PEHP Health & Benefits | PROUDLY SERVING UTAH PUBLIC EMPLOYEES

560 East 200 South » Salt Lake City, UT » 84102-2004 » 801-366-7555 or 800-765-7347 » www.pehp.org

Thank you for your request for an application packet for membership on the Public Employees Health (PEHP) Provider Networks.

In order to consider this request for membership, please return the following information via email to providerrelations@pehp.org.

SUBMIT FORM TO PEHP

- ☐ Completed application (see attached)
- ☐ Copy of signed and dated Release Form (see attached)
- ☐ Copy of Certificate of Liability Insurance (declaration sheet with limits clearly listed, date insurance was effective, and expiration date)
- ☐ Copy of 147C IRS Form
- ☐ Copy of Board Certification Certificate *(if applicable)*
- ☐ Copy of Drug Enforcement Agency (DEA) certificate *(if applicable)*

If you have any questions, please contact us at 801-366-7555 or email providerrelations@pehp.org.

Sincerely,
PEHP Provider Specialist Representative

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Instructions for Completing the Group Provider Credentialing Application

Thank you for requesting an application packet for membership in the Public Employees Health Plan (PEHP) Provider Panel. Please return the completed application with the requested information within 45 days. After 45 days, the contracting process will be suspended, and reapplying may be necessary. The credentialing process can take up to one month to complete and does not guarantee inclusion on any PEHP panel.

The information on the Application must be complete and accurate. An incomplete Application may delay processing or result in a denial of membership.

- Type or legibly complete the Application in black or blue ink.
- Submit completed Application as well as any requested addenda. If a Section of the Application does not apply to you, write N/A in the first box of that Section.
- Attach copies of the following documents when the application is submitted:
    - Evidence of Professional Liability Policy or Certification (declaration sheet with limits clearly listed, date insurance was effective, and expiration date)
    - Copy of 147C IRS Form
    - Board Certification *(if applicable)*
    - DEA Certificate *(if applicable)*

You will only be required to fill out the section that pertains to you. For example, if you are a medical provider, you will only fill out the Medical Provider Section. You will not need to complete the BCBA or Dental sections. If you are unclear on which section you need to fill out, please get in touch with us at 801-366-7555, or email providerrelations@pehp.org

Note: All medical claims must be sent via EDI (Electronic Data Interchange.) Please indicate your clearinghouse or UHIN information on the application. This is a requirement in order for the application to be complete. Furthermore, we require all providers to set up EFT (Electronic Funds Transfer) services to receive payments. You will receive a user name and password later in the application process that you can use to log in to our website and set up these services.

If you have any questions, please contact a PEHP Provider Specialist at 801-366-7555 or 800-765-7347.

Table of Contents

INSTRUCTIONS:
When filling out the Application, you will only be required to fill out the Section that pertains to you and your specialty. For example, if you are a medical provider, you will only fill out the Medical Provider Section. You will not need to complete the BCBA or Dental sections. If you are unclear on which section you need to fill out, please get in touch with us at 801-366-7555, or email providerrelations@pehp.org

All providers are to review Section 4 regarding the Electronic Data Interchange (EDI) regarding requirements.

Section 1 – Medical and Mental Health Group Provider Application

Section 2 –BCBA Group Provider Application

Section 3 – Dental Group Provider Application

Section 4 – Electronic Data Interchange (EDI) for All Providers

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PEHP Provider Credentialing Application

Section 1 – Medical and Mental Health Group Provider Application

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on the application, you will need to attach additional sheets and reference the question(s) being answered.

You will need to provide a current listing of all individual providers within the Group and include each provider's name, Utah State Medical License number, TIN, NPI, gender, specialty, sub-specialty, degree, languages spoken (other than English). Copies of the following documents must be submitted with this application for each individual provider:

- 147C IRS Form
- DEA Certificate *(if applicable)*
- Board Certification *(if applicable)*
- Evidence of Professional Liability Certificate / Policy, or a Group Liability Certificate / Policy

I. GROUP PRACTICE INFORMATION		
Group Name:		
Specialty:	Sub-Specialty:	
Clearing House Name:	Trading Partner Number for EDI:	
Taxonomy Code:		
Contact Person:	Email Address:	
Phone Number:	Fax Number:	
PRIMARY LOCATION		
Physical Address:	Suite #:	
City:	State:	Zip:
Phone Number:	Fax Number:	
Reimbursement Address:	Suite #:	
City:	State:	Zip:
Phone Number:	Fax Number:	
Billing Address *if different than above*:		Suite #:
City:	State:	Zip:
Phone Number:	Fax Number:	
Tax ID Number (TIN):	National Provider Identification Number (NPI) #:	

