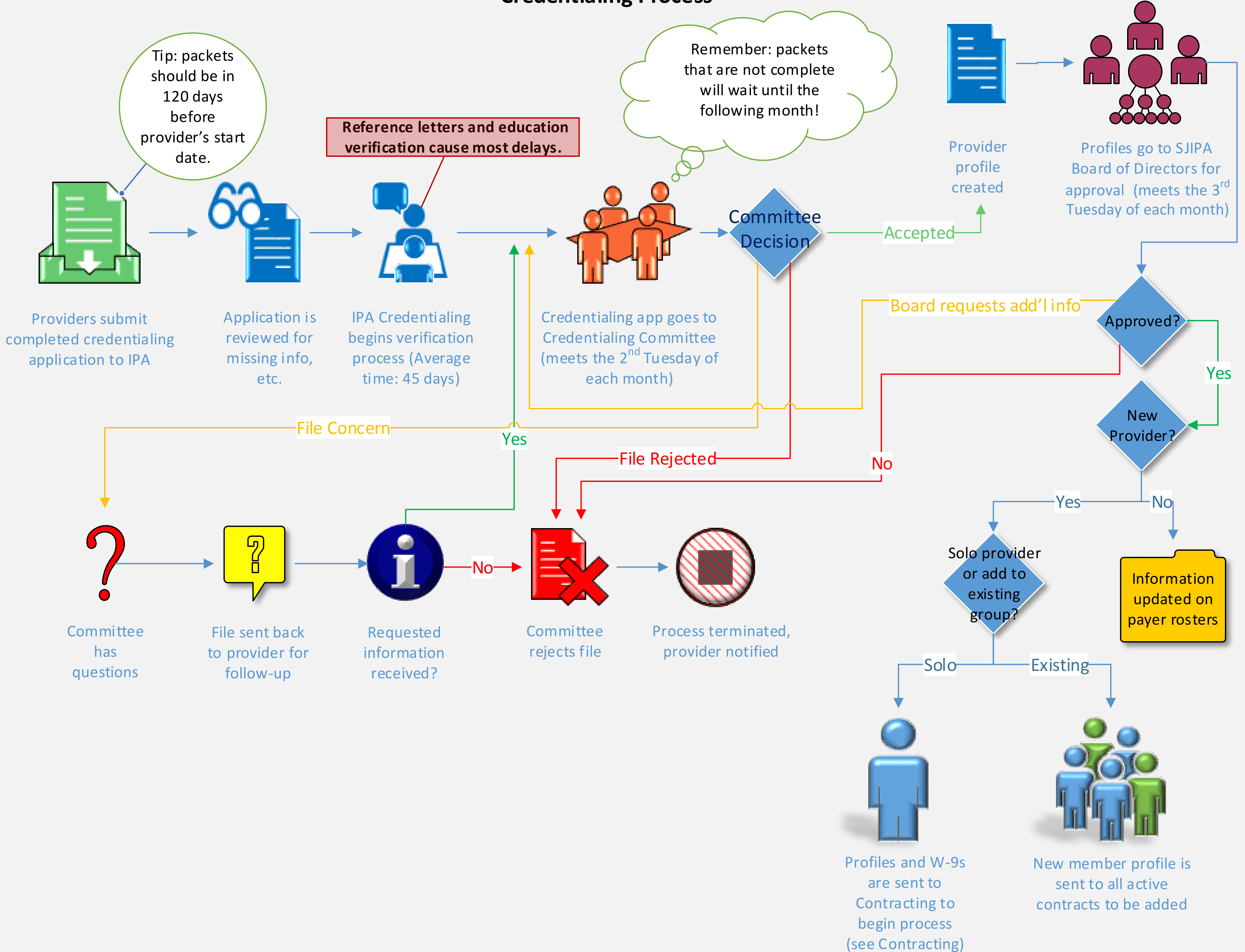
Credentialing Process



PROVIDER CREDENTIALING APPLICATION

Valid Dates:

August 8, 2018 - August 8, 2019

☐ Completed and signed application (and supplemental documents required by the healthcare organization if applicable).

☐ Completed and signed authorization, attestation and release form which must have been signed within sixty (60) days. Signature stamps and date stamps are not acceptable.

