ORGANIZATIONAL PROVIDER
APPLICATION CHECK SHEET

All questions on the application must be answered. Indicate N/A if a question is not applicable.

If there is more than one facility location be sure enclose the name and address of additional locations under question #9 on Page 3 of the application.

Please attach the following (applicable) documents. (**If not applicable indicate with N/A**)

____1. Current copy of license(s) for each facility location.

____2. Current copy of Department of Health Survey for each licensed facility location

____3. Current copy of Professional Liability Insurance with **$1,000,000/$3,000,000** limits

____4. Current copy of Drug Enforcement Administration (DEA) and CSR.

____5. Current copy of all professional **staff** **license/Certifications** (RN, PT, O2 Operator etc.)
**If any of the listed staff have current or previous restrictions and/or probations on their license or certification, please attach a letter explaining the circumstances relating to the restrictions or probation. Please note our office will verify all licensure and certifications prior to credentialing.*

____6. Copy of Medicare letter of participation.

____7. Copy of Medicaid letter of participation

____8. Current copy of all Accreditation /certification certificate(s), and survey results (see pg. 4, question #14)
***Must not be more than 3 years old*

____ 9. List of lawsuits filed against your organization during the past 2 years.
(See pg. 5 question #17 **use form on page 9)

___10. Sign and date the application

___11. **Sign and complete Provider Service Agreement**
(For Initial Credentialing, First year's payment is due up front for processing fee **SEE EXHIBT on PAGE 22*)

___12. Sign and date Authorization for Release of Information.

___13. **Attach a Letter of Interest on Company Letter Head**

___14. Current W9, signed and dated **(Form should have address of where checks will be mailed)**

___15. Website & Provider Directory Verification

SAN JUAN IPA FACILITY NETWORK
CREDENTIALING APPLICATION

Please return completed application and required documentation to:

San Juan IPA
110 East Apache Street
Farmington, NM 87401
(505) 564-7980
or
FAX: 505-325-7492

Please type or print legibly the following information:

GENERAL ORGANIZATIONAL PROVIDER INFORMATION

1. FACILITY NAME (legal business name):_____

   Doing Business as (if applicable): _____

2. Type of Facility/Services: _____

3. Primary Address: _____

   _____

4. Billing Name and Address (if different): _____
   (must match W9)

   _____

5. Please list your facility's:
   a. Emergency phone number: _____
   b. Main office phone number: _____
   c. Fax Number: _____
   d. Office Hours: _____
   e. Billing Phone Number: _____
   f. Billing Fax Number: _____

6. Do you have 24-hour coverage for your clients/patients: Yes_____ No: _____
   If so, indicate how it operates: _____

   _____

7. Languages spoken fluently by practitioner: _____
   Languages spoken fluently by office staff: _____

Does this office meet ADA accessibility requirements for patients?

Yes_____ No_____

Check all that apply:

Handicap Accessible: ☐ Building: ☐ Parking: ☐ Restroom: ☐

Services for Disable: ☐ Text Telephone: ☐ American Sign Language: ☐

Mental/Physical Impairment: ☐ Accessible by Public Transportation: ☐ Bus: ☐

8. Board Certified: Yes or No

Name: _____ Expiration Date: _____

If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted by examination in your specialty, please give attach a brief explanation. Explaining any gaps or delays in achieving Board certification by the recognized Board in your specialty area.

9. If there are additional office/service locations, please attach a separate sheet indicating the address, phone/fax numbers.

10. Federal Tax ID: _____

A. Reporting Name: _____

B. Reporting Address: _____

11. Facility NPI#: _____

12. Taxonomy Code: _____

13. Please list the names of the following or mark N/A if not applicable:

Chief Executive Officer/Director: _____

Medical Director: _____

Office Contact Name and Title: _____

Office Contact Phone #: _____

Office Manager: _____

Email address: _____

LICENSURE/REGULATORY INFORMATION

Please attach a copy of your license, and DEA/CSR (if applicable).

