



Arkansas Preferred Physician Application

For PHCS Use Only

PHCS is committed to helping members access PHCS Network providers. **To ensure appropriate referrals and facilitate timely payment of claims, we ask that you complete all items on this form.** Items marked with an asterisk (*) will be kept confidential to the extent permitted by law. If you need assistance completing this form, please call our Provider Relations Line at 1-800-950-7040.

INDICATIVE	LAST NAME	FIRST NAME	M.I.	TITLE (e.g., Jr., Sr., III)
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CERTIFICATIONS	*SOCIAL SECURITY NUMBER	*BIRTH DATE (mm/dd/yyyy)	GENDER	
	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	
E-MAIL <input type="text"/>				

CERTIFICATIONS	Specialty
	Please indicate the specialties in which you would like to receive referrals for new patients.
	Primary Specialty <input type="text"/>
	Other <input type="text"/>

PROF HISTORY	Education
	Medical School <input type="text"/> City, State <input type="text"/> Degree Awarded MD <input type="checkbox"/> DO <input type="checkbox"/>
	Country <input type="text"/> Attended (mm/dd/yyyy) From <input type="text"/> / <input type="text"/> / <input type="text"/> To <input type="text"/> / <input type="text"/> / <input type="text"/>

LANGUAGES	Please indicate language(s) spoken by provider in addition to English <input type="text"/>
	Please indicate if you communicate in Sign Language <input type="checkbox"/> Yes <input type="checkbox"/> No

INSURANCE	Professional Liability (Malpractice)	
	Do you intend to maintain your current professional liability insurance limits? If no, please enclose a detailed explanation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Comprehensive General Liability	
Carrier <input type="text"/>	Expiration Date (mm/dd/yyyy) <input type="text"/> / <input type="text"/> / <input type="text"/>	Levels: Per Occurrence \$ <input type="text"/> In Aggregate \$ <input type="text"/>

REGISTRATION	Current Federal DEA Certification	
	*Do you administer or prescribe controlled substances (Schedule II, III, V medications)? <input type="checkbox"/> Yes: DEA Certificate # <input type="text"/> - <input type="text"/> <input type="checkbox"/> No: I do not administer or prescribe controlled substances; I do not have a DEA number.	Arkansas State Medical Board License Number: <input type="text"/>

ADDRESSES	Address Information I
	• Please provide practice, billing and mailing information for each office in which you see patients under this contract. • Do you have additional addresses? If yes, please attach additional sheets as necessary. <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address 1 (Please provide your payment address first. Note: If this is also a practice address, it cannot be a P.O. Box.) <input type="checkbox"/> Payment Address <input type="checkbox"/> Practice Address <input type="checkbox"/> Mailing Address
	Street <input type="text"/> Suite <input type="text"/>
	City <input type="text"/> State <input type="text"/> Zip <input type="text"/> - <input type="text"/>

ADDRESSES	Phone Numbers
	Appointments <input type="text"/> - <input type="text"/> - <input type="text"/> Ext. <input type="text"/> Billing <input type="text"/> - <input type="text"/> - <input type="text"/> Ext. <input type="text"/>
	Fax <input type="text"/> - <input type="text"/> - <input type="text"/>

Is This Office	
Your primary practice location? <input type="checkbox"/> Yes <input type="checkbox"/> No	An address you wish to appear in the directory? <input type="checkbox"/> Yes <input type="checkbox"/> No
Open to new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accessible to handicapped patients? <input type="checkbox"/> Yes <input type="checkbox"/> No

Office Hours
MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY SUNDAY
From - To From - To From - To From - To From - To From - To From - To
After hours call coverage <input type="text"/>

ADDRESSES	Average Appointment Scheduling Time		
	New patient _____ Hours / Days / Weeks	Routine Visit _____ Hours / Days / Weeks	Urgent Visit _____ Hours / Days / Weeks
	Contact Name		
First Name	M.I.	Last Name	Title
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone	Fax		
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>		
	Ext. <input type="text"/>		

TAX INFORMATION	Tax ID Information I – Address I	
	<ul style="list-style-type: none"> Information listed below will assist PHCS customers to pay your claims properly. All information must correspond to the W-9 Form submitted to the IRS. Please enclose a copy of your W-9 Form. Your application will not be processed without it. 	
	Tax Identification Number	Tax ID Name _____
<input type="text"/>	Tax ID Address _____	
	(Note: This name must match the name associated with the Tax ID number on the W-9 Form.)	

ADDRESSES	Address Information II		
	<ul style="list-style-type: none"> Please provide practice, billing and mailing information for each office in which you see patients under this contract. 		
	<input type="checkbox"/> Payment Address	<input type="checkbox"/> Practice Address	<input type="checkbox"/> Mailing Address
Street	Suite		
<input type="text"/>	<input type="text"/>		
City	State	Zip	
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/>	

ADDRESSES	Phone Numbers		
	Appointments	Billing	
	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	
Fax	Ext. <input type="text"/>		
<input type="text"/> - <input type="text"/> - <input type="text"/>			

ADDRESSES	Is This Office	
	Your primary practice location? <input type="checkbox"/> Yes <input type="checkbox"/> No	An address you wish to appear in the directory? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Open to new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accessible to handicapped patients? <input type="checkbox"/> Yes <input type="checkbox"/> No

Office Hours	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
	From - To	From - To	From - To	From - To	From - To	From - To	From - To

After hours call coverage _____

ADDRESSES	Average Appointment Scheduling Time		
	New patient _____ Hours / Days / Weeks	Routine Visit _____ Hours / Days / Weeks	Urgent Visit _____ Hours / Days / Weeks
	Contact Name		
First Name	M.I.	Last Name	Title
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone	Fax		
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>		
	Ext. <input type="text"/>		

TAX INFORMATION	Tax ID Information II – Address II	
	<ul style="list-style-type: none"> Information listed below will assist PHCS customers to pay your claims properly. All information must correspond to the W-9 Form submitted to the IRS. Please enclose a copy of your W-9 Form. Your application will not be processed without it. 	
	Tax Identification Number	Tax ID Name _____
<input type="text"/>	Tax ID Address _____	
	(Note: This name must match the name associated with the Tax ID number on the W-9 Form.)	