☐ Current curriculum vitae or resume including months and years for all places of employment during the past fifteen (15) years. Explain any gaps of six (6) months or more during the past five (5) years.

☐ Copy of latest professional state license/certificate or registration. ☐ Pending

☐ Proof of current medical malpractice coverage that includes the effective date, amount and type of coverage. If your coverage will be expiring within the next sixty (60) days, please provide a copy of the renewal certificate. ☐ Pending

☐ Copy of current state Controlled Substance Registration. If your registration will be expiring within the next sixty (60) days, please provide a copy of the renewal certificate. ☐ Pending

☐ Copy of current federal DEA registration certificate. If your registration will be expiring within the next sixty (60) days, please provide a copy of the renewal certificate. ☐ Pending

☐ For hospital appointments, please attach privileges requested. Privileges forms are available on our website at https://ecreds.nmhsc.com

☐ Copy of ECFMG Certificate, if foreign medical graduate.

☐ Copies of continuing medical education credits obtained during the last two (2) years or since your last appointment.

☐ Documentation that supports any affirmative response on the Professional Practice Questionnaire, if needed.

☐ Any additional attachments required by the application.

Please fax, upload or e-mail completed application to:

San Juan IPA
Credentialing Department
Toll Free: (800) 317-3587
Direct: 505) 564-7989
Facsimile: (505) 564-7956
Email: **heatherd@sanjuanipa.com**
File drop: https://sanjuanipa.sharefile.com/share/filedrop

110 E. Apache, Farmington, NM 87401 (505) 564-7989

Date of Application: ______________

Name: ____
Last First Middle Maiden or Other Names Used

Circle all that apply and for which you are currently licensed: ☐MD ☐DO ☐DDS ☐DC ☐DPM ☐OD ☐PA ☐CNM ☐CNP ☐CRNA ☐RN ☐PT ☐OT ☐ST ☐DOrienMed ☐Acup ☐Clin Psych ☐Psych Assoc ☐LMHC ☐LPAT ☐LADAC ☐LISW ☐LMSW ☐LPC ☐LPCC ☐LMFT ☐CNS/Psych ☐CNS/Medical ☐Spch Path ☐OT

Other: ______________________ Specialty: ______________________

Gender: ☐ F ☐ M Citizenship: ______________ Place of Birth: ______________

Social Security Number: ______________ Date of Birth: ______________

State Tax ID#: ______________ ☐ Pending Federal Tax ID#: ______________ ☐ Pending

Medicare #: ______________ ☐ Pending Medicaid #: ______________ ☐ Pending

Unique Physician Identification Number (UPIN): ______________ ☐ Pending

National Provider Identifier Number (NPI): ______________ ☐ Applied

CLIA Number (if applicable): ______________ Approval Level: ______ Expiration Date: ______________

Home Address:

Street Address: ________________________________

City, State/Province and Zip Code: ________________________________

Telephone Number: ______________ Pager Number: ______________

Cell Phone Number: ______________ Spouse's Name (Optional): ______________

Credentials Correspondence Address:

Department: ________________________________

Street Address: ________________________________

City, State/Province and Zip Code: ________________________________

Email Address: ________________________________

Telephone Number: ______________ Facsimile Number: ______________

Military Service:

Branch: ______________ Dates: From: __________ To: __________

Rank: ______________ Type of Discharge: ______________

Immigration:

Immigration Status: ______________ Immigration Certification Number: ______________

ECFMG (Educational Commission for Foreign Medical Graduates) Number (if applicable): ______________

Date Issued: ______________ (Please attach a copy of your ECFMG certificate.}

Confidential

Languages:

Foreign Languages (spoken fluently by practitioner): ______________________________

Certifications:

ACLS CERTIFICATION	**ATLS CERTIFICATION**	**PALS CERTIFICATION**
Certified: ☐ Yes ☐ No	Certified: ☐ Yes ☐ No	Certified: ☐ Yes ☐ No
Expires:______________	Expires: ______________	Expires: ______________

HOSPITAL AND HEALTHCARE AFFILIATIONS

Are you a PCP?	☐ Yes ☐ No
Do you deliver babies?	☐ Yes ☐ No
Are you an MD, DO, or DPM?	☐ Yes ☐ No

If you answered yes to any question above, you must:

(a) Have admitting privileges at a hospital (list below) **OR**
(b) Provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

Do you have courtesy or consulting privileges at your current primary admitting facility? ☐ Yes ☐ No

If yes, do these courtesy or consulting privileges allow you to admit patients? ☐ Yes ☐ No

If no, provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

Please list all hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years, and your status (active, courtesy, consulting, etc.). If an institution is no longer in existence, please provide an alternative source of verification. Use a separate page, if necessary.

