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 have a system for tracking outcomes? ☐ No ☐ Yes. If yes, what system?

_____

(10) Do you use a computerized office management system? ☐ No ☐ Yes, if yes, what system? _____

(11) Do you have internet access? ☐ Yes ☐ No

If yes, e-mail address: _____

(12) 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 _____

_____

(13) Are you Medicare certified? ☐ No ☐ Yes
As an independent practice ☐ Rehab ☐ CARF/CORF ☐

(14) 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?

(15) 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.

(16) 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 _____

_____

(17) Please describe; list any specialty services that you provide at your facility. (Functional capacity, pain mgmt, biofeedback, etc.) _____

_____

(18) What is the average number of patients seen in your office per day? _____

(19) What is the waiting time to obtain an appointment in your office for:
Elective visits: _____ Urgent Problems: _____

(20) Please list your office hours:
Mon. _____ to _____
Tue. _____ to _____
Wed. _____ to _____
Thu. _____ to _____
Fri. _____ to _____

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 bodes?
		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.

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

STAFF DATA

(1) Number of full time licensed employees: _____PT's _____PTA's _____OT's _____OTA's _____SLP

(2) Number of part time licensed employees: _____PT's _____PTA's _____OT's _____OTA's _____SLP

(3) Does your office employee paraprofessionals for direct care? ☐ No ☐ Yes. If yes, how many and what are their functions? _____

(4) Do you have any support personnel that are trained in a specialty? ☐ No ☐ Yes. If yes, please identify their specialty _____

(5) Do you have any staff with specialty certification in therapy? ☐ No ☐ Yes. If yes, please identify their specialty _____

♦♦♦

PLEASE ATTACH:

- Copy of professional liability insurance face sheet
- Copy of general liability insurance face sheet
- Copies of licenses for ALL licensed staff
- Copy of your Medicare certification letter
- Curriculum vitaes for ALL licensed staff
- Completed W-9 form
- Copy of your lease if you are leasing your office space.
- $500 application fee (If for any reason, your application for membership is denied, all but $50 will be refunded to you. The $50 is for expenses related to credentialling.

Be sure to complete all questions on the application. Also, note an onsite inspection of your facility will be required prior to approval for membership (see onsite evaluation criteria list in the bylaws).

Does the city you are located in require a city business license? ☐yes ☐no, if yes please attach a copy.

POLICY STATEMENT and RELEASE OF LIABILITY

I FULLY UNDERSTAND THAT ANY SIGNIFICANT MISSTATEMENTS OR OMISSIONS CONCERNING THIS APPLICATION WILL CONSTITUTE CAUSE FOR DENIAL OR APPOINTMENT OR DISMISSAL FROM THE NETWORK TO WHICH I HAVE SUBMITTED THIS APPLICATION.

I understand and agree that as an applicant for network membership. I have the burden and responsibility of producing adequate information for the proper evaluation and credentialling of my qualifications, ethics, character, and competence. I also understand that REHAB NET as a not-for-profit organization will assess monthly dues as determined by the Board of Directors to support the operations of this organization.

I release from liability all representatives of REHAB NET, and its appointed agents in all their acts performed in good faith and without malice in connection with evaluating any application, credentials, competency and qualifications. I release from liability any and all individuals and organizations that provide information to REHAB NET, or its appointed representatives, in good faith and without malice concerning my application, credentials, competency and qualifications. I consent to the release of information by REHAB NET, or its appointed representatives to other healthcare entities upon request concerning me as long as such release of information is done in good faith and without malice and I release REHAB NET and its appointed representatives from liability in doing so. I hereby sign the Policy Statement and Release of Liability of my own free will.

____

Signature of Practice Owner Title Date

____

Print Name

NOTE: A PHOTOSTATIC COPY OF THIS PAGE IS AS BINDING AS THE ORIGINAL.

(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.

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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 bodes?
		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.

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_____ _____

Signature of Staff Member Date

STATEMENT OF OWNERSHIP

I hereby declare that _____ is at least 50% owned by the following physical, occupational or speech 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: _____