**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 __________

## 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. |
| | | 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".)

## 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 _____

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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.
- $250 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.

**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. |
| | | 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: ___________________________________________________