Current Primary Admitting Facility (Hospital Name): ______________________________

Street Address: ______________________________

City, State/Province, Country and Zip Code: ______________________________

Telephone Number: ______________________ Facsimile: ______________________

Appointment Dates: From:________ To:________ ☐ Present Type of Appointment: ______________

Privileges Assigned: ______________________________

Facility Name: ______________________________

Street Address: ______________________________

City, State/Province, Country and Zip Code: ______________________________

Telephone Number: ______________________ Facsimile: ______________________

Appointment Dates: From:________ To:________ ☐ Present Type of Appointment: ______________

Privileges Assigned: ______________________________

Facility Name: ______________________________

Street Address: ______________________________

City, State/Province, Country and Zip Code: ______________________________

Telephone Number: ______________________ Facsimile: ______________________

Appointment Dates: From:________ To:________ ☐ Present Type of Appointment: ______________

Privileges Assigned: ______________________________

Facility Name:
Street Address:______________________________
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ____________________ Facsimile:____________________
Appointment Dates: From:________ To:________ ☐ Present Type of Appointment:____________
Privileges Assigned:______________________________

WORK HISTORY

Please list all previous experience for the past fifteen (15) years, including months and years, listing the most recent first. Attach a separate page if necessary. Please attach a current CV or resume.

Organization: ______________________________ From:__________ To: __________
Mo/Yr Mo/Yr
Street Address: ______________________________ ☐ Present
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ____________________ Contact Person: ____________________
Type of Practice:______________________________

Organization: ______________________________ From:__________ To: __________
Mo/Yr Mo/Yr
Street Address: ______________________________ ☐ Present
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ____________________ Contact Person: ____________________
Type of Practice:______________________________

Organization: ______________________________ From:__________ To: __________
Mo/Yr Mo/Yr
Street Address: ______________________________ ☐ Present
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ____________________ Contact Person: ____________________
Type of Practice:______________________________

Organization: ______________________________ From:__________ To: __________
Mo/Yr Mo/Yr
Street Address: ______________________________ ☐ Present
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ____________________ Contact Person: ____________________
Type of Practice:______________________________

Organization: ______________________________ From:__________ To: __________
Mo/Yr Mo/Yr
Street Address: ______________________________ ☐ Present
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ____________________ Contact Person: ____________________
Type of Practice:______________________________

Please provide a written explanation for any gaps in work history of six (6) months or more.

____
____
____

PRACTICE LOCATIONS

Primary Practice/Group Name: ________________________ Effective Date:__________

Street Address: ____

City, State/Province and Zip Code: ____

Telephone Number:____________________ Facsimile Number: ______________

E-Mail Address: __________________ Answering Service Number: ______________

Foreign Languages (spoken fluently at practice): ________________________________

Office Manager or Contact Person:____

Billing Address: ☐ Same as above

Contact Person:____________________________ Tax ID #: ______________

Street Address:____

City, State/Province and Zip Code: ____

Telephone Number:____________________ Facsimile Number: ______________

Practice Associates: **Call Coverage** (if different):

________________________________ / ________________________

________________________________ / ________________________

________________________________ / ________________________

________________________________ / ________________________

What are the office hours for your Practice or Group Practice? (Provide days/hours):

____

____

What provisions have been made for after hours?________________________________

____

____

Other Practice Locations: (Attach a separate page for additional practice locations.)

Practice Name:____________________________ Tax ID #: ______________

Street Address: ____

City, State/Province and Zip Code: ____

Telephone Number:____________________ Facsimile Number: ______________

CONTINUING EDUCATION

1. If you are applying for privileges at a hospital or clinic, please attach documentation of all continuing education hours you have obtained in the last two (2) years or complete the attached statement of continuing medical education.
2. If you are applying for privileges at a hospital or clinic, please complete the enclosed privilege request form and ensure that you include any additional privileges that you are requesting. This will ensure your application is considered based upon the most accurate information available.

