HORIZON
NJ HEALTH

Horizon Blue Cross Blue Shield of New Jersey*

Independent licensees of the Blue Cross and Blue Shield Association*

Horizon NJ Health, a product of Horizon HMO*

Nurse Midwife/Nurse Practitioner/Physician Assistant Checklist

Thank you for your interest in Horizon NJ Health Manage Care Network. Enclosed is an application and information for your review and competition. Please use this check list as a guide during this process.

Provider Name: ____ Applying as: ☐PCP and/or ☐Specialist
County: ________________________________ Provider participates with Horizon BCBS of NJ? ☐ Yes or ☐ No
Office Manager/Contact: __________________________________ Telephone:___________________________

The following documentation is required to submit an application:

- ❑ Fully completed **NJ Universal Application** (Please review question 26 carefully. If you answer YES, no documentation is needed) **OR CAQH #**____
- ❑ **2 Signed Agreements –** Please DO NOT insert an effective date or alter the agreements. The agreements will be countersigned and dated with the effective date upon approval. An executed copy will be returned to you by mail.
- ❑ **W-9** form
- ❑ Copy of **Board Certification or proof of Board Eligibility (i.e. NCCPA, ANA, NAPNAP, ACNM).**
- ❑ Current copy of **State Registered Nurse's License, Physician Assistant License, Midwifery License and/or EN Practitioner's License**.**
- ❑ **Hospital and/or Birthing Center Privilege Letter(s)** – Must have a delineation of privileges; be dated within 6 months of request date; stating the provider has active privileges and is in good standing. This item is not required for Physician Assistant applicants.
- ❑ Must have a **Statement of Collaboration** from managing physician and management plan of care.
- ❑ **Curriculum Vitae** – please fill in requested information in addition to attaching CV
- ❑ Copy of **Malpractice Insurance Certificate** face sheet policy showing policy period and liability limits.**
- ❑ Documentation of **continuing Medical Education Credits**.
- ❑ **Special Needs Survey**
- ❑ American with Disabilities Act (**ADA**) **Provider Survey** (one per location)
- ❑ For Affordable Care Act eligible providers, please submit a Self or Group **ACA Attestation Form**

**** In order to avoid unnecessary delays please make sure all documentation is dated within the last six months and is not within 3 month of expiration.**

Upon credentialing, the physician/provider is required to attend a brief orientation session with the Professional Relations Representative assigned to your territory.

THE CREDENTIALING COMMITTEE MEETS ON A MONTHLY BASIS; THEREFORE, ONCE WE RECEIVE YOUR APPLICATION FOR PROCESSING PLEASE ALLOW 8-10 WEEKS.

Thank you very much for your attention to this matter. We look forward to having your office as part of our select physician network. Please send applications to:

Horizon NJ Health
210 Silvia Street
West Trenton, NJ 08628

New Jersey Universal Physician Application

(Please type or print)

SECTION 1

Personal Information

Physician Name (Last) (First) (MI) (Jr., Sr., etc.)	Professional Degree(s) *(MD, DO, DDS, DMD, DPM, DC)*	Social Security Number

Other Name Used	Years Associated with Former Name	Other Name Used	Years Associated with Former Name

Date of Birth (mm/dd/yyyy) / /	Gender ☐ Male ☐ Female	Are you eligible to work in the United States? ☐ Yes ☐ No

Home Mailing Address	City	State	Zip Code

Practice Location Information

Type of Service Provided ☐ Primary Care Specialist ☐ Non-Primary Care Specialist

Physician Group Name/Practice Name *(to appear in the directory)*	Group/Corporate Name *(as it appears on W-9)*, if different from Group Name/Practice Name

Primary Office Mailing Address	City	State	Zip Code

Primary Office Telephone No.	Primary Office Fax No.	Primary Office E-mail Address

Tax ID Number and Associated Individual Group Number and Name for This Location

Are you currently practicing at the above location? ☐ Yes ☐ No	If No, what is your expected start date?

Other Office Street Address	City	State	Zip Code

Telephone No.	Fax No.	E-mail Address

Do you want this site listed in the Directory? ☐ Yes ☐ No	Tax ID Number and Associated Individual Group Number and Name for This Location

Other Office Street Address	City	State	Zip Code

Telephone No.	Fax No.	E-mail Address

Do you want this site listed in the Directory? ☐ Yes ☐ No	Tax ID Number and Associated Individual Group Number and Name for This Location

Correspondence Office Street Address	City	State	Zip Code

Telephone No.	Fax No.	E-mail Address

If you have additional offices, please submit an attachment containing the above information and check this box: ☐

MC-5
DEC 05

License and Other Identification Numbers

(License Information - Include all license(s) and certifications in all States where you are currently or have previously been licensed.)

Type	State(s) of Registration	Do You Currently Practice In This State?	License/Certificate Number	Expiration Date	N/A
License		☐ Yes ☐ No			
License		☐ Yes ☐ No			
DEA Registration Certificate		☐ Yes ☐ No			
CDS Registration Certificate		☐ Yes ☐ No			
Other (CDS/DEA) (Specify)		☐ Yes ☐ No			

UPIN	National Provider ID (when available)	Are you a participating Medicare Provider?	Medicare Provider No.	Are you a participating Medicaid Provider?	Medicaid Provider No.