GROUP PRACTICE INFORMATION *(Continued)*			
SECONDARY LOCATION			
Physical Address:		Suite #:	
City:	State:		Zip:
Phone Number:		Fax Number:	
Reimbursement Address:		Suite #:	
City:	State:		Zip:
Phone Number:		Fax Number:	
Billing Address *if different than above*:			Suite #:
City:	State:		Zip:
Phone Number:		Fax Number:	
Tax ID Number (TIN):	National Provider Identification Number (NPI) #:		

II. INDIVIDUAL PROVIDERS IN GROUP INCLUDING MID-LEVEL PROVIDERS

Provider Name	Board Certified (Yes or No)	TIN & NPI Number	Gender	Specialty & Sub-Specialty	Language Spoken	DEA #	Degree

III. HOSPITAL AND SURGICAL CENTER AFFILIATIONS

Provider Name	Hospital / Surgical Center	TIN & NPI Number	Do you Admit	Active	Associate	Courtesy	Pending

IV. PEER REFERENCES

All individual providers within the group must have professional references from two (2) or more physicians who practice within the PEHP service area. These references should not be from family members or those affiliated by marriage. The referring physicians must have personal knowledge of the provider's recent professional performance, ethical character, current competence, current health status, and ability to work cooperatively with others.

List medical references from two or more physicians who practice within the PEHP service area.

Name of Reference:	Specialty:	Phone #:	
Mailing Address:		Suite #/Floor:	
City:	State:	Zip:	
Name of Reference:	Specialty:	Phone #:	
Mailing Address:		Suite #/Floor:	
City:	State:	Zip:	
Name of Reference:	Specialty:	Phone #:	
Mailing Address:		Suite #/Floor:	
City:	State:	Zip:	

Sub-Specialties for each Mental Health Provider

To maintain accurate information for PEHP's online provider listing, please select the sub-specialties under which you would like to be identified. *(If more providers need to be listed, please attach additional sheets)*

Provider Name: _____

Sub-Specialty:

☐ ADD/ADHD	☐ Dissociative Disorders	☐ Personality Disorder	
☐ Adjustment Disorder	☐ Eating Disorder	☐ Psychotic Disorders	
☐ Anxiety Disorder	☐ Impulse-Control Disorder	☐ Sexual/Gender Identity Disorder	
☐ Cognitive Disorder	☐ Mood Disorder	☐ Substance Abuse Related Disorders	
Age of Patient you treat:	☐ Child (0-12)	☐ Adolescent (13-18)	☐ Adult (19+)

Provider Name: _____

Sub-Specialty:

☐ ADD/ADHD	☐ Dissociative Disorders	☐ Personality Disorder	
☐ Adjustment Disorder	☐ Eating Disorder	☐ Psychotic Disorders	
☐ Anxiety Disorder	☐ Impulse-Control Disorder	☐ Sexual/Gender Identity Disorder	
☐ Cognitive Disorder	☐ Mood Disorder	☐ Substance Abuse Related Disorders	
Age of Patient you treat:	☐ Child (0-12)	☐ Adolescent (13-18)	☐ Adult (19+)

Sub-Specialties for each Mental Health Provider *(continued)*			
Provider Name: ____________________			
Sub-Specialty:			
☐ ADD/ADHD	☐ Dissociative Disorders	☐ Personality Disorder	
☐ Adjustment Disorder	☐ Eating Disorder	☐ Psychotic Disorders	
☐ Anxiety Disorder	☐ Impulse-Control Disorder	☐ Sexual/Gender Identity Disorder	
☐ Cognitive Disorder	☐ Mood Disorder	☐ Substance Abuse Related Disorders	
Age of Patient you treat:	☐ Child (0-12)	☐ Adolescent (13-18)	☐ Adult (19+)
Provider Name: ____________________			
Sub-Specialty:			
☐ ADD/ADHD	☐ Dissociative Disorders	☐ Personality Disorder	
☐ Adjustment Disorder	☐ Eating Disorder	☐ Psychotic Disorders	
☐ Anxiety Disorder	☐ Impulse-Control Disorder	☐ Sexual/Gender Identity Disorder	
☐ Cognitive Disorder	☐ Mood Disorder	☐ Substance Abuse Related Disorders	
Age of Patient you treat:	☐ Child (0-12)	☐ Adolescent (13-18)	☐ Adult (19+)
Provider Name: ____________________			
Sub-Specialty:			
☐ ADD/ADHD	☐ Dissociative Disorders	☐ Personality Disorder	
☐ Adjustment Disorder	☐ Eating Disorder	☐ Psychotic Disorders	
☐ Anxiety Disorder	☐ Impulse-Control Disorder	☐ Sexual/Gender Identity Disorder	
☐ Cognitive Disorder	☐ Mood Disorder	☐ Substance Abuse Related Disorders	
Age of Patient you treat:	☐ Child (0-12)	☐ Adolescent (13-18)	☐ Adult (19+)
Provider Name: ____________________			
Sub-Specialty:			
☐ ADD/ADHD	☐ Dissociative Disorders	☐ Personality Disorder	
☐ Adjustment Disorder	☐ Eating Disorder	☐ Psychotic Disorders	
☐ Anxiety Disorder	☐ Impulse-Control Disorder	☐ Sexual/Gender Identity Disorder	
☐ Cognitive Disorder	☐ Mood Disorder	☐ Substance Abuse Related Disorders	
Age of Patient you treat:	☐ Child (0-12)	☐ Adolescent (13-18)	☐ Adult (19+)