PROFESSIONAL REFERENCES

Please list five (5) professional peers with the same type of license, or a higher level of licensure, who are familiar with your professional performance in the past three (3) years.

Name and Title: ______________________________ Specialty: ______________________________
Street Address: ______________________________ Email: ______________________________
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ______________________________ Facsimile: ______________________________

Name and Title: ______________________________ Specialty: ______________________________
Street Address: ______________________________ Email: ______________________________
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ______________________________ Facsimile: ______________________________

Name and Title: ______________________________ Specialty: ______________________________
Street Address: ______________________________ Email: ______________________________
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ______________________________ Facsimile: ______________________________

Name and Title: ______________________________ Specialty: ______________________________
Street Address: ______________________________ Email: ______________________________
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ______________________________ Facsimile: ______________________________

Name and Title: ______________________________ Specialty: ______________________________
Street Address: ______________________________ Email: ______________________________
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ______________________________ Facsimile: ______________________________

LICENSURE REGISTRATION INFORMATION

List all licenses held in all jurisdictions. Attach a separate page, if necessary.

State Professional License/Certification Number: ______________________________ ☐ Pending
State: ____________ Issue Date: Expiration Date: ______________
State Professional License/Certification Number: ______________________________ ☐ Pending
State: ____________ Issue Date: Expiration Date: ______________
State Professional License/Certification Number: ______________________________ ☐ Pending
State: ____________ Issue Date: Expiration Date: ______________

DRUG CERTIFICATION INFORMATION

Federal Drug Enforcement Administration (DEA) Registration: ☐ N/A
DEA Number: ______________ Expiration Date: ______________ ☐ Pending

State Controlled Substance Registration (CSR): ☐ N/A
CSR Number: ______________ Expiration Date: ______________ State: ________ ☐ Pending
CSR Number: ______________ Expiration Date: ______________ State: ________ ☐ Pending

EDUCATION

List all medical, osteopathic, dental or podiatric schools attended for graduate education and list all hospitals where you received training for post-graduate training. Attach a copy of your certificate. Disclose every residency program initiated, whether completed or not, and all completed programs. Attach a separate page, if necessary. Check the type of education listed.

☐Undergraduate ☐Graduate ☐Post Graduate ☐Internship ☐Residency ☐Fellowship ☐Teaching position

Institution:______________________________ Dates Attended: From:__________ Mo/Yr

Street Address:______________________________ To:__________ Mo/Yr

City, State/Province, Country, Zip: ______________________ Graduation Year:__________

Degree Earned:______________________ or Specialty: ______________________

If teaching appointment: Department/Position: ______________________________

☐Undergraduate ☐Graduate ☐Post Graduate ☐Internship ☐Residency ☐Fellowship ☐Teaching position

Institution:______________________________ Dates Attended: From:__________ Mo/Yr

Street Address:______________________________ To:__________ Mo/Yr

City, State/Province, Country, Zip: ______________________ Graduation Year:__________

Degree Earned:______________________ or Specialty: ______________________

If teaching appointment: Department/Position: ______________________________

☐Undergraduate ☐Graduate ☐Post Graduate ☐Internship ☐Residency ☐Fellowship ☐Teaching position

Institution:______________________________ Dates Attended: From:__________ Mo/Yr

Street Address:______________________________ To:__________ Mo/Yr

City, State/Province, Country, Zip: ______________________ Graduation Year:__________

Degree Earned:______________________ or Specialty: ______________________

If teaching appointment: Department/Position: ______________________________

☐Undergraduate ☐Graduate ☐Post Graduate ☐Internship ☐Residency ☐Fellowship ☐Teaching position

Institution:______________________________ Dates Attended: From:__________ Mo/Yr

Street Address:______________________________ To:__________ Mo/Yr

City, State/Province, Country, Zip: ______________________ Graduation Year:__________

Degree Earned:______________________ or Specialty: ______________________

If teaching appointment: Department/Position: ______________________________

☐Undergraduate ☐Graduate ☐Post Graduate ☐Internship ☐Residency ☐Fellowship ☐Teaching position