A. State Operator's License Number: _____
B. License Type: _____
C. Expiration Date: _____
D. DEA/Controlled Substance Registration Numbers (as applicable):
   A. DEA: _____ Expiration: _____
   B. CSR: _____ Expiration: _____

14. Please list your accreditation/HCFA Certification survey status and expiration date if applicable below. ***Please attach a copy of each of the accreditation/certification certificate(s), and survey results*. **Survey results must not be more than 3 years old.**

JCAHO:	Yes_____	No_____	Expiration date: _____
*__CARF__:	Yes_____	No_____	Expiration date: _____
AAAHC:	Yes_____	No_____	Expiration date: _____
CLIA:	Yes_____	No_____	Expiration date: _____
AAAASF:	Yes_____	No_____	Expiration date: _____
ACHC:	Yes_____	No_____	Expiration date: _____
*__ACR__:	Yes_____	No_____	Expiration date: _____
AOA:	Yes_____	No_____	Expiration date: _____
CAP:	Yes_____	No_____	Expiration date: _____
CCAC:	Yes_____	No_____	Expiration date: _____
CHAPS:	Yes_____	No_____	Expiration date: _____
COLA:	Yes_____	No_____	Expiration date: _____
HFAP:	Yes_____	No_____	Expiration date: _____
TCT:	Yes_____	No_____	Expiration date: _____
DMEPOS:	Yes_____	No_____	Expiration date: _____
*__CIHQ:__	Yes_____	No_____	Expiration date: _____
*__IMQ__:	Yes_____	No_____	Expiration date: _____
*__A2LA__	Yes_____	No_____	Expiration date: _____
*__ASHI__	Yes_____	No_____	Expiration date: _____
*__DNV NIAHO__	Yes_____	No_____	Expiration date: _____

*ACR= American College of Radiology
*CARF= Commission on Accreditation of Rehabilitation Facilities
*CIHQ= Center for Improvement in Healthcare Quality
*IMQ= Institute for Medical Quality
*A2LA= American Association for Laboratory Accreditation
*ASHI= American Society for Histocompatibility and Immunogenetics
*DNV NIAHO= Det Norske Veritas National Integrated Accreditation for Healthcare Organizations

MEDICARE (Please attach copy of letter)
Certification Yes_____ No_____ Expiration date: _____
MEDICARE FACILITY NUMBER: _____

MEDICAID: (Please attach copy of letter)
Certification Yes_____ No_____ Expiration date: _____
MEDICAID FACILITY NUMBER:_____

15. Has this facility been sanctioned, placed on probation, had limitations placed on your licensure, certification or accreditation by any state, federal, licensing, or accrediting body (such as JCAHO, PRO, etc). Yes_____ No_____
If yes, please attach an explanation.

PROFESSONAL LIABILITY INSURANCE INFORMATION

16. Please list liability insurance carrier. The Professional Liability Insurance with $1,000,000 per occurrence/$3,000,000 aggregate limits

Carrier			**Current** ☐	**Pending** ☐
Address				
Dates Insured	From	To	**Policy Coverage Limits**	**$ Amount**
Professional Liability	Yes _____ No _____	Self Insured	Yes _____ No _____	
General Liability	Yes _____ No _____	Self Insured	Yes _____ No _____	
Worker's Compensation	Yes _____ No _____	Self Insured	Yes _____ No _____	

17. Have any lawsuits been filed against your organization during the past two years?
Yes: _____ No _____
If so, please provide a list of such lawsuits, which should include all information that is a matter of public record (parties involved, dates, county of filing, etc. use page 9 claim form)

Signature: _____

Print Name and Title: _____

Authorized Representative of: _____
(Organization Name)

Date: _____

IPA

ORGANIZATIONAL PROVIDER APPLICATION
DESIGNATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I have applied for membership with the San Juan IPA. All information provided in my application or in connection with my application is correct and complete to the best of my knowledge and belief. I hereby authorize the San Juan Independent Practice Association (SJIPA) and its staff, to verify and supplement this information. I authorize any and all of the following persons and organizations to provide information to the above, including the National Practitioner Data Bank, any applicable state licensing or certifying boards(s), training institutions(s), the Drug Enforcement Agency, any malpractice insurance carrier, any hospital, health maintenance organization, or other medical facility where I have practiced, and any other person or organization having knowledge of my professional qualifications or credentials. The information to be provided hereunder includes, without limitations, favorable and unfavorable information, including any state or hospital disciplinary actions or procedures, medical malpractice coverage and claims, suits and settlements, licensing and certification information, DEA registration, medical training, hospital affiliations, performance records or similar related information.

I understand that I have the right to review information obtained by the San Juan IPA from any outside source with the exception of references, recommendations, or other peer review protected information. In the event that credentialing information obtained from other sources varies substantially from that provided by me, the San Juan IPA Credentialing Coordinator will notify me either in writing or via telephone. I may submit written correction of erroneous information submitted by another source within 30 days of notification. I hereby release each person and organization described above from any and all liability caused by or related to any good faith communication of information pursuant to this authorization.