International Medical Graduates: Are you certified by the Educational Council for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No	If yes, ECFMG Number	ECFMG Issue Date

Medical Education

School Issuing Professional Degree (Medical, Dental, Chiropractic)	Degree	Attendance Dates	
Address	City	State/Country	Zip Code

If you have attended additional schools, please submit an attachment containing the above information and check this box: ☐

Post-Graduate Education ☐ Internship ☐ Fellowship ☐ Residency ☐ Teaching Appointment	Institution Name		
Address	City	State	Zip Code
Specialty	Start Date (Month/Year)	End Date (Month/Year)	

Post-Graduate Education ☐ Internship ☐ Fellowship ☐ Residency ☐ Teaching Appointment	Institution Name		
Address	City	State	Zip Code
Specialty	Start Date (Month/Year)	End Date (Month/Year)	

Post-Graduate Education ☐ Internship ☐ Fellowship ☐ Residency ☐ Teaching Appointment	Institution Name		
Address	City	State	Zip Code
Specialty	Start Date (Month/Year)	End Date (Month/Year)	

If you completed additional training, please submit an attachment containing the above information and check this box: ☐

Other Graduate Level Education for Which a Degree Was Obtained - Type of Program (Psychology, Public Health, MBA, etc.)	Institution Name		
Address	City	State	Zip Code
Degree Obtained	Date of Graduation (Month/Year)		

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Professional/Medical Specialty Information

Primary Specialty	Board Certified? ☐ Yes ☐ No	Name of Certifying Board
Initial Certification Date	Recertification Date (s) *(if applicable)*	Expiration Date *(if applicable)*

Do you wish to be listed in the directory under this specialty?	If not Board Certified, indicate any of the following that apply:
HMO ☐ Yes ☐ No PPO ☐ Yes ☐ No POS ☐ Yes ☐ No	☐ I have taken exam, results pending for: ____________ (board) ☐ I am intending to sit for the Boards on: ____________ (date) ☐ I am not planning to take the Boards.

Secondary Specialty	Board Certified? ☐ Yes ☐ No	Name of Certifying Board
Initial Certification Date	Recertification Date (s) *(if applicable)*	Expiration Date *(if applicable)*

Do you wish to be listed in the directory under this specialty?	If not Board Certified, indicate any of the following that apply:
HMO ☐ Yes ☐ No PPO ☐ Yes ☐ No POS ☐ Yes ☐ No	☐ I have taken exam, results pending for: ____________ (board) ☐ I am intending to sit for the Boards on: ____________ (date) ☐ I am not planning to take the Boards.

Additional Specialty	Board Certified? ☐ Yes ☐ No	Name of Certifying Board
Initial Certification Date	Recertification Date (s) *(if applicable)*	Expiration Date *(if applicable)*

Do you wish to be listed in the directory under this specialty?	If not Board Certified, indicate any of the following that apply:
HMO ☐ Yes ☐ No PPO ☐ Yes ☐ No POS ☐ Yes ☐ No	☐ I have taken exam, results pending for: ____________ (board) ☐ I am intending to sit for the Boards on: ____________ (date) ☐ I am not planning to take the Boards.

List Additional Areas of Professional Practice, Interest or Focus (HIV/AIDS, etc.)

Hospital Affiliations and Privileges

Do you have hospital privileges?	If you do not admit patients, what admitting arrangements do you have?
☐ Yes ☐ No	

If you have privileges, please complete the section below. Include all hospitals where you have privileges.

Primary Hospital where you have Admitting Privileges			Telephone Number		
Address		City		State	Zip Code
Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges	Are Privileges Temporary? ☐ Yes ☐ No	Of the total admissions to all hospitals in the past year, what percentage is to this specific hospital?		
Other Hospital Where you Have Privileges			Telephone Number		
Address		City		State	Zip Code
Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges	Are Privileges Temporary? ☐ Yes ☐ No	Of the total admissions to all hospitals in the past year, what percentage is to this specific hospital?		
Other Hospital Where you Have Privileges			Telephone Number		
Address		City		State	Zip Code
Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges	Are Privileges Temporary? ☐ Yes ☐ No	Of the total admissions to all hospitals in the past year, what percentage is to this specific hospital?		
Additional Hospital Where you Have Privileges			Telephone Number		
Address		City		State	Zip Code
Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges	Are Privileges Temporary? ☐ Yes ☐ No	Of the total admissions to all hospitals in the past year, what percentage is to this specific hospital?		

If you have additional hospital affiliations, please submit an attachment containing the above information and check this box: ☐

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

List all other hospitals where you have previously had privileges.			
Hospital Name		Dates of Affiliation	
Address	City	State	Zip Code
Hospital Name		Dates of Affiliation	
Address	City	State	Zip Code

If you have other previous hospital affiliations, please submit an attachment containing the above information and check this box: ☐

Work History

Include chronological work history since completion of training.			
Practice/Employer Name		Start Date/End Date	
Address	City	State	Zip Code
Practice/Employer Name		Start Date/End Date	
Address	City	State	Zip Code
Practice/Employer Name		Start Date/End Date	
Address	City	State	Zip Code
Practice/Employer Name		Start Date/End Date	
Address	City	State	Zip Code

For additional work history, please submit an attachment containing the above information and check this box: ☐