Institution:______________________________ Dates Attended: From:__________ Mo/Yr

Street Address:______________________________ To:__________ Mo/Yr

City, State/Province, Country, Zip: ______________________ Graduation Year:__________

Degree Earned:______________________ or Specialty: ______________________

If teaching appointment: Department/Position: ______________________________

☐Undergraduate ☐Graduate ☐Post Graduate ☐Internship ☐Residency ☐Fellowship ☐Teaching position

Institution:______________________________ Dates Attended: From:__________ Mo/Yr

Street Address:______________________________ To:__________ Mo/Yr

City, State/Province, Country, Zip: ______________________ Graduation Year:__________

Degree Earned:______________________ or Specialty: ______________________

If teaching appointment: Department/Position: ______________________________

SPECIALTY BOARD CERTIFICATIONS

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 a brief explanation on an attached sheet. Explain any gaps or delays in achieving Board certification by the recognized Board in your specialty area.

☐ **Board or** ☐ **Specialty or** ☐ **Subspecialty** ____________________

Date Certified:__________ Date Last Recertified:__________ Expiration Date:__________ ☐ N/A

Certification Number: __________ Accepted for Examination ☐Yes ☐No Expiration Date: __________

If not accepted, have you made application? ☐ Yes ☐ No If no, provide an explanation:__________

____

☐ **Board or** ☐ **Specialty or** ☐ **Subspecialty** ____________________

Date Certified:__________ Date Last Recertified:__________ Expiration Date:__________ ☐ N/A

Certification Number: __________ Accepted for Examination ☐Yes ☐No Expiration Date: __________

If not accepted, have you made application? ☐ Yes ☐ No If no, provide an explanation:__________

____

☐ **Board or** ☐ **Specialty or** ☐ **Subspecialty** ____________________

Date Certified:__________ Date Last Recertified:__________ Expiration Date:__________ ☐ N/A

Certification Number: __________ Accepted for Examination ☐Yes ☐No Expiration Date: __________

If not accepted, have you made application? ☐ Yes ☐ No If no, provide an explanation:__________

____

☐ **Board or** ☐ **Specialty or** ☐ **Subspecialty** ____________________

Date Certified:__________ Date Last Recertified:__________ Expiration Date:__________ ☐ N/A

Certification Number: __________ Accepted for Examination ☐Yes ☐No Expiration Date: __________

If not accepted, have you made application? ☐ Yes ☐ No If no, provide an explanation:__________

____

MEDICAL MALPRACTICE INSURANCE

Do you have current medical malpractice insurance? ☐ Yes ☐ No

Please list medical malpractice insurance carriers for the past five (5) years. Attach a separate page, if necessary.

Current Carrier: ____________________ Limits: __________

Street Address: ____________________ ☐ Current ☐ Pending

City, State/Province, Country and Zip Code: ____________________

Dates Insured: From:__________ To:__________ Policy Number: __________

Carrier: ____________________ Limits: __________

Street Address:____________________

City, State/Province, Country and Zip Code: ____________________

Dates Insured: From:__________ To:__________ Policy Number: __________

Carrier: ____________________ Limits: __________

Street Address:____________________

City, State/Province, Country and Zip Code: ____________________

Dates Insured: From:__________ To:__________ Policy Number:__________

PROFESSIONAL PRACTICE QUESTIONS

Please answer the following Yes or No questions. Note that "N/A" is not an acceptable response except for question #16. **If you answer YES to any question, you must give details including name, address, and telephone number of significant parties on a separate sheet of paper. You must respond to each question.**