I understand that my application does not entitle me to status as a participating member of the SJIPA. I also understand upon request that I have the right to be informed of the status of my credentialing or re-credentialing application. I agree to provide and permit SJIPA, upon request, to review my office location, medical records and any other information required to verify National Committee on Quality Assurance (NCQA) compliance including HEDIS reporting, and to notify SJIPA within two (2) business days of any changes in the application information.

This authorization shall remain valid for as long as I maintain a professional relationship with SJIPA and any party furnishing information pursuant to this authorization is entitled to rely on the representation of SJIPA that this authorization is currently valid. A photocopy of this authorization is as valid as the original.

_____ _____
Signature Date

Authorized representative of: _____
(Applying Organization)

SAN JUAN

IPA

110 E. Apache Street, Farmington, NM 87401

Applicant's Attestation

I hereby apply for membership with the San Juan IPA. I have signed the required credentialing application, consent and release of information forms. I understand that any misrepresentation, misstatement, or omission from this application, whether intentional or not, may be cause for automatic and immediate rejection of this application and may result in the denial of membership. Upon subsequent discovery of such misrepresentation, misstatement or omission, the San Juan IPA may immediately terminate my membership.

Once approved as a member of the San Juan IPA, I understand that my practice is subject to review as part of the organization's performance improvement activities.

I certify that the information I have provided and the statements I have made on this application are correct, true, and complete to the best of my knowledge. I will abide by the applicable bylaws, rules and regulations, and policies and procedures of the San Juan IPA.

I further agree that, in the event there should arise an adverse ruling with respect to my status as a member of the San Juan IPA, I will exhaust the administrative remedies afforded by the entity's bylaws before resorting to litigation.

_____

Facility Name

_____ _____

Authorized Representative **Date**

Please Return Application to:

San Juan IPA
110 East Apache Street
Farmington, NM 87401
Phone: (505) 325-7492
Fax: (505) 564-7956

SAN JUAN

IPA

110 E. Apache Street, Farmington, NM 87401

WEBSITE & PROVIDER DIRECTORY VERIFICATION

As a new/current member of the San Juan IPA, this is a request for verification of your business name, physical address, and phone number that will appear on the San Juan IPA website and payer provider directory as applicable.

Please note below the information and return the form with your San Juan IPA Credentialing packet to San Juan IPA by via fax (505) 325-7492 or Mail at the above address. If you have any questions, please feel free to give Tina Johnson a call at (505) 564-7980. Thank you!

BUSINESS NAME: _____

PHYSICAL ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE NO: _____

By signing, you have verified and approve to have your business information as noted above to be published on the San Juan IPA website and in the San Juan IPA Provider Directory.

_____
(Print) Name of Applicant

_____ _____
Authorized Representative Date

LETTER OF INTENT

To whom it may Concern:

_____ would like to be credentialed by the
(name and/or practice name)
San Juan IPA. It is my/our intention to apply for membership to the San Juan IPA, and would like the opportunity to contract with all affiliated insurers. I/we will be providing the following services: _____
(*Provider and/or Facility Specialty)*

_____
Provider Signature/Degree

_____
Printed Provider Name/Degree

_____
Date

SAN JUAN
IPA

110 E. Apache Street, Farmington, NM 87401

SUPPLEMENTAL CLAIM INFORMATION

Please supply the following information regarding any instance of claim, suit or incident which may give rise to a claim whether dismissed, settled out of court, judgment, or pending. Answer all questions completely. *This form should be photocopied and filled out separately for each claim.* Please print clearly.

APPLICANT (Defendant) Name:
DATE OF ALLEGED ERROR: **DATE OF CLAIM:**
INDICATE WHETHER: CLAIM, SUIT, OR INCIDENT HAS BEEN REPORTED TO YOUR INSURANCE CARRIER:
NAME OF INSURER: **AGENT:** **PHONE#:** **POLICY#**
LOCATION OF COURT WHERE ORIGINAL COMPLAINT WAS FILED:
DEFENDANT'S LEGAL REPRESENTATIVE: (Include name, address, and telephone #):
STATUS OF COMPLAINT:
If closed please indicate: ☐ COURT JUDGEMENT **FINDING FOR**: ☐ You ☐ Plaintiff Date:
Determined by: ☐ Judge ☐ Jury ☐ Out-of- Settlement Date of Settlement: Amount Paid of Your Behalf: $
Settlement Amount: $ Compensation: $ Punitive: $ Total: $
☐ Case Dismissed: ☐ Against You ☐ Case Pending ☐ Against All Defendants Date:
DESCRIPTION OF CLAIM: *(Please provide enough information to allow evaluation)*
1) Incident Location:
2) Alleged act, error, or omission upon which claimant bases claim:
3) Description of type and extent or damage allegedly sustained:
4) Give a complete narration of the case, relating events in chronological order: *(You may use a seperate sheet of paper if more space is needed)*