Please provide an explanation of any gaps greater than six months in each work history.	
Date	Explanation
Date	Explanation
Are you currently on active military duty or on military reserve? ☐ Yes ☐ No	

References

Please provide three professional references that are not partners in your own group practice and are not relatives.	
Name	Street Address City, State, Zip Code

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Professional Liability Insurance Coverage					
Are you self-insured? ☐ Yes ☐ No					
Name of Current Malpractice Insurance Carrier or Self-Insured Entity			Telephone Number	Effective Date	Expiration Date
Address			City	State	Zip Code
Policy Number	Amount of Coverage per Occurrence	Amount of Coverage Aggregate	Type of Coverage ☐ Individual ☐ Shared		Length of Time with Carrier
Name of Previous Malpractice Insurance Carrier or Self-Insured Entity			Telephone Number	Effective Date	Expiration Date
Address			City	State	Zip Code
Policy Number	Amount of Coverage per Occurrence	Amount of Coverage Aggregate	Type of Coverage ☐ Individual ☐ Shared		Length of Time with Carrier

Status/Role in Practice
☐ Owner ☐ Partner ☐ Employee ☐ Officer ☐ Shareholder

Interests in Outside Clinical Lab(s)		
If you own/co-own, or have interests in any other outside clinical lab, please fill in below:		
Legal Billing Name	TIN (Attach copy of W-9)	Clinical Description
Please provide a summary pattern for this business:		

Office Coverage	
List names of colleague(s) providing regular coverage and his/her specialty(ies).	
Name	Provider Specialty

Partners	
List full names of all partners in your practice (attach list for large group).	
Name (Last, First, MI)	Name (Last, First, MI)

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Other Practice Information (specify for each site)

Site 1	**Site 2**
Office Address:	Office Address:
Type of Practice: ☐Solo ☐Single Specialty Group ☐Multi-Specialty Group	Type of Practice: ☐Solo ☐Single Specialty Group ☐Multi-Specialty Group
Office Manager or Business Office Staff Contact:: Name: ______ Telephone No.: ______ Fax No.: ______	Office Manager or Business Office Staff Contact:: Name: ______ Telephone No.: ______ Fax No.: ______
Credentialing Contact (if different from above): Name: ______ Telephone No.: ______ Fax No.: ______ E-mail: ______ Address: ______ City: ______ State: ______ Zip: ______	Credentialing Contact (if different from above): Name: ______ Telephone No.: ______ Fax No.: ______ E-mail: ______ Address: ______ City: ______ State: ______ Zip: ______
Billing Information: Billing Rep. Name: ______ Address: ______ City: ______ State: ______ Zip: ______ Telephone No.: ______ Fax No.: ______ E-mail: ______ Dept. Name if Hosp.-Based: ______ Check should be payable to ______ Do you have capability of electronic billing? ☐Yes ☐No	Billing Information: Billing Rep. Name: ______ Address: ______ City: ______ State: ______ Zip: ______ Telephone No.: ______ Fax No.: ______ E-mail: ______ Dept. Name if Hosp.-Based: ______ Check should be payable to ______ Do you have capability of electronic billing? ☐Yes ☐No

Office Business Hours (hours patients are seen):

Day	No Office Hours	Morning	Afternoon	Evening	Day	No Office Hours	Morning	Afternoon	Evening
MON	☐				MON	☐			
TUES	☐				TUES	☐			
WED	☐				WED	☐			
THUR	☐				THUR	☐			
FRI	☐				FRI	☐			
SAT	☐				SAT	☐			
SUN	☐				SUN	☐			

Site 1	Site 2
After hours, back office phone number for health plan business use only:	After hours, back office phone number for health plan business use only:
Do you provide 24 hour/7 day a week phone coverage for this site? ☐ Yes ☐ No If yes, indicate type: ☐ Answering service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions	Do you provide 24 hour/7 day a week phone coverage for this site? ☐ Yes ☐ No If yes, indicate type: ☐ Answering service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions

(Continue on next page.)

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Other Practice Information (specify for each site)

(Continued from previous page.)

