ARNP APPLICATION

Please attach:

1. Current VITAE
2. Malpractice declaration page
3. Copy of license
4. Current DEA registration
5. Copy of diploma
6. Completed W-9

Attach additional information on separate sheets if needed.

Date of application_____ DOB: _____

Name: _____
Last First MI

Citizenship _____ Status of Visa, if applicable _____

Name of group or clinic_____

Social Security #_____ TAX ID # _____

Medicare (UPIN) #_____ Medicaid #_____

License #_____ DEA Certificate #_____

NPI #_____

Please list the physician with whom you have protocol.

_____
Name

_____
Address

_____
Phone Number

_____

PROFESSIONAL LIABILITY INSURANCE

Insurance carrier_____

Policy #_____ Coverage dates from_____to _____

Coverage limits: Per occurrence_____ Aggregate_____

OFFICE LOCATION

Group Practice Name: _____

Do you bill under this group name? _____YES _____ NO

Primary Office Address	Secondary Office Address
_____	_____
_____	_____
_____	_____
( ) _____ Telephone	( ) _____ Telephone
( ) _____ FAX	( ) _____ FAX
Contact Person:_____	Contact Person:_____

BILLING

Checks should be made payable to:_____

Mail checks to: _____

_____

EDUCATION:

Nursing School_____ Year of Graduation_____

Location :_____Type of Degree_____

Graduate School_____ Year of Graduation_____

Location_____ Type of Degree_____

HOSPITAL AFFILIATIONS

List hospital name, location, and your hospital status (active, provisional, courtesy)

1. _____

2. _____

3. _____

PROFESSIONAL AFFILIATIONS

_____
Professional Organization/Committee

_____
Professional Organization/Committee

_____
Professional Organization/Committee

References

Please list three professional colleagues experienced with your professional work who we may contact for references:

_____ _____
Name Title

_____ _____
Company Phone

_____ _____
Name Title

_____ _____
Company Phone

_____ _____
Name Title

_____ _____
Company Phone

DISCIPLINARY ACTIONS

Has your license to practice medicine in any jurisdiction ever been suspended, revoked, or not renewed? yes ____ no ____

Have you ever voluntarily surrendered your license to practice medicine to avoid suspension or a disciplinary action? yes ____ no ___

Are you currently having, or have you been involved in any malpractice suits? yes ____ no ____

Has any malpractice carrier ever made an out-of court settlement or paid a professional liability claim on your behalf ? yes ____ no ____

Has your malpractice insurance ever been denied, cancelled, or restricted? yes ____ no ____

Have you ever been convicted of a felony, moral or ethical crime? yes ____ no ____

Have you ever been expelled, suspended from, or disciplined under the Medicare or Medicaid programs? yes ____ no ____

Have you ever been refused membership as hospital medical staff? yes ____ no ____

Have your requests for specific clinical privileges ever been denied or granted with stated limitations? yes ____ no ____

Are you now, or have you ever been, subject to discipline by any licensing authority or professional organization. yes ____ no ____

Do you have any ownership interest in any medical facility or joint ownership of any medical services or equipment with a facility to which you might refer patients? yes ____ no ___

Do you currently, or have you ever had a physical or mental health condition (including alcohol/substance abuse) that currently affects, ever affected, or could reasonably affect your ability to perform professional or medical practice duties appropriately? yes___ no___

Have you ever had any such condition in the past that is now resolved without the need for continuing therapy or medication? yes___ no___

Are you currently or at any time during the last ten years been hospitalized or received any other type of institutional care for any such condition/problem? yes___ no___

If you answered YES to any of the above questions, please provide a detailed description of all the relevant facts, on a separate sheet, including time frame, background and disposition.

SPECIFIC WAIVER AND CONSENT FOR CREDENTIALING AND UTILIZATION INFORMATION AND DATA

I, the undersigned, (hereinafter referred to as "Participating Physician") apply to become a member of the provider network of MehraVista Health.

I fully understand and agree that if there is any significant misrepresentation, misstatement, or omission of any information provided by me to MehraVista Health, whether intentional or not, shall constitute cause for an automatic termination of my membership.

I request that MehraVista Health process my application with regard to my clinical privileges and credentialing as a Participating Physician of MehraVista Health. As a condition of application and membership, I agree that to the fullest extent permitted by law, I extend immunity to release and hold harmless MehraVista Health, its successors and assigns, together with any of the employees, agents, independent contractors and physicians from liability relating to the sharing of information concerning my clinical privileges and credentials to become a participating Physician of MehraVista Health, together with all organizations or persons participating in or obtaining or providing information relative to my application and/or membership in the MehraVista Health network, for any communications, reports, records, statements, documents, recommendations or disclosures involving my clinical privileges and my credentials to become and/or remain a Participating Physician of MehraVista Health.

I recognize that this release and hold harmless shall have continuing effect, such that any information which is subsequently developed, or any decision subsequently rendered by MehraVista Health Credentialing Committee which affects, restricts or terminates my application or membership to the MehraVista Health network shall also be subject to release, and to immunity, and held harmless by me, my heirs and any assigns.

Furthermore, I agree to provide face-to- face services for which I have been contracted, and may not delegate such services to any other practitioner whether a participating provider or not with MehraVista Health.

I grant this permission continuously to the above mentioned party, beginning with the date of submission of my application to become a Participating Provider of the MehraVista Health network for as long as I am a member of the MehraVista Health network.

APPLICANT SIGNATURE _____ Date_____

Please print name_____

ATTENTION: PROFESSIONAL LIABILITY INSURACE CARRIER

_____

_____

_____

ADDRESS TO NOTIFY: MehraVista Health
Attention: Credentialing Dept.
32196 US Highway 19 N
Suite B
Palm Harbor, Fl, 34684

Please consider this letter your instruction to authorization to notify the Credentialing Department of MehraVista Health if there should be any change or lapse in my medical malpractice insurance.

_____ _____
Signature Date

_____
Print or type name

FEE SCHEDULE -ARNP

CPT CODE	REIMBURSEMENT
90801 (Initial psychiatric evaluation)	$135
90862(15 minute medication check)	$55