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Professional Authorization to Release Information Form

By this application _____ **agrees to the following:**

- Authorize Public Employees Health Program to evaluate its credentials or act upon our application. This authorization includes consulting with any person, organization, institution or licensing entity or inspecting records relevant to our competence and qualifications.

- Release from liability all Public Employees Health Program employees, consultants, and administrators for acts performed without malice during the application evaluation.

- Release from liability all institutions, organizations, and individuals who without malice furnished information concerning our mental and physical health status and ethical behavior to Public Employees Health Program.

Print Name Here: _____

Signature: _____ Date: _____

(Stamped Signature is Not Acceptable)

PROFESSIONAL LIABILITY QUESTIONNAIRE

1. Yes ☐ No ☐ In the past ten years, have any professional liability claims, malpractice claims, or letters of Intent to sue been filed against the group or any individual provider in the group?

   If yes, how many? _____ How many are pending? _____

2. Yes ☐ No ☐ In the past ten years, has any judgment in any professional liability case been entered against the group or any individual provider in the group?

3. Yes ☐ No ☐ In the past ten years, has the group or any individual provider in the group been denied professional liability insurance, had a policy cancelled, had a professional liability insurer refuse the group or any individual provider in the group a policy or placed limitations on the scope of the coverage of the group or any individual provider in the group, or has any professional liability carrier expressed any intent to deny, cancel, not renew, or limit the professional liability insurance or its coverage of the group or any individual provider in the group?

If the answer to any question **1 through 3 is "yes"**, please include the nature of the case, the date, and a summary of the care given on the Professional Liability Form provided. Please enclose a copy of the original complaint and the settlement award.

4. Yes ☐ No ☐ Has any individual provider in the group ever had their license to practice medicine in any jurisdiction suspended, revoked, or otherwise limited?

5. Yes ☐ No ☐ Have any individual provider in the group been denied a license or the right to take an examination for licensing in any state, province, or country?

6. Yes ☐ No ☐ Have any individual provider ever been called before any licensing board for unethical conduct, or fees, or for interrogation concerning any violations of the laws or regulations pertaining to the profession for which you are applying?

7. Yes ☐ No ☐ Has any individual provider in the group ever had a license to prescribe or administer controlled substances ever been revoked or suspended?

8. Yes ☐ No ☐ Have any individual provider in the group ever been convicted of a violation of any state or federal controlled substance act, drug, or narcotic law?

9. Yes ☐ No ☐ Have any individual provider in the group ever been convicted of, or plead guilty to a felony?

10. Yes ☐ No ☐ Have any individual provider in the group ever been suspended from receiving payment under the Medicare or Medicaid programs?

11. Yes ☐ No ☐ Has any action been taken, whether still pending or completed, by any governmental agency or law enforcement body against the group or any individual provider in the group, for the alleged failure of the group or any individual provider in the group, to comply with laws, statutes, regulations, or other legal requirements which may be applicable to the rendering of service to patients or to the practice of the profession of the group or any individual provider in the group?

12. Yes ☐ No ☐ Has the group or any individual provider in the group ever been denied membership or renewal thereof, or been subject to disciplinary action in any dental organization?

If the answer to any question **4 through 12 is "Yes"**, please enclose a letter giving the date, jurisdiction, and nature of the charges and judgment, as well as the action taken.