Site 1, Continued	Site 2, Continued
Do you accept new patients into the practice? ..... ☐Yes ☐No -All new patients? ☐Yes ☐No -Existing patients with change of payor? ☐Yes ☐No -New patients from physician referral? ☐Yes ☐No -New Medicare patients? ☐Yes ☐No -New Medicaid patients? ☐Yes ☐No If this information varies by health plan, provide explanation:	Do you accept new patients into the practice? ..... ☐Yes ☐No -All new patients? ☐Yes ☐No -Existing patients with change of payor? ☐Yes ☐No -New patients from physician referral? ☐Yes ☐No -New Medicare patients? ☐Yes ☐No -New Medicaid patients? ☐Yes ☐No If this information varies by health plan, provide explanation:
Are there any practice limitations? ☐ Yes ☐ No If yes, indicate limitations below: Gender: ☐Male Only ☐Female Only ☐N/A Patient Age Limitation (List Ages): ☐N/A ______ List Other Limitations: ______	Are there any practice limitations? ☐ Yes ☐ No If yes, indicate limitations below: Gender: ☐Male Only ☐Female Only ☐N/A Patient Age Limitation (List Ages): ☐N/A ______ List Other Limitations: ______
Do mid-level practitioners such as nurse practitioners, physician assistants, midwives, social workers or other non-physician providers care for patients in your practice? ☐Yes ☐No If yes, provide the following information for each staff member: Name: ______ Professional Designation: ______ State License Number: Name: ______ Professional Designation: ______ State License Number:	Do mid-level practitioners such as nurse practitioners, physician assistants, midwives, social workers or other non-physician providers care for patients in your practice? ☐Yes ☐No If yes, indicate limitations below: Name: ______ Professional Designation: ______ State License Number: Name: ______ Professional Designation: ______ State License Number:
Please attach a list of any additional mid-level practitioners.	*Please attach a list of any additional mid-level practitioners.*
Non-English Languages spoken: by health care professional: ______ by office personnel: ______ Are interpreters available? ☐Yes ☐No If yes, specify languages: ______	Non-English Languages spoken: by health care professional: ______ by office personnel: ______ Are interpreters available? ☐Yes ☐No If yes, specify languages: ______
Does this office meet ADA accessibility standards? ☐Yes ☐No	Does this office meet ADA accessibility standards? ☐Yes ☐No
Does this site provide handicapped accessibility for each of the following: Building ☐Yes ☐No Parking ☐Yes ☐No Restroom ☐Yes ☐No Other: ______	Does this site provide handicapped accessibility for each of the following: Building ☐Yes ☐No Parking ☐Yes ☐No Restroom ☐Yes ☐No Other: ______
Does this site have other services for the disabled? ☐Yes ☐No If yes, indicate type: Text Telephony - TTY ☐Yes ☐No American Sign Language-ASL ☐Yes ☐No Mental/Physical Impairment Services ☐Yes ☐No Other: ______	Does this site have other services for the disabled? ☐Yes ☐No If yes, indicate type: Text Telephony - TTY ☐Yes ☐No American Sign Language-ASL ☐Yes ☐No Mental/Physical Impairment Services ☐Yes ☐No Other: ______

(Continue on next page.)

Other Practice Information (specify for each site)

(Continued from previous page.)

Site 1, Continued	Site 2, Continued
Is this site accessible by public transportation? ☐Yes ☐No Bus ☐Yes ☐No Subway ☐Yes ☐No Regional Train ☐Yes ☐No Other: ______	Is this site accessible by public transportation? ☐Yes ☐No Bus ☐Yes ☐No Subway ☐Yes ☐No Regional Train ☐Yes ☐No Other: ______
Does this site provide childcare services? ☐Yes ☐No	Does this site provide childcare services? ☐Yes ☐No
Does this office qualify as a minority business enterprise? ☐Yes ☐No	Does this office qualify as a minority business enterprise? ☐Yes ☐No
Do you or does someone in your office have the following certifications? *(Indicate for each office location.)* Yes No Exp.Date BLS (Basic Life Support) ☐ ☐ ______ ACLS (Advanced Cardiac Life Support) ☐ ☐ ______ ALSO (Advanced Life Support in OB) ☐ ☐ ______ PALS (Pediatric Advanced Life Support) ☐ ☐ ______ ATLS (Advanced Trauma Life Support) ☐ ☐ ______ NALS (Neonatal Advanced Life Support) ☐ ☐ ______ CPR (Cardio-Pulmonary Resuscitation) ☐ ☐ ______	Do you or does someone in your office have the following certifications? *(Indicate for each office location.)* Yes No Exp.Date BLS (Basic Life Support) ☐ ☐ ______ ACLS (Advanced Cardiac Life Support) ☐ ☐ ______ ALSO (Advanced Life Support in OB) ☐ ☐ ______ PALS (Pediatric Advanced Life Support) ☐ ☐ ______ ATLS (Advanced Trauma Life Support) ☐ ☐ ______ NALS (Neonatal Advanced Life Support) ☐ ☐ ______ CPR (Cardio-Pulmonary Resuscitation) ☐ ☐ ______
Does your site provide any of the following services on site? *(Indicate for each office location.)* Laboratory Services ☐Yes ☐No Certificate of Participation from CLIA or another accrediting/certifying program [AAFP, COLA, CAP, Medical Laboratory Evaluation (MLE)] Program ☐Yes ☐No If yes, list program: ______ Radiology Services ☐Yes ☐No X-Ray Certification ☐Yes ☐No If yes, include type: ______ EKG's ☐Yes ☐No Care of Minor Lacerations ☐Yes ☐No Pulmonary Function Testing ☐Yes ☐No Allergy Injections ☐Yes ☐No Allergy Skin Testing ☐Yes ☐No Office Gynecology (Routine Pelvic/Pap) ☐Yes ☐No Drawing Blood ☐Yes ☐No Age Appropriate Immunizations ☐Yes ☐No Flexible Sigmoidoscopy ☐Yes ☐No Tympanometry/Audiometry Screening ☐Yes ☐No Asthma Treatment ☐Yes ☐No Osteopathic Manipulation ☐Yes ☐No IV Hydration/Treatment ☐Yes ☐No Cardiac Stress Tests ☐Yes ☐No Physical Therapy ☐Yes ☐No	Does your site provide any of the following services on site? *(Indicate for each office location.)* Laboratory Services ☐Yes ☐No Certificate of Participation from CLIA or another accrediting/certifying program [AAFP, COLA, CAP, Medical Laboratory Evaluation (MLE)] Program ☐Yes ☐No If yes, list program: ______ Radiology Services ☐Yes ☐No X-Ray Certification ☐Yes ☐No If yes, include type: ______ EKG's ☐Yes ☐No Care of Minor Lacerations ☐Yes ☐No Pulmonary Function Testing ☐Yes ☐No Allergy Injections ☐Yes ☐No Allergy Skin Testing ☐Yes ☐No Office Gynecology (Routine Pelvic/Pap) ☐Yes ☐No Drawing Blood ☐Yes ☐No Age Appropriate Immunizations ☐Yes ☐No Flexible Sigmoidoscopy ☐Yes ☐No Tympanometry/Audiometry Screening ☐Yes ☐No Asthma Treatment ☐Yes ☐No Osteopathic Manipulation ☐Yes ☐No IV Hydration/Treatment ☐Yes ☐No Cardiac Stress Tests ☐Yes ☐No Physical Therapy ☐Yes ☐No
Additional Office Procedures Provided (incl. surgical procedures)	Additional Office Procedures Provided (incl. surgical procedures)
Is anesthesia administered in your office? ☐Yes ☐No If Yes, what class or category of anesthesia do you use? ______ Who administers it? ______	Is anesthesia administered in your office? ☐Yes ☐No If Yes, what class or category of anesthesia do you use? ______ Who administers it? ______