ATTESTATION / RELEASE	<p>I hereby submit this application for participation in the Private Healthcare Systems, Inc. (“PHCS”) Network. I understand that this application will be reviewed based on the information I have provided herein.</p> <p>I hereby certify that the information contained and enclosed with this form is complete, accurate and true, and that information found to be false could result in denial or subsequent termination of my participation in the PHCS Network.</p> <p>A photocopy of this permission will be as valid as the original.</p>		
	X _____	_____	_____
	Signature of Provider	Name (please type or print)	Date (mm,dd,yy)

* Information will be kept confidential to the extent permitted by law.

REMEMBER TO ENCLOSE

- 1. **Completed and signed Arkansas Preferred Physician Application.**
- 2. **One (1) completed and signed copy of the PHCS Participating Professional Agreement (with all Exhibits stapled to the Agreement if applicable).**
- 3. **Copy of W-9 Form.**
- 4. **Copy of Curriculum Vitae. (optional)**

Don't Forget To

- Sign and date** the Arkansas Preferred Physician Application
- Keep a photocopy** of the Application for your records.

PHCS USE ONLY

PPO Fee Schedule _____ Agreement ID _____

OA Fee Schedule _____ Agreement ID _____

* Information will be kept confidential to the extent permitted by law.
PRVP077-AR (11/04)

Questions? Call 1-800-950-7040
1100 Winter St. Waltham, MA 02451-9370

AUTHORIZATION AND RELEASE

I hereby authorize the Arkansas State Medical Board to provide my credentialing information gathered by the Board to Private Healthcare Systems, Inc. with whom I am affiliating.

This Authorization shall remain in effect for a period not to exceed two (2) years or until revoked by me in writing.

Typed or Printed Name of Physician: _____

Licensure Number: _____

Signature of Physician: _____ Date: _____
(Stamped signature is not acceptable)

**This document does not authorize the Arkansas State Medical Board to release information collected to third parties except as later authorized by the above physician and Arkansas law.*

A&R.doc
Revised: 5/22/2002
Approved: 6/7/2002

You do not need to complete this form if you have provided one to the Arkansas State Medical Board's CCVS within the last 120 days.

Arkansas State Medical Board
Centralized Credentials Verification Service
Phone: (501) 603-3574
(501) 296-1966
Fax: (501) 296-1806
www.armedicalboard.org

FAX back to ASMB
within 10 days of receipt

DO NOT MAIL

SINCE YOUR LAST ATTESTATION

Yes _____ No _____ Do you currently maintain malpractice insurance coverage? *CVO 5.1; 5.2***

Policy number: _____ Coverage amounts: _____ Expiration date: _____

*If you answer yes to any of the following, please provide a complete explanation of the circumstances.
All explanations should be provided on an attached page.*

1. Yes _____ No _____ Have your privileges or medical staff membership at any hospital or other healthcare organization been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending? *MS5.5.2* (intent); CR7.5.3**; CVO5.1.4***
2. Yes _____ No _____ Have you been charged or convicted of (including a plea of guilty or nolo contendere) a felony? *CVO5.1.3***
3. Yes _____ No _____ Has your license or certificate to practice medicine or Drug Enforcement Administration registration in any jurisdiction been challenged, denied, reduced, limited, suspended, revoked, placed on probation, not renewed, voluntarily or involuntarily relinquished, or is any such action pending? *MS5.5.1**
4. Yes _____ No _____ Have you been or are you presently being treated for alcoholism or substance abuse? If Yes, was this voluntary or the result of a Medical Board action? *MS5.4.3*; CR7.5.2**; CVO5.1.1***
5. Yes _____ No _____ Have you been or are you presently being treated for a mental health condition? If Yes, was this voluntary or the result of a Medical Board action? *MS5.4.3*; CR7.5.2**; CVO5.1.1***
6. Yes _____ No _____ Do you currently, or have you had since your last renewal, any physical or mental health condition, including alcohol or drug dependency, which, with or without accommodation, affects or is reasonably likely to affect your ability to practice medicine or to perform professional or medical staff duties appropriately? *MS5.4.3*; CR7.5.1**; CVO5.1.1***
7. Yes _____ No _____ Are you presently involved in the use of any illegal substance? *CR7.5.2**; CVO5.1.2***
8. Yes _____ No _____ Have any claims or damages arising out of medical malpractice been made against you, or has any professional liability lawsuit been filed against you? *ASMB*** (Medical Practices Act 17-95-103)*
9. Yes _____ No _____ Have any judgments been entered against you, or settlements been agreed to, in professional liability cases? *MS5.5.3.1**

**MS – Joint Commission on Accreditation of Healthcare Organizations Standard*

***CR; CVO – National Committee for Quality Assurance Standard*

****ASMB – Arkansas State Medical Board Requirement*

ATTESTATION

I affirm that all information contained in the original application or most recent update is true, correct, current, and complete in all respects to the best of my ability. I accept the responsibility to keep the Arkansas State Medical Board advised of any change or appropriate addition to any information contained in this form between now and the time such information is updated by subsequent renewals.

Licensee's Signature (No Rubber Stamps)

Date

Licensee's Printed Name

License Number