PROFESSIONAL LIABILITY QUESTIONNAIRE *(Continued)*

13.	Yes ☐	No ☐	Has any individual provider in the group ever had treatment, or is presently undergoing treatment, or ever been recommended for treatment for narcotics, sedatives, or other drug dependencies or addictions?
14.	Yes ☐	No ☐	Has any individual provider in the group ever had treatment, or is presently undergoing treatment, or ever been recommended for treatment for alcohol abuse or addiction?
15.	Yes ☐	No ☐	Has any individual provider in the group ever had treatment, or is presently undergoing treatment, or ever been recommended for treatment for psychiatric therapy for emotional illness?
16.	Yes ☐	No ☐	Are the individual providers in the group aware or been advised that they have any temporary or permanent physical or mental condition or impairment which, by its nature or because of its treatment, might interfere with their ability to practice their profession with reasonable skill and safety?

If the answer to any question **15 through 16 is "Yes"**, please enclose a letter giving details of your use, condition, or addiction and include the name and address of the treating professional and/or institution.

PEHP PROFESSIONAL LIABILITY INFORMATION FORM

Provider Name: _____

Tax ID Number: _____ **NPI Number**: _____

For each malpractice action that the provider has been involved in during the past ten years, please print or type in detail the answers to each of the following questions. If more than one case exists, please photocopy this sheet for a separate response for each case. ***Full disclosure of the information requested below is necessary for completion of the credentialing process.*** All information will be kept confidential.

Date of Occurrence: _____ **Carrier Involved**: _____

What is the status of the case?

☐ Pending ☐ Settled Out of Court ☐ Found for Plaintiff

☐ Dropped ☐ Dismissed ☐ Found for Defendant

If damages where paid, either by settlement or court award, what was the amount?

Paid on provider's behalf: $ _____ Paid by all parties: _____

What is/was provider's status?

☐ Primary Defendant ☐ Co-Defendant ☐ Other

In the space below (attach additional pages if needed), provide detailed information of the following:

A. What was the alleged harm to the patient?

_____

_____

_____

B. What was provider alleged to have done incorrectly or failed to have done correctly?

_____

_____

_____

C. Provide any other details pertinent to the case.

_____

_____

_____

D. Identify any other parties who are named in the suit.

_____

_____

_____

E. Provide the name and Phone number of the attorney who represented the provider in the suit.

_____

Provider Signature: _____ **Date**: _____

Group Credentialing Attestation Form

I hereby certify and warrant to PEHP that the group has a credentialing and recredentialing process for the individual participating provider that complies with the National Council on Quality Assurance ("NCQA") standards.

I further certify and warrant to PEHP that the information contained in the foregoing application is accurate and true and that I fully understand that any misstatement or omissions in this application will constitute cause for denial of the application for participation or termination of the provider agreement.

I further understand and agree that PEHP's acceptance of this application does not constitute acceptance as a participating provider until provider receives both written notice of approval of the application and PEHP's acceptance letter.

Provider Signature: _____ **Date**: _____

Section 2 – Group BCBA Provider Application

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on the original application, attach additional sheets and reference the question(s) being answered. Current copies of the following documents must be submitted with this application:

- Professional Liability Policy or Certification
- 147C IRS form
- Board Certification *(if applicable)*

I. GROUP PRACTICE INFORMATION		
Group Name:		
Clearing House Name:	Trading Partner Number for EDI:	
Contact Person:	Email Address:	
Phone Number:	Fax Number:	Website URL:
PRIMARY LOCATION		
Physical Address:	Suite #:	
City:	State:	Zip:
Phone Number:	Fax Number:	
Reimbursement Address:	Suite #:	
City:	State:	Zip:
Phone Number:	Fax Number:	
Billing Address *if different than above*:		Suite #:
City:	State:	Zip:
Phone Number:	Fax Number:	
Tax ID Number (TIN):	National Provider Identification Number (NPI) #:	
SECONDARY LOCATION		
Physical Address:	Suite #:	
City:	State:	Zip:
Phone Number:	Fax Number:	
Reimbursement Address:	Suite #:	
City:	State:	Zip:
Phone Number:	Fax Number:	
Billing Address *if different than above*:		Suite #:
City:	State:	Zip:
Phone Number:	Fax Number:	
Tax ID Number (TIN):	National Provider Identification Number (NPI) #:	

II. INDIVIDUAL PROVIDERS IN GROUP INCLUDING BCBA-D, BCBA, BCABA, & RBT

Provider Name	TIN & NPI Number	Gender	Language Spoken	Certification (BCBA-D, BCBA, BCABA, RBT)

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Authorization to Release and Verify Information Form

I hereby affirm that the information submitted in the Participating Provider Application and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I fully understand that any material misstatements, omissions, or false information I knowingly make may constitute cause for denial of my application for participation or termination of the provider agreement. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation and re- evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

I hereby give to PEHP the authority to consult with, and obtain from, any and all individuals and organizations who can provide information concerning my professional liability coverage and claims, information bearing on my professional competence, training, character, ethical qualifications, ability to work cooperatively with others, and any other information necessary to process this application, other than health status which must include a separate release for information. This release shall be valid until my application is accepted or denied.