For additional office sites, please submit an attachment containing the above information and check this box: ☐

Patient Scheduling

What is patient wait time for emergency care? .... ______________________

What is patient wait time for urgent care? .... ______________________

What is patient wait time for symptomatic care? .... ______________________

What is patient wait time for scheduling routine visits? .... ______________________

What is patient wait time for scheduling routine care? .... ______________________

What is average wait time for patients between waiting room and examination? ______________________

What is average wait time in minutes for returning a patient's call? .... ______________________

Required Attachments or Supplemental Information

Please attach hard copy or scanned documents of the following:

- Copy(ies) of DEA registration certificate(s)
- Copy of state Controlled Dangerous Substance (CDS) registration certificate(s)
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and provider's name
- Copy(ies) of W-9(s) for verification of each tax identification number used
- Copy of workers compensation certificate of coverage, if applicable

SECTION 2 - DISCLOSURE QUESTIONS

Please answer each question and include an explanation for any question answered "Yes."

Licensure

1. Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board? .... ☐ Yes ☐ No

2. Have you ever received a reprimand or been fined by any state licensing board? .... ☐ Yes ☐ No

Hospital Privileges and Other Affiliations

3. Have your clinical privileges at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? .... ☐ Yes ☐ No

4. Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?.. ☐ Yes ☐ No

5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? .... ☐ Yes ☐ No

Education, Training and Board Certification

6. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? .... ☐ Yes ☐ No

7. Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?.. ☐ Yes ☐ No

8. Have any of your board certifications or eligibility ever been revoked? .... ☐ Yes ☐ No

9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? .... ☐ Yes ☐ No

DEA or CDS Certification/Authorization

10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished? ☐ Yes ☐ No

Medicare, Medicaid or Other Governmental Program Participation

11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, subject to a recovery action or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs? ☐ Yes ☐ No

Other Sanctions or Investigations

12. Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program? ☐ Yes ☐ No

13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? ☐ Yes ☐ No

14. Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? ☐ Yes ☐ No

15. Has a patient, employee, or co-worker ever accused you of sexual harassment or other illegal misconduct that resulted in an investigation, sanction or other formal action? ☐ Yes ☐ No

16. Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency? ☐ Yes ☐ No

Professional Liability Insurance Information and Claims History

17. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? ☐ Yes ☐ No

18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history? ☐ Yes ☐ No

Malpractice Claims History

19. Have you ever had any malpractice actions (pending, settled, dropped, dismissed, arbitrated, mediated or litigated)? If yes, provide information for each case on the attached form located at the end of the Disclosure questions (list all separately). ☐ Yes ☐ No

For any malpractice actions, please complete addendum and check this box: ☐

Criminal/Civil History
(Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all relevant circumstances, including the nature of the crime.)

20. Have you ever been arrested, charged or indicted for, convicted of, pled guilty to, or pled nolo contendere to any felony, crime or other offense in the last ten years or been found liable or responsible for or named as a defendant in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional? ☐ Yes ☐ No

21. Have you ever been arrested, charged or indicted for, convicted of, pled guilty to, or pled nolo contendere to any felony, crime or other offense in the last ten years or been found liable or responsible for or been named as a defendant in any civil offense that alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? ☐ Yes ☐ No

22. Have you ever been court-martialed for actions related to your duties as a medical professional? ☐ Yes ☐ No

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Ability to Perform Job

23. Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22 It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.) ☐ Yes ☐ No
24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? ☐ Yes ☐ No
25. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients? ☐ Yes ☐ No
26. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? ☐ Yes ☐ No

Please provide information below for Malpractice Actions indicated for Disclosure Question #19.