Question	Yes	No
1. Has your professional liability coverage ever been terminated by action of the insurance company (except as a result of the company ceasing to offer insurance coverage to physicians or other practitioners)?	☐ Yes	☐ No
2. Have you ever been denied professional liability insurance coverage?	☐ Yes	☐ No
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	☐ Yes	☐ No
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	☐ Yes	☐ No
5. Have you ever had any sanctions imposed by Medicare and/or Medicaid?	☐ Yes	☐ No
6. Have you ever been convicted of a misdemeanor or felony (excluding minor traffic violations) in the United States or any crime in another country?	☐ Yes	☐ No
7. Have you ever been arrested, indicted, charged, or been a defendant in a trial, regardless of the outcome, of any crime involving: • Intoxication • Illegal use, possession or distribution of an illegal substance • Trafficking of DEA Schedule II drugs • Sexual offenses • Domestic violence • Harm to a minor	☐ Yes	☐ No
8. Have you ever been subject to investigation by a governmental entity or licensing board that could have resulted, or did result, in licensure sanctions or other adverse actions, irrespective of the outcome?	☐ Yes	☐ No
9. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered, or denied?	☐ Yes	☐ No
10. Are any currently held licenses pending investigation or being challenged?	☐ Yes	☐ No
11. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	☐ Yes	☐ No
12. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings)?	☐ Yes	☐ No
13. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked or not renewed, except for medical records delinquency?	☐ Yes	☐ No
14. Have you ever agreed not to exercise your clinical privileges while under investigation?	☐ Yes	☐ No
15. Have you ever resigned from a healthcare entity while under investigation for or to avoid modification, suspension, or termination of privileges?	☐ Yes	☐ No
16. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or surrendered, or is it currently being challenged?	☐ Yes	☐ No ☐ N/A
17. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please list on a separate sheet of paper for each case: • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery that led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.	☐ Yes	☐ No

Question	Yes	No
18. Do you know of any reason why you cannot perform the essential duties of the clinical privileges/functions which you are requesting, with or without a reasonable accommodation according to acceptable standards of professional performance and without posing a direct threat to patients?	☐ Yes	☐ No
19. Do you use illegal drugs or have you illegally used drugs in the past five years?	☐ Yes	☐ No
20. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, prescription medication or alcohol?	☐ Yes	☐ No
21. Have you ever, for any reason:		
a. Resigned from or withdrawn from a medical or professional school or postgraduate training program?	☐ Yes	☐ No
b. Been suspended, dismissed, or expelled from a medical or professional school or postgraduate training program?	☐ Yes	☐ No
c. Been placed on probation or remediation, including academic probation or remediation, by a medical or professional school or postgraduate training program?	☐ Yes	☐ No
d. Taken a leave of absence or break from, or had any interruptions or extensions in, a medical or professional school or postgraduate training program for any reason, personal or professional (including illness or disability, pregnancy or maternity, any academic issues, or other similar reasons)?	☐ Yes	☐ No

_______________________________ _______________________________

Signature of Applicant **Date**

SAN JUAN IPA
110 E. Apache, Farmington, NM 87401 (505) 564-7989

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 type or 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:**

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-Court 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 separate sheet of paper if more space is needed)*

I have applied for appointment/reappointment with the San Juan IPA. I hereby authorize the San Juan IPA, its 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.

______________________________ ______________________

Signature of Applicant **Date**

SAN JUAN IPA
CREDENTIALING SERVICE
STANDARD AUTHORIZATION, ATTESTATION AND RELEASE

Authority to Release: I consent to complete disclosure by the recipient of this release to San Juan Independent Practice Association ("San Juan IPA") of all relevant information pertaining to my professional qualifications, moral character, physical and mental health (hereinafter "qualifications") on behalf of those organizations and their authorized representatives (hereafter "San Juan IPA") to which I have applied as a health care provider and which have designated San Juan IPA as their agent. I authorize the recipient to make available and/or disclose to San Juan IPA all such information in its files from any university, professional school, licensing authority, accreditation board, hospital, physician, dentist, professional society, insurance carrier, law enforcement agency, military service, or any other person or entity deemed necessary or appropriate in the investigation and processing of my application.

I request and authorize the recipient to release the requested information and I expressly waive any claim of privilege or privacy with respect to the released information bearing on my admission to, retention or termination of medical staff appointment or clinical privileges. I release and discharge San Juan IPA, the Health Care Entity and the medical, dental, podiatry and ancillary staffs or panels, credentials committees, administrators, review and approval boards or committees, governing boards, whether or not designated by these titles, and their agents, servants or employees authorized by representatives and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquiries concerning me or disclosures made in good faith in connection with my application for appointment to the Health Care Entity's Medical Staff or Provider Panel.

This authorization is limited to the acquisition and disclosure of information required by state or federal law, and information which is acquired or disclosed pursuant to activities protected by the state's Review Organizational Immunity Act and the Health Care Quality Improvement Act of 1986.