After acceptance, access to information shall be governed by a participating provider agreement. I hereby release from any and all liability those individuals and organizations who provide or process information pertinent to this application in good faith and without malice. I understand and agree that acceptance of my application does not constitute acceptance as a participating provider until such time as I receive written notice of approval of the application from PEHP.

I signify my willingness to appear for reviews or onsite visits with regard to my application. Any information obtained in connection with this application shall be treated confidentially to maintain the applicant's right of privacy and shall ensure that the information is only available to personnel or agents of PEHP with a need to know such information. This requirement also applies to information related to third parties, including patients and peers.

Print Name Here: _____

Signature: _____ Date: _____

(Stamped Signature is Not Acceptable)

BCBA PROFESSIONAL LIABILITY QUESTIONNAIRE

1. Yes ☐ No ☐ In the past ten years, has any professional liability claims, malpractice claims, or letters of intent to sue been filed against the group or any individual provider in the group?

   If yes, how many? _____ How many are pending? _____

2. Yes ☐ No ☐ In the past ten years, has any judgment in any professional liability case been entered against the group or any individual provider in the group?

3. Yes ☐ No ☐ In the past ten years, has the group or any individual provider in the group been denied professional liability insurance, had a policy cancelled, had a professional liability insurer refuse the group or any individual provider in the group a policy or placed limitations on the scope of the coverage of the group or any individual provider in the group, or has any professional liability carrier expressed any intent to deny, cancel, not renew, or limit the professional liability insurance or its coverage of the group or any individual provider in the group?

If the answer to any question **1 through 3 is "yes"**, please include the nature of the case, the date, and a summary of the care given on the Professional Liability Form provided. Please enclose a copy of the original complaint and the settlement award.

4. Yes ☐ No ☐ Has any individual provider in the group ever had their license to practice medicine in any jurisdiction suspended, revoked or otherwise limited?

5. Yes ☐ No ☐ Have any individual provider in the group ever been denied a license or the right to take an examination for licensing in any state, province, or country?

6. Yes ☐ No ☐ Have any individual provider in the group ever been called before any licensing or certification board for unethical conduct or for fees, or been interrogated concerning any violation of the laws or regulations pertaining to the profession for which you are applying?

7. Yes ☐ No ☐ Has any individual provider in the group ever had a license to prescribe or administer controlled substances revoked or suspended?

8. Yes ☐ No ☐ Have any individual provider in the group ever been convicted of a violation of any state or federal controlled substance act, drug, or narcotic law?

9. Yes ☐ No ☐ Have any individual provider in the group ever been convicted of or plead guilty to a felony?

10. Yes ☐ No ☐ Have the group or any individual provider in the group ever been suspended from receiving payment under the Medicare or Medicaid programs?

11. Yes ☐ No ☐ Has any action been taken, whether still pending or completed, by any governmental agency or law enforcement body against the group or any individual provider in the group, for the alleged failure of the group or any individual provider in the group, to comply with laws, statutes, regulations, or other legal requirements which may be applicable to the rendering of service to patients or to the practice of the profession of the group or any individual provider in the group

12. Yes ☐ No ☐ Has the group or any individual provider in the group ever been denied membership or renewal thereof, or been subject to disciplinary action in any dental organization?

If the answer to any question **4 through 12 is "Yes"**, please enclose a letter giving the date, jurisdiction, and nature of the charges and judgment, as well as the action taken.

BCBA PROFESSIONAL LIABILITY QUESTIONNAIRE *(Continued)*

13. Yes ☐ No ☐ Has any individual provider in the group ever had treatment, or is presently undergoing treatment, or ever been recommended for treatment for narcotics, sedatives, or other drug dependencies or addictions?

14. Yes ☐ No ☐ Has any individual provider in the group ever had treatment, or is presently undergoing treatment, or ever been recommended for treatment for alcohol abuse or addiction?

15. Yes ☐ No ☐ Has any individual provider in the group ever had treatment, or is presently undergoing treatment, or ever been recommended for treatment for psychiatric therapy for emotional illness?