Date of occurrence: ______________________

Date claim was filed: ______________________

Claim/case status: ______________________

____

Professional liability carrier involved: ______________________

Address: ______________________

Telephone Number: ______________________

Policy Number: ______________________

Amount of award or settlement and amount paid: ______________________

Method of resolution: ☐Dismissed ☐Settled (with prejudice) ☐Settled (without prejudice) ☐Judgment for defendant(s) ☐Judgment for plaintiff(s) ☐Mediation or arbitration

Description of allegations: ______________________

____

____

____

Were you primary defendant or co-defendant? ______________________

Number of other co-defendants: ______________________

Your involvement in case (attending, consulting, etc.): ______________________

Description of alleged injury to the patient: ______________________

____

____

____

To the best of your knowledge, is this case included in the National Practitioner Data Bank (NPDB)? ☐Yes ☐No

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Please provide information below for any Disclosure Questions in Section II answered "Yes."	
Question No.	Explanation

Provider Initials: ______________________________ Date: ______________________________

SECTION 3 - AUTHORIZATION, ATTESTATION AND RELEASE

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as “Participation”) at or with ______________________________ (indicate managed care company(s) to which you are applying) (hereinafter, individually referred to as the “Entity”), and any of the Entity’s affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorizations

Investigation Concerning Application for Participation: I hereby authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity’s affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as “Agents”), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Third-Party Sources to Release Information Concerning Application for Participation: I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Release and Exchange of Disciplinary Information: I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party’s agents to release “Disciplinary Information,” as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, “Disciplinary Information” means information concerning: (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Provider Initials: ______________________ Date: ______________________

Releases

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

Attestation

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that the information provided on this application may be shared with appropriate State and federal agencies.

I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further understand and agree that submitting false, misleading or incomplete information may result in the imposition of administrative, civil and/or criminal sanctions, in accordance with State and federal law.

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Name (Print or Type)	Social Security Number
Signature	Date

Physician Assistant
Statement of Collaboration

This statement certifies that:

____is the Managing Physician of
(Managing Physician)

Record who works in collaboration with _________________________________,
(PA)

who practices as a _________________________________ and coordinates medical
(Specialty)

services provided to Horizon NJ Health members, as stated in the American Academy of

Physician Assistant's Standards of Practice. Our standard of practice/policies are

☐ attached hereto or are ☐ available for review during site visit to our facility.

____
Managing Physician Signature

____
Managing Physician name (printed)

Date: ____________________________________

Form **W-9**
(Rev. January 2003)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ________ ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

Note: *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person ▶** **Date ▶**

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a **nonresident alien or a foreign entity** not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments (29% **after** December 31, 2003; 28% **after** December 31, 2005). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under **4** above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note: *You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).*

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note: *If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.*

Exempt payees. Backup withholding is **not required** on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2);

2. The United States or any of its agencies or instrumentalities;

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities;

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities; or

5. An international organization or any of its agencies or instrumentalities.

Other payees that **may be exempt** from backup withholding include:

6. A corporation;

7. A foreign central bank of issue;

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States;

9. A futures commission merchant registered with the Commodity Futures Trading Commission;

10. A real estate investment trust;

11. An entity registered at all times during the tax year under the Investment Company Act of 1940;

12. A common trust fund operated by a bank under section 584(a);

13. A financial institution;

14. A middleman known in the investment community as a nominee or custodian; or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, **1** through **15.**

If the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for **9**
Broker transactions	Exempt recipients **1** through **13.** Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients **1** through **5**
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients **1** through **7** [2]

[1] See **Form 1099-MISC**, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are **not exempt** from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner **LLC** that is disregarded as an entity separate from its owner (see **Limited liability company (LLC)** on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note: *See the chart on page 4 for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5,** Application for a Social Security Card, from your local Social Security Administration office or get this form on-line at **www.ssa.gov/online/ss5.html**. You may also get this form by calling 1-800-772-1213. Use **Form W-7,** Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or **Form SS-4,** Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at **www.irs.gov**.

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN* ***or*** *that you intend to apply for one soon.*

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see **Exempt from backup withholding** on page 2.

Signature requirements. Complete the certification as indicated in **1** through **5** below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item **2** in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item **2** of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA or Archer MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] **You must show your individual name,** but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or Archer MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, or to Federal and state agencies to enforce Federal nontax criminal laws and to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

HORIZON
NJ HEALTH

Horizon Blue Cross Blue Shield of New Jersey*

Independent licensees of the Blue Cross and Blue Shield Association*

Horizon NJ Health, a product of Horizon HMO*

Professional Relations

Confidential Malpractice Information

Provider Name: ____

Date of Occurrence: ____

Malpractice Carrier: ____

Complaint/Allegation: _______________________________________

____

____

____

Role in the event: ____

____

____

____

Your own opinion of what occurred: ___________________________

____

____

____

Current Status of suit: ______________________________________

Signature: ________________________ Date: ______________

HORIZON
NJ HEALTH

Horizon Blue Cross Blue Shield of New Jersey*

Independent licensees of the Blue Cross and Blue Shield Association*

Horizon NJ Health, a product of Horizon HMO*

PROVIDER NETWORK SPECIAL NEEDS SURVEY

(Please complete all blank fields)

PHYSICIAN INFORMATION TAX ID#:________________

Name:____**Specialty:**______________________

Medicaid #:________________________**NPI#:**______________________

SERVICE ADDRESS

Address:____

City:____________________________ **State:**________**Zip:** ____________________

Telephone:____________________________ **Fax:** ______________________________

(Please check Yes or No and provide explanation if necessary)

1. Do you have formal training and/or experience treating adults/children with special needs including persons with physical, mental, substance abuse or developmental disabilities? Yes ☐ No ☐