I have applied for membership with San Juan IPA. I hereby authorize the San Juan IPA, it's staff and their representatives to consult with the attorney as noted above regarding information bearing on the case as related above. This authorization includes the right to the release of any and all documents, recommendations, reports, statements or disclosures relating to said case.

Authorized Representative Date

Disclosure of Ownership and Control Interest Form

Purpose: In compliance with 42 CFR 457.935, 42 CFR §455.104, §455.105, and §455.106, providers/*disclosing entities* are required to disclose including, but not limited to, information regarding (1) the identity of all *persons with an ownership or control interest* in the provider/*disclosing entity*, or in any *subcontractor* in which the provider/*disclosing entity* has a direct or *indirect ownership* of 5 percent or more including the identity of *managing employees*, and *other disclosing entities*; (2) certain business transactions and *significant business transactions* between the provider/*disclosing entity* and *subcontractors*/*wholly owned suppliers*; and (3) the identity of any *person with an ownership or control interest* in the provider/*disclosing entity* or who is an *agent*, or a *managing employee* of the provider/*disclosing entity* that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs. Any authorized/designated representative of the provider/*disclosing entity* may complete and sign this form on behalf of the provider/*disclosing entity*.

Instructions For Completing the Ownership & Control Interest Disclosure Form

1) Read all definitions and instructions outlined throughout the Form and then reference the definitions and instructions while completing the Form. Terms with corresponding regulatory definitions are italicized and underlined throughout this Form. Please review the applicable definition before responding to the question.
2) Definitions for Disclosure of Ownership and Control Interest Form - See Appendix A
3) Completion and submission of this Statement/Disclosure is a condition of participation as a credentialed or enrolled provider in the New Mexico Centennial Medicaid Managed Care Network or the State Children's Health Insurance Program (CHIP) network for services to members under Medicaid and CHIP benefit plans.
4) Answer all questions as of the current date i.e. request date.
5) If there is no information to include, indicate "None" or "Not applicable" (N/A) in the space provided. Do not leave blank spaces unless advised to do otherwise in the instructions. Incomplete Forms will be reported back to HSD.
6) If more space is needed, please attach additional sheets.
7) In any space requesting 'Name,' if it is the name of an individual, include First, Middle and Last.
8) Business & Service Address: The address for corporate/legal entities must include, as applicable, the primary business address, every business location, and P.O. Box address. Individuals must provide their home address.
9) Provide the Employer Identification Number (EIN) or Tax Identification Number (TIN) for legal entities. Provide the Social Security Number (SSN) for individuals.
10) This Statement/Disclosure should be submitted with your MCO application, or at initial and renewal of a contract or agreement and any time there is a revision to the information. A Statement must also be provided within 35 calendar days of a request for this information.
11) Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements and contracts.

How to Determine Ownership or Control Percentages (42 CFR 455.102).

12) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Disclosure of Ownership and Control Interest Form

NAME OF PROVIDER/*DISCLOSING ENTITY* BEING CONTRACTED: _____

NAME OF GROUP PRACTICE WHERE MEMBERS WILL BE SEEN: _____

TAX ID # OF PROVIDER/*DISCLOSING ENTITY*: _____

Section 1 –Disclosure Regarding *Managing Employees* (42 CFR 455.104(b)(4))

1) Does the provider/*disclosing entity* have any *Managing Employees*? ☐ **Yes** ☐ **No**
If **Yes**, provide the following details for any *managing employee* of the provider/*disclosing entity.*
**See the definition of *managing employee*

NAME	SSN	Birthdate	Complete Address (street/city/state/zip)	NPI	Position

Section 2 – Criminal Offense Disclosure (42 CFR 455.106)

2) Has the provider, or any *person* ((individual or entity) *who has ownership or controlling interest* in the provider/*disclosing entity*, or who is an *agent* or *managing employee* of the provider/*disclosing entity*, ever been convicted of a criminal offense related to that person's involvement in any program established under Titles XVIII (Medicare), XIX (Medicaid), XXI (SCHIP), or Title XX (Social Services Block Grants) since the inception of those programs? ☐ **Yes** ☐ **No** (verify exclusion through the applicable federal and state specific exclusion databases.)
If **Yes**, provide the following details and a description of offense(s). Use additional pages if necessary.