16. Yes ☐ No ☐ Are the individual providers in the group aware or been advised that they have any temporary or permanent physical or mental condition or impairment which, by its nature or because of its treatment, might interfere with their ability to practice their profession with reasonable skill and safety?

If the answer to any question **13 through 16 is "Yes"**, please enclose a letter giving details of your use, condition, or addiction and include the name and address of the treating professional and/or institution.

PEHP BCBA PROFESSIONAL LIABILITY INFORMATION FORM

Provider Name: _____

Tax ID Number: _____ **NPI Number**: _____

For each malpractice action that the provider has been involved in during the past ten years, please print or type in detail the answers to each of the following questions. If more than one case exists, please photocopy this sheet for a separate response for each case. ***Full disclosure of the information requested below is necessary for completion of the credentialing process.*** All information will be kept confidential.

Date of Occurrence: _____ **Carrier Involved**: _____

What is the status of the action/case?

☐ Pending ☐ Settled Out of Court ☐ Found for Plaintiff

☐ Dropped ☐ Dismissed ☐ Found for Defendant

If damages where paid, either by settlement or court award, what was the amount?

Paid on provider's behalf: $ _____ Paid by all parties: _____

What is/was provider's status?

☐ Primary Defendant ☐ Co-Defendant ☐ Other

In the space below (attach additional pages if needed), provide detailed information of the following:

A. What was the alleged harm to the patient?

_____

_____

_____

B. What was provider alleged to have done incorrectly or failed to have done correctly?

_____

_____

_____

C. Provide any other details pertinent to the action/case.

_____

_____

_____

D. Identify any other parties who are named in the action/case.

_____

_____

_____

E. Provide the name and Phone number of the attorney who represented the provider in the suit.

_____

Provider Signature: _____ **Date**: _____

Group Credentialing/Attestation Form

I hereby certify and warrant to PEHP that the group has a credentialing and recredentialing process for the individual participating provider that complies with the National Council on Quality Assurance ("NCQA") standards.

I further certify and warrant to PEHP that the information contained in the foregoing application is accurate and true and that I fully understand that any misstatement or omissions in this application will constitute cause for denial of the application for participation or termination of the provider agreement.

I further understand and agree that PEHP's acceptance of this application does not constitute acceptance as a participating provider until provider receives both written notice of approval of the application and PEHP's acceptance letter.

Print Name and Title: _____

Signature: _____ Date: _____

Section 3 – Group Dental Provider Application

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on the application, you will need to attach additional sheets and reference the question(s) being answered.

You will need to provide a current listing of all individual providers within the Group and include each provider's name, Utah State Dental License number, TIN, NPI, gender, specialty, sub-specialty, degree, languages spoken (other than English). Copies of the following documents must be submitted with this application for each individual provider:

- 147C IRS Form
- DEA Certificate *(if applicable)*
- Board Certification *(if applicable)*
- Evidence of Professional Liability Certificate / Policy, or a Group Liability Certificate / Policy

I. GROUP PRACTICE INFORMATION

Group Name:		
Specialty:	Sub-Specialty:	
Clearing House Name:	Trading Partner Number for EDI:	
Taxonomy Code:		
Contact Person:	Email Address:	
Phone Number:	Fax Number:	
Utah Trading Parter Number for Electronic Billing (EDI) :		
PRIMARY LOCATION		
Physical Address:	Suite #:	
City:	State:	Zip:
Phone Number:	Fax Number:	
Reimbursement Address:	Suite #:	
City:	State:	Zip:
Phone Number:	Fax Number:	
Billing Address *if different than above*:	Suite #:	
City:	State:	Zip:
Phone Number:	Fax Number:	
Tax ID Number (TIN):	National Provider Identification Number (NPI) #:	
SECONDARY LOCATION		
Physical Address:	Suite #:	
City:	State:	Zip:
Phone Number:	Fax Number:	
Reimbursement Address:	Suite #:	
City:	State:	Zip:
Phone Number:	Fax Number:	
Billing Address *if different than above*:	Suite #:	
City:	State:	Zip:
Phone Number:	Fax Number:	
Tax ID Number (TIN):	National Provider Identification Number (NPI) #:	

II. INDIVIDUAL PROVIDERS IN GROUP INCLUDING MID-LEVEL PROVIDERS							
Provider Name	**Board Certified (Yes or No)**	**TIN & NPI Number**	**Gender**	**Specialty & Sub-Specialty**	**Language Spoken**	**DEA #**	**Degree & Certification**

