

MANAGED CARE SUPPLEMENT

This supplement must be completed only if you are submitting an application to a health plan, managed care organization, physician network or physician-hospital organization.

Check the status for which you are applying:

Primary Care Physician Only Specialty Care Physician Only Primary and Specialty Care Physician

I want to participate as this specialty : Primary _____ Secondary: _____

Do you regularly use a hospital emergency room for coverage of your patients (other than for emergency care)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you admit patients to the hospital under your own service?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you provide treatment to workers' compensation patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you practice family medicine, do you provide obstetrical care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you limit the age of patients you treat?	<input type="checkbox"/> Yes _____ min/max <input type="checkbox"/> No
Will you accept new patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No (Practice limited to existing pts.)
Do your facilities provide parking for the handicapped?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are your facilities wheelchair accessible?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your office multilingual? If yes, which language(s)? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your office employ a physician assistant, nurse practitioner or nurse midwife for direct care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Please check all that apply: <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Nurse Midwife Please submit any applicable plan of supervision if a PA, NP or CNM is employed in the office.	

Services you provide: Do you routinely provide the following services directly for your patients?

Routine Office Visits	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pap Smears	<input type="checkbox"/> Yes <input type="checkbox"/> No
In-Hospital Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodic Physical Exams	<input type="checkbox"/> Yes <input type="checkbox"/> No
Immunizations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prevention Care and Education	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your business telephone have an answering service/machine that is accessible at all times when you are not in the office?			<input type="checkbox"/> Yes <input type="checkbox"/> No
What arrangements do you have for 24 hour coverage for your patients when you are unavailable?			
Identify physicians in your coverage group.			
Please indicate instructions given to patients relating to after hours access to your office.			
List the name of the hospital(s) in Maine where you currently hold or have applied for staff privileges.			

MANAGED CARE SUPPLEMENT CONTINUED

What days and hours are **you** available to see patients in your office?

What days and hours is **your office** open and staffed to see patients?

	FROM	TO		FROM	TO
Monday			Monday		
Tuesday			Tuesday		
Wednesday			Wednesday		
Thursday			Thursday		
Friday			Friday		
Saturday			Saturday		
Sunday			Sunday		

Office Manager/Contact: _____

Credentialing Contact: _____

Please check type of practice: Individual Employee Partnership Office Sharing Corporation Group

Name of Individual or Corporation that should appear on reimbursement check

Street or PO Box City/State/Zip

Tax ID used at this address: _____

This Tax ID# is a- Federal Tax Identification No. Social Security No. Group ID No.

If you use more than one Tax ID number, please submit an IRS W-9 form for each.

REFERENCES

If the references listed on page 6 were not managed care participating physicians, please list two (2) physicians who are participating with a managed care organization.

Name	Phone	Fax
Address	City/State/Zip	
Name	Phone	Fax
Address	City/State/Zip	

I understand information submitted herein becomes part of my Application for participating with the Plan.

Signature

Date