Dimension Health, Inc. (PPO)

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

PREFERRED PROVIDER ORGANIZATION UPDATE

PERSONAL

Name in full: _____**Date**_____
Last First Middle Title (MD, DO, etc)

Social Security#_____Medicare#_____Medicaid#_____UPIN_____
Date of Birth _____ **NPI#_____**

PROFESSIONAL

Primary Office Address: _____

City: _____**State**_____**Zip Code**_____**Phone #** ( ) _____

Fax # ( ) _____ **E-Mail** _____

Contact: _____**Tax ID#**_____

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____ _

PLEASE ATTACH ADDITIONAL OFFICE LOCATIONS

Group Name:_____ **Group TaxID#**_____

Billing Address:_____

Partners:_____

Languages Spoken By Staff: _____**By 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)**

SPECIALTY

Primary Care Physician

Family Medicine_____ Internal Medicine_____ Pediatrics_____ OB/GYN____ GYN_____

OR

Specialty Care Physician

Please Specify One Specialty_____
(This is the specialty under which you will be listed in the directory)

CERTIFICATION

AMERICAN BOARD CERTIFICATION _____ (ATTACH COPY)

Date of Certification_____ **Date of Recertification** (If applicable) _____

AMERICAN BOARD QUALIFIED_____

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

_____ **(ATTACH COPY)**
Name of Board

HOSPITAL PRIVILEGES

Primary Hospital_____Membership Category_____

Other Hospitals_____

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 judgement 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 / DISCIPLINARY ACTIVITY

Since you're last credentialing:

1) Have you had a judgment against you or settled a claim exceeding $10,000.00.
   YES_____ NO _____ (**If Yes, please provide details**.)

2) Have you been subject to disciplinary action by any hospital, State or Federal Regulatory Agency?
   YES_____ NO _____ (**If Yes, please provide details**.)

ATTESTATION STATEMENT

I certify that all the information provided on this form is complete and accurate. I authorize Dimension Health, Inc., to consult with and inspect any documents from individuals and organizations having information bearing on my qualifications, and I hereby authorize such individuals and organizations to release such information to Dimension Health, Inc. I understand if any false information is provided on this it shall be presumed to be provided intentionally and may be grounds for termination by Dimension Health, Inc. I agree that Dimension Health, Inc., 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 document.

_____ _____

Signature of Physician **Date**

NOTE: COPIES OF THE FOLLOWING DOCUMENTS MUST ACCOMPANY THIS APPLICATION

- CURRENT CURRICULUM VITAE / RESUME
- CURRENT FLORIDA MEDICAL LICENSE
- CURRENT DEA LICENSE
- BOARD CERTIFICATE
- CURRENT MALPRACTICE FACE SHEET (OR WAIVER, IF APPLICABLE)
- SUMMARY OF ANY DISCIPLINARY ACTION / MALPRACTICE CLAIMS

PLEASE RETURN ORIGINAL APPLICATION AND SUPPORTING DOCUMENTS TO:

DIMENSION HEALTH, INC.
PROVIDER RELATIONS
5881 N.W. 151ST STREET
SUITE 201
MIAMI LAKES, FL 33014