III. PEER REFERENCES		
All individual providers within the group must have professional references from two (2) or more dentists who practice within the PEHP service area. These references should not be from family members or those affiliated by marriage. The referring dentists must have personal knowledge of the provider's recent professional performance, ethical character, current competence, current health status, and ability to work cooperatively with others. List dental references from two or more dentists who practice within the PEHP service area.		
Name:		
Street Address:		Suite #:
City & State:	Zip:	Phone Number:
Name:		
Street Address:		Suite #:
City & State:	Zip:	Phone Number:
Name:		
Street Address:		Suite #:
City & State:	Zip:	Phone Number:

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PEHP Professional Authorization to Release Information Form

By this application _____ **agrees to the following:**

- Authorize Public Employees Health Program to evaluate its credentials or act upon our application. This authorization includes consulting with any person, organization, institution or licensing entity or inspecting records relevant to our competence and qualifications.
- Release from liability all Public Employees Health Program employees, consultants, and administrators for acts performed without malice during the application evaluation.
- Release from liability all institutions, organizations, and individuals who without malice furnished information concerning our mental and physical health status and ethical behavior to Public Employees Health Program.

Print Name Here: _____

Signature: _____ Date: _____

(Stamped Signature is Not Acceptable)

DENTAL PROFESSIONAL LIABILITY QUESTIONNAIRE

1. Yes ☐ No ☐ In the past ten years, have any professional liability claims, malpractice claims, or letters of Intent to sue been filed against the group or any individual provider in the group?

   If yes, how many? _____ How many are pending? _____

2. Yes ☐ No ☐ In the past ten years, has any judgment in any professional liability case been entered against the group or any individual provider in the group?

3. Yes ☐ No ☐ In the past ten years, has the group or any individual provider in the group been denied professional liability insurance, had a policy cancelled, had a professional liability insurer refuse the group or any individual provider in the group a policy or placed limitations on the scope of the coverage of the group or any individual provider in the group, or has any professional liability carrier expressed any intent to deny, cancel, not renew, or limit the professional liability insurance or its coverage of the group or any individual provider in the group?

If the answer to any question **1 through 3 is "Yes"**, include the nature of the case, the date, and a summary of the care given on the Professional Liability Form provided. Please enclose a copy of the original complaint and the settlement award.

4. Yes ☐ No ☐ Has any individual provider in the group ever had their license to practice medicine in any jurisdiction suspended, revoked, or otherwise limited?

5. Yes ☐ No ☐ Have any individual provider in the group ever been denied a license or the right to take an examination for licensing in any state, province, or country?

6. Yes ☐ No ☐ Have any individual provider in the group ever been called before any licensing board for unethical conduct or fees, or been interrogated concerning any violations of the laws or regulations pertaining to the profession for which you are applying?

7. Yes ☐ No ☐ Has any individual provider in the group ever had a license to prescribe or administer controlled substances revoked or suspended?

8. Yes ☐ No ☐ Have any individual provider in the group ever been convicted of a violation of any state or federal controlled substance act, drug, or narcotic law?

9. Yes ☐ No ☐ Have any individual provider in the group ever been convicted of or plead guilty to a felony?

10. Yes ☐ No ☐ Have the group or any individual provider in the group ever been suspended from receiving payment under the Medicare or Medicaid programs?

11. Yes ☐ No ☐ Has any action been taken, whether still pending or completed, by any governmental agency or law enforcement body against the group or any individual provider in the group, for the alleged failure of the group or any individual provider in the group, to comply with laws, statutes, regulations, or other legal requirements which may be applicable to the rendering of service to patients or to the practice of the profession of the group or any individual provider in the group?

12. Yes ☐ No ☐ Has the group or any individual provider in the group ever been denied membership or renewal thereof, or been subject to disciplinary action in any dental organization?

If the answer to any question **4 through 12 is "Yes"**, please enclose a letter giving the date, jurisdiction, and nature of the charges and judgment, as well as the action taken.

DENTAL PROFESSIONAL LIABILITY QUESTIONNAIRE *(Continued)*

13. Yes ☐ No ☐ Has any individual provider in the group ever had treatment, or is presently undergoing treatment, or ever been recommended for treatment for narcotics, sedatives, or other drug dependencies or addictions?

14. Yes ☐ No ☐ Has any individual provider in the group ever had treatment, or is presently undergoing treatment, or ever been recommended for treatment for alcohol abuse or addiction?

15. Yes ☐ No ☐ Has any individual provider in the group ever had treatment, or is presently undergoing treatment, or ever been recommended for treatment for psychiatric therapy for emotional illness?