DDD?	Yes ☐	No ☐
Blind?	Yes ☐	No ☐
Deaf?	Yes ☐	No ☐
Non-Ambulatory?	Yes ☐	No ☐
Non-Verbal?	Yes ☐	No ☐
HIV/Aids?	Yes ☐	No ☐
Aged?	Yes ☐	No ☐

If "Yes", please explain: ____

____

____

2. Do you have a specific area of interest or expertise in any medical or behavioral conditions / disorders? Yes ☐ No ☐

If "Yes", please explain: ____

____

Physician Signature or Designee:______________________________ **Date:**________________________

Horizon Blue Cross Blue Shield of New Jersey*

Horizon NJ Health

210 Silvia Street
West Trenton, NJ 08628
Phone: (609) 718-9001
www.horizonNJhealth.com

Americans with Disabilities ACT (ADA) Provider Survey

Physician Name ______________________________NPI:_______________________________

Group Name ____

Address* ___________________________________Office Phone_________________________

___________________________________Office Fax___________________________

____

(Complete a separate survey form for each office location.)

Part I. (This section to be answered by all providers):

1. Number of staff members (includes all medical professionals, members or partners of the professional association, technicians and support staff), employed at this office: ______________.

2. Year when the building in which provider's office is located was constructed: ___________.

3. Floor(s) of building on which provider's office is located: ___________.

4. Please answer following questions regarding architectural accessibility to provider's office:

   a) Is handicap parking available: Yes ☐ No ☐

[Parking for disabled persons must be located on the shortest accessible route of travel from adjacent parking to an accessible building entrance. In parking facilities that do not serve a particular building accessible parking spaces should be located on the shortest route to an accessible pedestrian entrance to the parking facility. When buildings have multiple accessible entrances with adjacent parking, accessible parking spaces should be dispersed and located near the accessible entrances which should be as level as possible with surface slopes not exceeding ¼ inch per foot in all directions. Each parking space should be marked with an R708 sign from the Manual of Uniform Traffic Control Devices displaying the International Symbol of Accessibility. The bottom edge of the sign shall be mounted approximately 60 inches above the parking lot surface. See sample attached.]

Information in brackets [thus]
from New Jersey Protection & Advocacy, Inc.

[Standard accessible spaces must have an access aisle at least 5 feet wide, and at least one of every eight accessible spaces must be van-accessible. Spaces that provide van access must have an access aisle at least 8 feet wide. The number of spaces for disabled persons that must be provided is determined by the total number of parking spaces available. For example:

1 – 25 spaces	**1 Accessible Space**
25 – 50 spaces	**2 Accessible Spaces**
51 – 75 spaces	**3 Accessible Spaces**
76 – 100 spaces	**4 Accessible Spaces**

[See ADAAG, 4.6]

b) Is path of travel from the parking lot to the entrance of the building in which the provider's office located barrier-free? Yes ☐ No ☐

[The path of travel should be continuous, barrier-free and slip-resistant. Curb ramps (also known as curb cuts) are required wherever an accessible route crosses a curb. It is important that transitions to curb ramps be flush. Lips at the bottom of ramps impede the momentum needed to propel a wheelchair up a slope. The running slope of a curb ramp cannot exceed 1:12. The minimum clear width of a curb ramp is 36 inches. It is also important that parked cars, lampposts, utility poles and other elements placed along sidewalks not obstruct connecting accessible routes. See ADAAG, 4.7]

c) Is there street-level access or an accessible ramp into the building in which the provider's office is located? Yes ☐ No ☐

[Where the running slope of an accessible route is more than 5%, it is considered a ramp. Slope and length determine a ramp's usability. A maximum slope of 1:12 is recommended, but the "least possible" slope is encouraged. Slopes should be consistent along the full length of the run. The minimum clear width for ramps is 36 inches and is measured between the leading edge of the handrails. Handrails with a diameter of 1 ¼ to 1 ½ inches are required on both sides for ramps with a rise of more that 6 inches or a horizontal length of more than 72 inches. Covering ramps with a canopy or roof is not required but should be considered to protect the ramp from becoming wet or icy. Landings at the top and bottom must be at least 60 inches long for maneuvering space. See ADAAG, 4.8]

d) If the provider's office is not on the first floor, is the office served by a working elevator which is accessible by a wheelchair or motorized scooter? Yes ☐ No ☐

[The call buttons for the elevator should be no more that 42 inches high. The elevator should have both visible and verbal indicators and the controls should have raised and Braille lettering. See ADAAG, 4.10]

e) Are the provider's office and other patient areas accessible by wheelchair and motorized scooter? Yes ☐ No ☐

[A continuous minimum clear width of 36 inches is required for accessible routes. A reduction to 32 inches is allowed for linear distances of no more that 24 inches, such as a doorway. For a double door, at least one leaf must be 32 inches wide. The threshold of a doorway must be ¼ inch or less, and if beveled, no more that ¾ inch high. The door handle must be no higher than 48 inches and operable with a closed fist. U-shaped handles are recommended].