NAME	SSN	Birthdate	Description

Section 3 – Person(s) with Ownership or Control Interest Disclosure (42 CFR 455.104(b)(1)

3) Are there any *persons* (individual or entity) *with an ownership or control interest* in the provider/*disclosing entity*? ☐ **Yes** ☐ **No**
If **Yes**, provide the following details and include the title (for example, CEO, owner, board member etc).
* For corporations/entities that have an ownership or control interest in the Disclosing Provider, please separately list its primary business address, every business location and post office box address.
**See the definition of *person with an ownership or control interest* and *disclosing entity*

NAME	**TIN or SSN, as applicable	Birthdate	Title	Address (street/city/state/zip)	% Ownership Interest

Disclosure of Ownership and Control Interest Form

Section 4A – Direct or Indirect Ownership of 5% or More in a Subcontractor Disclosure (42 CFR 455.104(b)(1))

4A) Does the provider/*disclosing entity* have a Direct or *Indirect Ownership Interest* of 5% or more in any *Subcontractor*? ☐ **Yes** ☐ **No**

If **Yes**, provide the following details about the *subcontractor*.

**See the definition of the following terms: *subcontractor* and *indirect ownership interest,*

NAME	****TIN or SSN,** as applicable	**Birthdate**	**Title**	**Address (street/city/state/zip)**	**% Ownership Interest**

Section 4B – Direct or Indirect Ownership of 5% or More in a Subcontractor Disclosure (42 CFR 455.104(b)(1))

4B) Does the provider/*disclosing entity* have a Direct or *Indirect Ownership Interest* of 5% or more in any *Subcontractor*? ☐ **Yes** ☐ **No**

If Yes, provide the information below about any *person (individual or entity) with an ownership or control interest*, in any *subcontractor* in which the provider/ disclosing entity has a 5 percent or more direct or *indirect ownership or control interest*.

**See the definition of the following terms*: subcontractor* and *indirect ownership interest,*

Name of Subcontractor (from section 4A)	**Name of Person(s) with an ownership or control interest in the *subcontractor***	****TIN or SSN,** as applicable **of Person(s) with an ownership or control interest in the *subcontractor***	**Birthdate of Person(s) with an ownership or control interest in the *subcontractor***	**Address (street/city/state/zip) of Person(s) with an ownership or control interest in the *subcontractor***	**% Ownership Interest**

Section 5A – Relationships Disclosure (42 CFR 455.104(b)(2))

5A) Are any of the individuals disclosed in Section 3 above related to each other as a spouse, parent, child, or sibling?
☐ **Yes** ☐ **No** If **Yes**, provide the following details

NAME(From Section 3)	**Nature of Relationship (e.g., spouse)**	**Related to Name(From Section 3)**

Disclosure of Ownership and Control Interest Form

Section 5B – Relationships Disclosure (42 CFR 455.104(b)(2))

5B) Are any of the individuals disclosed in **Section 3** above related to any of the individuals disclosed in **Section 4B** as a spouse, parent, child, or sibling? ☐ **Yes** ☐ **No** (spouse, parent, child, sibling? If yes, give the name(s) of person(s) and relationship(s). Use additional pages if necessary. If **Yes**, provide the following details

NAME(From Section 3)	Nature of Relationship (e.g., spouse)	Related to Name(From Section 4B)

Section 6 – *Other Disclosing Entity* Disclosure (42 CFR 455.104(b)(3))

6.1) Does the provider/*disclosing entity or any one named in* ***Section 3*** have an Ownership or Control Interest in any other Medicaid provider? ☐ **Yes** ☐ **No** ☐ **N/A**

6.2) Does the provider/*disclosing entity or any one named in* ***Section 3*** have an Ownership or Control Interest in any *other disclosing entity* that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V (Maternal and Child Health Services Block Grant), XVIII (Medicare), XX (Block Grants to States for Social Services) , or Title XXI (State Children's Health Insurance Program) of the Social Security Act? ☐ **Yes** ☐ **No** ☐ **N/A**

If Yes to Items 1 or 2 of this Section 6, provide the following details:

**See the definition of the following terms: *other disclosing entity* and *ownership interest*

NAME (From Section 3)	Name of *other disclosing entity or other Medicaid Provider*	**SSN and/or TIN**, as applicable **of the *other disclosing entity or other Medicaid Provider***

Section 7A – Business Transactions Disclosure (42 CFR 455.105)

7A) Business Transactions - Subcontractors: Has the provider/*disclosing entity* had any business transactions with a *Subcontractor* totaling more than $25,000 in the previous twelve (12) month period (12-month period ending as of the date on this request)? ☐ **Yes** ☐ **No** If **Yes**, provide the following details

**See the definition of *subcontractor*

Name of ***subcontractor***	****TIN or SSN,** as applicable of *subcontractor*	Birthdate	Address (street/city/state/zip)	Transaction Amount

Disclosure of Ownership and Control Interest Form

Section 7B – Significant Business Transactions Disclosure (42 CFR 455.105)

7B) Significant Business Transactions: Has the provider/*disclosing entity* had any *Significant Business Transactions* with a Wholly Owned Supplier or subcontractor during the previous 5-year period (5-year period ending as of the date on this request)? ☐ **Yes** ☐ **No** If **Yes**, provide the following details

**See the definition of the following terms: *subcontractor*, *wholly-owned supplier*, and *significant business transactions*

Type of entity	**Name**	****TIN or SSN,** as applicable	**Birthdate**	**Address (street/city/state/zip)**	**Transaction Amount**
Wholly Owned Supplier Subcontractor					
Wholly Owned Supplier Subcontractor					

Section 8 – Attestation

8) Through signature below, I hereby certify that persons with ownership and control interest in the provider/*disclosing entity* or in a *subcontractor*, *agents*, *subcontractors*, *managing employees*, and any employees providing healthcare services as part of this application are screened with the applicable background check including, but is not limited to, verification against the applicable state and federal exclusion databases . I hereby represent and warrant that all information contained in this form is true, correct, and complete in all aspects. I understand that misleading, inaccurate, or incomplete data may result in a denial of participation or termination of an existing contract. I further understand completion of this form does not guarantee participation with the Managed Care Organization.

Name:_____ Title:_____
(Print or Type: First/Middle/Last) (Print or Type)

Signature:_____ Date (MM/DD/YYYY):_____
(Provider/Disclosing Entity or Authorized Agent of the Provider/Disclosing Entity)

Disclosure of Ownership and Control Interest Form

I. APPENDIX A

DEFINITIONS

#	Term/Words	Definition
1	*Agent*	**Agent** means any person who has been delegated the authority to obligate or act on behalf of a provider. It also means any person who has express or implied authority to obligate or act on behalf of an entity (42 CFR 1001.1001).
2	*Disclosing entity*	**Disclosing entity** means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent. * For purposes of completing the Medicaid Disclosure Form, solo practitioners and the group contracting entity are also treated as a "disclosing entity." **Group Providers - The contracting group entity should complete the Form on behalf of the group.
3	*Fiscal agent*	**Fiscal agent** means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.
4	*Group of practitioners*	**Group of practitioners** means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).
5	*Health Insuring Organization (HIO)*	Health insuring organization (HIO) has the meaning specified in §438.2.
6	*Indirect ownership interest*	**Indirect ownership interest** means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. It also means an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue (42 CFR 1001.1001). (For example, an individual has a 10 percent ownership interest in the entity at issue if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the entity in issue.)
7	*Managed care entity*	**Managed care entity** (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs. These terms are defined in 42 CFR § 438.2.
8	*Managing employee*	**Managing employee** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.

9	*Other disclosing entity*	Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes: a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII); b. Any Medicare intermediary or carrier; and c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.
10	*Ownership interest*	Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity. It also means an interest in: a. The capital, the stock or the profits of the entity, or b. Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.
11	*Person with an ownership or control interest*	Person with an ownership or control interest means a person or corporation that: a) Has an ownership interest totaling 5 percent or more in a disclosing entity; b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity; c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity; d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; e) Is an officer or director of a disclosing entity that is organized as a corporation; or f) Is a partner in a disclosing entity that is organized as a partnership.
12	*Prepaid ambulatory health plan (PAHP)*	Prepaid ambulatory health plan (PAHP) has the meaning specified in §438.2.
13	*Prepaid inpatient health plan (PIHP)*	Prepaid inpatient health plan (PIHP) has the meaning specified in § 438.2.
14	*Primary care case manager (PCCM)*	Primary care case manager (PCCM) has the meaning specified in § 438.2.
15	*Significant business transaction*	Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $ 25,000 and 5 percent of a provider's total operating expenses.
16	*Subcontractor*	Subcontractor means: a. An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

