSENT and RELEASE / ATTESTATION FORM**

**(Complete for Each Licensed Staff Member)**

**Provider Authorization and Attestation** - Any alteration or failure to sign and date this form will delay the processing of your application.

I hereby give permission to Rehabilitation Network of Arkansas, Inc. (Rehab Net) and/or its designee(s) to request information regarding my professional credentials and qualifications from educational facilities, professional certificate boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, present and past employers, and any other entity needed to obtain information necessary to complete the credentialing process, which may include a criminal history background check.

The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and or professional competence, character, ethics, or any other matter applicable to the credentialing procedure. I release and agree to hold harmless Rehab Net and its designee(s) and their respective authorized representatives, from any and all liability for any damages, costs and expenses which may result from the gathering of and good faith use of the information gathered during the credentialing process.

I hereby authorize the education facilities, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, present and past employers to submit information requested by Rehab Net directly and/or through its designee(s) including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and lawsuit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I hereby further release and agree to hold harmless any such entity referenced in the previous sentence, their representatives, employees, and agents from any damages which may result from providing this information as long as such release of information is done in good faith and without malice.

I agree that a photocopy or facsimile of this document with my signature may be accepted by any person or entity from which information is needed to complete the credentialing process. The photocopy or facsimile is sought with the same authority as the original, and I specifically waive written notice from any such entity or individual who may provide information based upon this authorized request.

I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application by Rehab Net may result in denial of my application or termination of my participation in Rehab Net. I further understand that any misrepresentation, misstatement, or omission from this application, if discovered after network participation has been awarded to me, may lead to immediate suspension or termination of my network status. I agree to use my best efforts to inform Rehab Net in writing, within 15 days, if there is any change in the information contained in this application as a result of developments subsequent to my signing this application.

If I am accepted for participation, I consent to the inspection of my patient records as necessary for peer, utilization, and quality review purposes and agree to be bound by the participation agreement, credentialing plan and provider manual.

I understand that I have the right to review and correct erroneous information obtained by Rehab Net to evaluate my credentialing application. This includes information obtained from any outside primary source (e.g., malpractice insurance carriers, state licensing boards, Criminal History Background Checks, etc). The review must take place within 6 months of this application. Any corrections must be made in writing within 30 days of the review. This does not require Rehab Net to allow a provider to review references, recommendations or other information that is peer-review protected.

I represent that the information provided in or attached to this application is complete, accurate and true to the best of my knowledge and that I have current malpractice protection through a commercial carrier. Prior to review of this application by Rehab Net's Credentialing Committee, additional information will be accepted to correct incomplete, inaccurate or conflicting credentialing information.

I agree that the submission of the application does not constitute approval or acceptance as a participating provider.

This organization does not discriminate on the basis of race, color, national origin, age, or disability.

If at any time during the credentialing process you have any questions regarding the status of your application, please call 1-866-548-6003 and speak with the executive director.

**This attestation statement must be signed no more than 60 days prior to the credentialing decision. If the credentialing review and decision takes place more than 60 days after the signature below, the provider must re-sign and date this application page attesting that all application information remains current, complete, and correct.**

**Your signature is required to complete this application. STAMPED SIGNATURES ARE NOT ACCEPTABLE.**

Name (Please Print or Type) \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_

**STATEMENT OF OWNERSHIP**

I hereby declare that \_\_\_\_\_ is at least  
50% owned by the following physical therapist(s), \_\_\_\_\_.  
Listed are all other part owners of the facility \_\_\_\_\_  
\_\_\_\_\_

Signature of Accountant: \_\_\_\_\_

Print Name of Accountant: \_\_\_\_\_

State of Arkansas

County of \_\_\_\_\_

Subscribe and sworn to before me on this \_\_\_\_\_ day \_\_\_\_\_, 20\_\_\_\_\_

Who is personally known to me or has produced \_\_\_\_\_ for  
identification.

Notary Public

My Commission expires on:

_____	_____	_____
Date	Notary Public (signature)	Notary Public (print)

My Commission number is: \_\_\_\_\_