16. Yes ☐ No ☐ Are the individual providers in the group aware or been advised that they have any temporary or permanent physical or mental condition or impairment which, by its nature or because of its treatment, might interfere with their ability to practice their profession with reasonable skill and safety?

If the answer to any question **13 through 16 is "Yes"**, please enclose a letter giving details of your use, condition, or addiction and include the name and address of the treating professional and/or institution.

PROFESSIONAL LIABILITY INFORMATION

Provider Name: _____

Tax ID Number: _____ **NPI Number**: _____

For each malpractice action/case that the provider has been involved in during the past ten years, please print or type in detail the answers to each of the following questions. If more than one action/case exists, please copy this sheet for a separate response for each action/case. ***Full disclosure of the information requested below is necessary for completion of the credentialing process.*** All information will be kept confidential.

Date of Occurrence: _____ **Carrier Involved**: _____

What is the status of the case?

☐ Pending ☐ Settled Out of Court ☐ Found for Plaintiff

☐ Dropped ☐ Dismissed ☐ Found for Defendant

If damages where paid, either by settlement or court award, what was the amount?

Paid on provider's behalf: $ _____ Paid by all parties: $ _____

What is/was provider's status?

☐ Primary Defendant ☐ Co-Defendant ☐ Other

In the space below (attach additional pages if needed), provide detailed information of the following:

A. What was the alleged harm to the patient?

_____

_____

_____

B. What was provider alleged to have done incorrectly or failed to have done correctly?

_____

_____

_____

C. Provide any other details pertinent to the action/case.

_____

_____

_____

D. Identify any other parties who are named in the action/case.

_____

_____

_____

E. Provide the name and Phone number of the attorney who represented the provider in the action/case.

_____

Provider Signature: _____ **Date**: _____

Group Credentialing/Attestation Form

I hereby certify and warrant to PEHP that the group has a credentialing and recredentialing process for the individual participating provider that complies with the National Council on Quality Assurance ("NCQA") standards.

I further certify and warrant to PEHP that the information contained in the foregoing application is accurate and true and that I fully understand that any misstatement or omissions in this application will constitute cause for denial of the application for participation or termination of the provider agreement.

I further understand and agree that PEHP's acceptance of this application does not constitute acceptance as a participating provider until provider receives both written notice of approval of the application and PEHP's acceptance letter.

Print Name and Title: _____

Signature: _____ Date: _____

Section 4 – Electronic Data Interchange (EDI)

ELECTRONIC DATA INTERCHANGE (EDI) INFORMATION FOR ALL PROVIDERS

All providers are required to submit claims electronically. PEHP currently accepts claims through the Utah Health Information Network (UHIN); through a number of clearinghouses that submit through UHIN; or providers can set up and submit individual claims through the PEHP Provider Portal.

Providers who wish to submit claims themselves and not through a clearinghouse:

- Providers will need to contact UHIN and establish a Trading Partner Number. The Trading Partner Number will be used for all payers that accept claims through UHIN. To enroll with UHIN please call **801-466-7705.**
- Once the Trading Partner Number has been established, please contact the EDI department at PEHP, **801-366-7544 or 800-753-7818,** to arrange testing. We will need your Trading Partner Number, tax ID, contact name, phone number and NPI.

Adding a New Provider to a Practice:

When a new provider is added to the practice, please contact the EDI Department to add the new provider to the correct trading partner to avoid claim rejections. Please contact the EDI department by phone, **801-366-7544 or 800-753-7818** or E-Mail **edi.helpdesk@pehp.org**. They will need to know the Trading Partner Number as well as the provider's NPI.

PEHP currently supports the following transactions:

- **Health Care Claim**: PEHP accepts Dental, Professional, and Institutional claims. PEHP will return a Functional Acknowledgement (997) report and a Front-End Acknowledgement (277fe) report.

- **Health Care Eligibility and Benefit Inquiry**: Real time or batch eligibility and benefit requests. Currently available through the UHINT tool, may also be available through your practice management system.
- **Health Care Claims Status Inquiry**: Real time or batch status reports on claims that were previously submitted. Currently available through the UHINT tool, may also be available through your practice management system.
- **Health Care Claim Payment and Remittance Advice**: Providers will have the option of receiving an Electronic Provider Remittance (835) or printing a paper remittance from our website. Either option allows provider to sign up for Electronic Funds Transfer.

Electronic Funds Transfer:

PEHP will send an electronic provider remittance to the provider and send the funds to the provider's bank. Providers will also have the option of viewing their remittance on the PEHP website. Only providers who receive electronic remittance are eligible for electronic funds transfer.