17	*Supplier*	Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).
18	*Termination*	Termination means – a) For a-- i. Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and ii. Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. b) (i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary. (ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated. c) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to-- (i) Fraud; (ii) Integrity; or (iii) Quality.
19	*Wholly owned supplier*	Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

CONFIDENTIAL

SAN JUAN INDEPENDENT PRACTICE ASSOCIATION
PROVIDER SERVICE AGREEMENT AND AUTHORIZATION FOR DISCLOSURE

The San Juan Independent Practice Association (hereinafter referred to as "SJIPA"), and _____ ***(Name)*** (hereinafter referred to as "PROVIDER"), are mutually desirous of entering into an Agreement effective _____/____/_____ whereby the Provider makes available certain health care services to Health Maintenance Organizations, Health Care Services Organizations, Preferred Provider Organizations, self-insured employers, and other medical delivery systems on behalf of their members, customers, insureds and employees (hereinafter collectively referred to as "HEALTH PLANS"), under agreements and arrangements entered into by SJIPA.

NOW, THEREFORE, the parties agree to the following:

1. SJIPA shall from time to time enter into agreements with HEALTH PLANS. PROVIDER acknowledges that the SJIPA will enter into contracts with HEALTH PLANS for provision of health care services to the members, customers, insureds and employees of HEALTH PLANS and PROVIDER, at their sole discretion, can agree to fulfill all obligations and responsibilities required of PROVIDER individually pursuant to such contracts; provided that SJIPA shall not obligate PROVIDER to a contractual agreement with any HEALTH PLAN unless and until the contract terms agree to fee schedules set forth in the Exhibits, Amendments or Addendums (as may be labeled) to each HEALTH PLAN contract, which PROVIDER has accepted in writing.

2. PROVIDER agrees to deliver reasonable and medically necessary health care services to persons covered by contracted HEALTH PLANS. PROVIDER shall deliver such services within the scope of PROVIDER'S license, certification, and/or expertise and shall render such services in the same manner, with the same standards, and within the same time availability as offered to all other persons.

3. PROVIDER agrees to submit claims for health care services within ninety (90) days of date of service on CMS Form 1500 or other standard format for all medical and related services rendered under a HEALTH PLAN. The claim shall include, all the required data elements necessary for accurate adjudication of the claim for health care services without the need for additional information from outside the HEALTH PLAN's system, and any other information specifically required by the HEALTH PLAN under which the claim for health care services is submitted.

4. PROVIDER agrees and covenants to accept the compensation provided by the applicable HEALTH PLAN as full and final compensation for covered services provided by the applicable HEALTH PLAN, including payment for all applicable gross receipts taxes owed for such services unless otherwise provided for in the HEALTH PLAN. This provision shall not prohibit collection by PROVIDER of any outstanding deductible, co-insurance, or co-payment amounts in accordance with the terms of the applicable HEALTH PLAN, nor collection of payment for non-covered services provided the patient by PROVIDER.

5. PROVIDER agrees to participate and cooperate with any utilization review and quality assurance programs of SJIPA and any HEALTH PLANS with such programs requiring the cooperation and participation of PROVIDER.

6. PROVIDER agrees to maintain such treatment, billing, and other records, and provide such information to SJIPA, any state or federal agency, and any HEALTH PLAN as may be necessary for compliance with any applicable federal or state rule or regulation, the terms of any health plan, as well as for SJIPA and HEALTH PLAN program management purposes. PROVIDER agrees that SJIPA and HEALTH PLANS shall have access to on-site review of such records at reasonable times upon demand after reasonable notice.

7. PROVIDER agrees to cooperate with and provide information to SJIPA for the purpose of credentialing PROVIDER with any hospital, treatment facility, or health plan, if applicable. PROVIDER shall also provide updates to that information at specified intervals for any recredentialing purposes. ***PROVIDER hereby authorizes any hospital on whose medical staff PROVIDER is a member or has applied for membership to disclose to SJIPA or HEALTH PLANS all information in the hospital's possession concerning PROVIDER.*** SJIPA and any HEALTH PLAN shall use any information provided to them under this paragraph solely for one or more of the purposes designated in § 41-9-2.E (NMSA, 1989), and shall utilize their best efforts to maintain the confidentiality of that information as required by § 41-9-5 (NMSA, 1989).

