Dimension Health, Inc.

5881 N.W. 151st Street, Suite 201
Miami Lakes, Florida 33014
Phone: (305) 823-7664
www.dimensionhealth.com

PREFERRED PROVIDER ORGANIZATION APPLICATION

Information Will Be Kept Confidential By Dimension Health, Inc.

PERSONAL

Name in full:_____**Date**_____
Last First Middle Title

Social Security#_____Medicare#_____Medicaid#_____UPIN_____

NPI # _____

Date of Birth_____Place of Birth_____Sex_____

OPTIONAL: This section for state reporting purposes only.
Race:White_____Black_____Asian_____Other(Please specify)_____

PROFESSIONAL

Primary Office Address:_____

City:_____State_____Zip Code_____Phone #_____

Fax #::_____**Tax ID#**_____

E-Mail Address:_____ **Contact**:
_____

Office Hours:
Mon_____Tues_____Wed_____Thurs_____Fri_____Sat_____Sun_____

Secondary Office Address:_____

City:_____State_____Zip Code_____Phone #_____

Contact:_____Tax ID#_____

Office Hours: Mon_____Tues_____Wed_____Thurs_____Fri_____Sat_____Sun____ _

Billing Address:_____

Group Name:_____Group TaxID#_____

Partners:_____
_

Languages Spoken By Staff:_____Provider_____

AFTER HOURS COVERAGE

Answering Service_____Beeper_____Other_____
Phone# Number Covering Physician(s)

LICENSURE & CERTIFICATION

License #_____Expiration Date_____(ATTACH COPY)

DEA # _____Expiration Date_____(ATTACH COPY)

ECFMG Certificate#_____(ATTACH COPY)

EDUCATION & TRAINING

Pre-medical Education: College or University_____

City/State/Country_____Degree_____

Date of Graduation_____

Medical School:_____

City/State/Country_____Degree_____

Attended From_____ to _____

Internship(Institution)_____

City/State/Country_____Type(Straight, Rotating)_____

Attended From_____ to _____

Residency(Institution)_____

City/State/Country_____Number of Years_____

Attended From_____ to _____

Fellowship(Institution)_____

City/State/Country_____Number of Years_____

Attended From _____ to _____

SPECIALTY

Primary Care Physician

Family Medicine_____ Internal Medicine_____ Pediatrics_____ OB/GYN____ GYN_____

OR

Specialty Care Physician

Please Specify Specialty_____

CERTIFICATION

AMERICAN BOARD CERTIFICATION _____(ATTACH COPY)
Date of Certification_____ Date of Recertification(If applicable)_____

AMERICAN BOARD ELIGIBILITY_____(ATTACH COPY OF DOCUMENTATION OF ELIGIBILITY)

OTHER SPECIALTY BOARDS(e.g. Osteopathy, Podiatry, etc.)

_____(ATTACH COPY)
Name of Board

HOSPITAL PRIVILEGES

Primary Hospital_____Membership Category_____

Other Hospitals__

_____

WORK HISTORY: Please enclose a copy of the Curriculum Vitae

PRACTICE INFORMATION If yes has been answered (*except for questions H & I*), please enclose details.

A. Have you ever resigned your staff or clinical privileges or have such privileges ever been limited, revoked, suspended, not renewed, reduced or subjected to probationary conditions, or have proceedings towards any of these ends ever been instituted or recommended by a Medical Staff committee or governing board at any hospital or similar institution, or are proceedings towards any of those ends presently pending?
Yes_____ No_____

B. Has your membership in any local, state or national professional society or organization ever been revoked, suspended, not renewed or are revocation or suspension proceedings presently pending?
Yes_____ No_____

C. Has your license and authority to practice any profession in any jurisdiction ever been revoked, suspended, denied, voluntarily relinquished or subjected to probationary conditions, or have proceedings towards any of these ends ever been instituted, or are proceedings towards any of these ends presently pending?
Yes_____ No_____

D. Have you ever been convicted of a felony, or are felony proceedings, indictments or information presently pending?
Yes_____ No_____

E. Have you ever been or are you presently the subject of an investigation by any state or federal agency or body, including Medicare and Medicaid, regarding your professional activities?
Yes_____ No_____

F. Has your Drug Enforcement Agency controlled substances authorization or other authorization ever been denied, revoked, suspended, or voluntarily or otherwise relinquished, reduced or not renewed, or are proceedings towards any of those ends presently pending?
Yes_____ No_____

G. Have you ever been terminated from a managed care plan?
Yes_____ No_____

H. Can you perform the essential functions related to the position for which you are applying with or without accommodation?
Yes_____ No_____

I. Are you currently free of any illegal drug use?
Yes_____ No_____

J. Have you ever been denied professional malpractice or liability insurance or have you ever had a professional malpractice or liability insurance policy cancelled?
Yes_____ No_____

PROFESSIONAL LIABILITY PROTECTION

I Maintain (Check One):

___ Professional liability coverage of at least $250,000 per claim and $750,000 aggregate. Please enclose a copy of the policy face sheet.

___ Irrevocable letter of credit for at least $250,000 per claim and $750,000 aggregate. Please enclose a copy of the letter.

___ Escrow Account for at least $250,000 per claim and $750,000 aggregate. Please enclose a copy of the documents establishing the Escrow Account.

___ I have agreed to be personally responsible for the payment of any settlement or final judgment up to $250,000 including all court fees and accrued interest for which the physician is responsible. Please enclose a copy of the notarized certificate of Financial Responsibility filed with the Florida Department of Professional Regulation.

Please sign. _____ **Date**_____

MALPRACTICE ACTIVITY

Are you now or have you ever been during the past five years a defendant in an alleged malpractice suit?
Yes____ No____

If the answer is yes, please answer the following:

Were any judgements entered against you for an amount exceeding $10,000?
Yes____ No____

Were any suits settled for an amount exceeding $10,000?
Yes____ No____

During the past five years have you settled any alleged medical malpractice claims not involving litigation for an amount in excess of $10,000?
Yes___ No____

If yes has been answered please provide a brief summary of each suit or claim including a summary of the occurrence which created the claim and a description of each judgement or settlement agreement.

ATTESTATION STATEMENT

I CERTIFY THAT ALL THE INFORMATION PROVIDED ON THIS APPLICATION IS COMPLETE AND ACCURATE. I AUTHORIZE DIMENSION HEALTH TO CONSULT WITH AND INSPECT ANY DOCUMENTS FROM INDIVIDUALS AND ORGANIZATIONS HAVING INFORMATION BEARING ON MY QUALIFICATIONS. I UNDERSTAND IF FALSE INFORMATION IS PROVIDED ON THIS IT MAY BE GROUNDS FOR TERMINATION BY DIMENSION HEALTH. I AGREE THAT DIMENSION HEALTH, ITS REPRESENTATIVES AND ANY INDIVIDUALS OR ENTITIES PROVIDING INFORMATION IN GOOD FAITH, SHALL NOT BE LIABLE FOR ANY ACT OF OMISSION RELATED TO THE VERIFICATION OF INFORMATION CONTAINED IN THIS APPLICATION.

_____ _____

Signature of Physician **Date**

NOTE: Copies of the following must accompany this application:

Curriculum Vitae
Current Florida Medical License
Current DEA License
ECFMG (If Applicable)
Board Certification (ABMS Certificate, Other Specialty Board)
Board Eligibility(Certificate of Fellowship or Residency)
Current malpractice face sheet
Summary of any malpractice suits or settlements