[Registration and patient interview areas with built-in counters should be 28 – 34 inches high with knee spaces at least 27 inches high, 30 inches wide, and 19 inches deep. If this is not readily achievable, alternative measures such as a table or clipboard should be provided. See ADAAG, 4.2]

f) Are examination rooms accessible by wheelchair and motorized scooters? Yes ☐ No ☐

[Standard equipment is often difficult for people with disabilities to use. For example, standard height examining tables and traditional scales cannot be used by many people with disabilities. An adjustable height examining table is a good solution as is a portable low table. Additionally, allowing some tests to be performed from a wheelchair is also acceptable.]

g) Are the office's restrooms accessible by wheelchair and motorized scooter? Yes ☐ No ☐

[Signs to the restroom should be mounted on the wall. The doorway should be 32 inches clear with accessible handle 48 inches from the ground or less. The doors should be easily opened and the entry should provide 36 inches of clear width for forward movement and a 5-foot T-shaped clear space for turns. A minimum of 48 inches clear of the door swing is needed between the two doors of an entry vestibule. The past two fixtures should be 36 inches clear. The stall door should be operable with a closed fist. The toilet seat should be 17 – 19 inches high with grab bars on the wall near and behind the toilet. The sink should have a 30 inch wide by 48 inch deep clear space in front with a rim no higher than 34 inches and 29 inches from the floor to the bottom of the sink. The faucets should be operable with a closed fist and the soap dispenser should be within a reachable range. See ADAAG, 4.15 – 4.26.]

[Please also note: Issues of accessibility also include access for people with sensory impairments. It is customary to offer to orient a person with a vision impairment to his or her surroundings. If the person accepts the offer of assistance, a staff person should offer his or her arm and guide the person alerting him to obstacles along the way.

Methods of making printed material and forms accessible to people with vision impairments must be considered such as offering large print material, good lighting near the office, and inexpensive magnifier, or audio cassette materials. For people with hearing or speech impairments, short communication in writing is acceptable. Please

allow time to foster effective communication, if necessary. Providing a sign language interpreter may be necessary when discussing complex matters.]

If you answered "yes" to every question 4a through 4g above, please skip the remaining questions and sign the attached certification.

If you answered "no" to any question 4a through 4g, and:

a) The building in which the office is located was **built before January 1992 and structural alterations were made to the building after January 1992**, please **answer the questions in Part II** and sign certification.

b) The building in which the office is located was built **before January 1992, no alterations were made after that date and 15 or more staff are employed** at the office, please **answer questions in Part III** and sign certification.

c) The building in which the office is located was **built before January 1992, no alterations were made to it after that date and fewer than 15 staff are employed** at the provider's office, please answer the question in Part IV and sign certification.

Part II- Building constructed before 1992 with structural alterations made to building after that date:

5. What alterations were made to the building? ____

____

6. If the altered portions of the building affected the usability of the facility, are the altered portions of the office readily accessible to and usable by mobility–impaired and disabled individuals?

   Yes ☐ No ☐

7. If the answer to question 6 is "no", explain: ____

____

Part III – Building constructed before January 1992 – no alterations made to the building after that date—provider has 15 or more staff employed at that location:

8. Does the provider or group have an alternate accessible location where services can be provided to mobility impaired or disabled individuals? Yes ☐ No ☐

9. If the answer to question 8 is “yes”, please describe the facility, including its location and distance from the provider’s office.

____

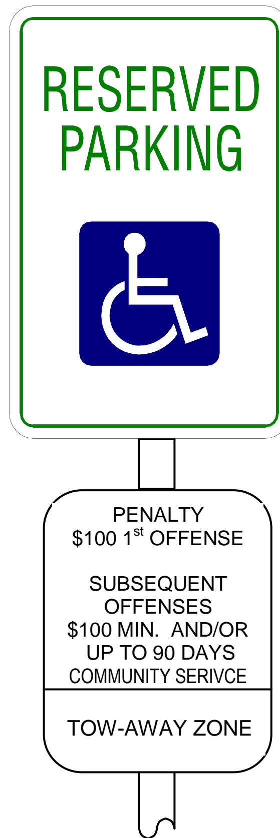
____

10. If the answer to question 8 is “no”, will the provider accommodate mobility impaired and disabled individuals through home visits? Yes ☐ No ☐

Part IV – Building constructed before January 1992—no alterations made to building after that date—provider has fewer than 15 staff employed at that location.

11. If you determine after conferring with a mobility-impaired or disabled individual, that you are unable to see the individual in your office without making significant architectural alterations to the building or office, are you, the provider, willing to see the patient at a mutually acceptable and appropriate accessible location?
Yes ☐ No ☐

New Jersey Handicapped Parking Laws



THE INDIVIDUAL COMPLETING THIS FORM MUST SIGN THE CERTIFICATION

CERTIFICATION OF ADA COMPLIANCE

Statement I

I hereby certify that I have reviewed the Americans with Disabilities Act (ADA), requirements which are set out on the attached sheet, that I have answered the above questions truthfully and the to best of my knowledge and that this (office/group practice) as well as the building in which it is located, meets the requirements of the ADA.

______________________________ Provider Name

______________________________ Provider Group Name

______________________________ Signature

______________________________ Date

-OR-

Statement II

I hereby certify that I have reviewed the Americans with Disabilities Act (ADA), requirements which are set out on the attached sheet, that I have answered the above questions truthfully and the to best of my knowledge and that this (office/group practice) has 15 staff members or less. Therefore, the ADA requirements do not apply.

______________________________ Provider Name

______________________________ Provider Group Name

______________________________ Signature

______________________________ Date