8. Each party to this Agreement shall comply with the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164 ("HIPAA Privacy Rule" or "Privacy Rule") and state law requirements regarding the privacy of protected health information or personally identifiable information (as defined by statute). Each party will implement procedures, processes, agreements with business associates and other actions necessary to protect the privacy of protected health information and personally identifiable information in accordance with the provisions of the applicable statutes and rules and regulations.

9. PROVIDER agrees to obtain and maintain comprehensive general liability insurance and professional liability insurance in the amounts required by statute or in amounts that are reasonable and customary for an insured bearing risks similar to PROVIDER. Certificates of Insurance coverage shall be supplied by PROVIDER to SJIPA.

10. PROVIDER agrees, except in cases of emergency health services, medical necessity, or appropriate referral when required, to give preference to using physicians and ancillary providers and facilities who are Participating Providers of HEALTH PLANS and provide covered services to persons covered under HEALTH PLANS as a means of supporting and promoting a viable health care community in northwest New Mexico and making convenient health services available to the residents of northwest New Mexico. Referrals are within the sole discretion of the PROVIDER.

11. PROVIDER shall notify SJIPA in writing within twenty (20) days of any of the following events: (a) change of clinic or practice ownership; (b) change of business address; (c) commencement of any legal, governmental, or administrative action that might materially impair PROVIDERS ability to provide health care services to any HEALTH PLAN.

12. None of the provisions of this Agreement are intended to create or shall be construed to create any relationship between PROVIDER and either SJIPA or HEALTH PLANS other than that of an independent contractor solely for the purposes of affecting the provisions of this Agreement and the HEALTH PLANS.

13. PROVIDER agrees to indemnify SJIPA, their respective employees and agents, and to hold them harmless from any claims, loss, damages, and expenses including the cost of defense, including reasonable attorneys' fees, asserted against the SJIPA that is caused by or arising out of the PROVIDER'S sole act or omission in connection with provision of health care services provided to members of HEALTH PLANS pursuant to this Agreement.

14. SJIPA agrees to indemnify PROVIDER, their respective employees and agents, and to hold them harmless from any claims, loss, damages, and expenses including the cost of defense, including reasonable attorneys' fees, caused by or arising out of the SJIPA'S sole act or omission in connection with provision of services provided to members of HEALTH PLANS pursuant to this Agreement.

15. Notwithstanding anything to the contrary set forth in this Agreement, PROVIDER agrees to fully comply and cooperate with all programs, policies, and procedures of SJIPA and HEALTH PLANS applicable to the PROVIDER as the same may be adopted by SJIPA and HEALTH PLANS from time to time.

16. PROVIDER agrees to pay dues to SJIPA in the applicable amounts outlined on Exhibit A attached hereto.

17. Any notice required under this Agreement will be sent as follows:

To SJIPA:
SJIPA
Attention: Chief Executive Officer 110 E. Apache St.
Farmington, NM 87401

To PROVIDER:
_____[Provider /Faclity Name]
_____Attention: [If Applicable]
_____[Address]

The term for this Agreement shall be the effective period for any credentialing or recredentialing issued to the PROVIDER pursuant to this Agreement. Either party to this Agreement may terminate the Agreement without cause by giving sixty (60) days written notice.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in their names by the undersigned officers, the same being duly authorized to do so.

SAN JUAN INDEPENDENT PRACTICE ASSOCIATION

By: _____

Title: Chief Executive Officer_____

Date: _____

Name: _____

By: _____

Title: _____

Date: _____

3127483

Exhibit:

San Juan IPA Membership Dues

Beginning **July 1, 2016** dues for San Juan IPA are as follows:

Category	1st year (lump sum)	2nd year (per quarter)	3rd year and beyond (per quarter)
Physician – non-employed MD, DO, DDS	$1000.00	$225.00	$125.00
Physician – hospital employed	$1000.00	$225.00	$100.00
Midlevel providers/Chiropractic/PT: PA, CNP, CNM, CRNA, DC, PT, RN 1st assist	$1000.00	$225.00	$100.00
Ancillary/behavioral health providers: OT, ST, PhD, OD, DOM, LISW, LPCC, LMFT, LMHC, etc.	$300.00	$75.00	$75.00
Facilities: Free standing laboratory Free standing radiology Free standing surgery center Free standing endoscopy center Sleep center	$1000.00	$250.00	$250.00
Other providers: Nursing homes Home Health DME providers Prosthetic/Orthopedic providers	$200.00	$50.00	$50.00