Attestation: 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 designated health care entity. I acknowledge that I have received and reviewed a copy of the bylaws, if applicable, of the designated health care entity. I further agree that, in the event there should arise an adverse ruling with respect to my status and/or clinical privileges, I will exhaust the administrative remedies afforded by the entity's bylaws before resorting to litigation.

Signature stamps and date stamps are not acceptable.

____
Applicant Signature

____________________________________ ____________________________________
Printed Name Date

Please fax, upload or e-mail completed application to:

San Juan IPA
Credentialing Department
Toll Free: (800) 317-3587
Direct: 505) 564-7989
Facsimile: (505) 564-7956
Email: heatherd@sanjuanipa.com
File drop: https://sanjuanipa.sharefile.com/share/filedrop

Agreement to Supervise
Dependent Allied Health Professional

I, ____, MD/DO, acknowledge _______________________ ___________________(Applicant's Name) is employed by _______________________________________ (Name of Facility). The applicant has requested authorization to provide patient care services at _______ ______________________________________(Name of Facility) as an Allied Health Professional (AHP). If permission to practice is granted, I will supervise all services provided by the AHP.

I agree to arrange for supervision of the applicant by another qualified member of the active medical staff, in the same specialty, in the event I am unavailable and I will ensure that any substitute complies with all conditions of practice during the supervision.

I agree to answer any questions regarding the applicant's practice and provide information to any medical staff or member that may be reviewing the practice of the applicant.

I agree to immediately notify the San Juan IPA Credentialing department in the event any of the following occur. I understand that I will continue to be responsible for the applicant until the San Juan IPA Credentialing department receives written notice of any action.

- My approval to supervise the AHP is revoked, limited, or otherwise altered by action of the applicable state licensing agency.

- Notification is given of investigation of the AHP by the applicable state licensing authority.

___________________________________ ___________________________________
Signature of Supervising Physician Date

____
Typed or Printed Name

Confidential

MCR Opt Out Attestation

I hereby apply for membership with the San Juan IPA. I have signed the required credentialing application, and I hereby consent that I:

HAVE ☐ ***HAVE NOT*** ☐ *(please choose one)*

filed a Medicare Opt-Out notice in the past two years. I understand that I am not allowed to opt out of Medicare, and still be able to participate in Medicare Advantage products.

________________________________ ________________________________
Signature of Applicant Date

____
Typed or Printed Name

San Juan IPA Member Attestation and Authorization and Release

I have applied for membership with the San Juan Independent Practice Association (San Juan IPA/SJIPA). 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 IPA 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 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.

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 San Juan IPA within two business days of any changes in the application information.

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.

____________________________ ____________________________

Signature of Applicant Date

I SAN JUAN
PA

110 E. Apache, Farmington, NM 87401 (505) 564-7989

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 the information below and return the form with your San Juan IPA Credentialing packet to Heather DeLaBarcena, Credentialing Coordinator via fax at (505) 564-7956, or via e-mail, at HeatherD@SanJuanIPA.com. If by e-mail, please send with ***credentialing application - "provider name"*** as the subject line, and with high importance. If you have any questions, please feel free to give me a call at (505) 564-7989. Thank you!

BUSINESS NAME: ______________________________

PHYSICAL ADDRESS: ______________________________

CITY/STATE/ZIP: ______________________________

PHONE NO: ______________________________

By signing, you verify that the above information is correct, and approve to have your business information as noted above published on the San Juan IPA website, and reported to all applicable insurances for listing in their respective directories.

____
(Print) Name of Applicant

______________________________ ______________________________
Signature of Applicant Date

SAN JUAN
IPA
110 E. Apache, Farmington, NM 87401 (505) 564-7989

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

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* ☐ **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 owner-ship 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)

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

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 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:_______________________________________
(Provider/Disclosing Entity or Authorized Agent of the Provider/Disclosing Entity)

Date:____

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*	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*	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.

SAN JUAN INDEPENDENT PRACTICE ASSOCIATION

PROVIDER SERVICE AGREEMENT AND AUTHORIZATION FOR DISCLOSURE

The San Juan Independent Practice Association (hereinafter referred to as "SJIPA"), and ________________________________ (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 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, San Juan IPA

Date: ____

[**Insert Provider 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