UCSF Medical Group Health Plan Enrollment for MDs

University of California
San Francisco Medical Group

Contact Phone:

E-mail:

Provider Information

1) **Name** Last	First	Middle	Suffix *(Sr., Jr. etc)*	Degree *(MD, NP)*	2) **Are you enrolled in Medicare?** Yes ☐ No ☐ **PTAN:**	3) **Are you enrolled in Medi-Cal?** Yes ☐ No ☐ **PIN:**

Medicare/Medi-Cal

If you have more than one instance that needs to be addressed on the disclosures below, please use an additional page or attach an additional questionnaire with only the respective questions completed. It is the individual health care provider's responsibility to notify UCSF Medical Group Credentialing promptly should any changes occur in this application while it is being processed

4) Are you Board Certified? **Yes** ☐ **No** ☐ | **5)** Are you Board Eligible? **Yes** ☐ **No** ☐

6) (DHS 6207 11/11: K1) ***Within ten years of the date of this statement,*** have you the applicant/provider, been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ***If "Yes"****, please provide date of conviction (mm/dd/yyyy)* **Yes** ☐ **No** ☐

7) (DHS 6207 11/11: K2) **Within ten years of the date of this statement,** have you, the applicant/provider been found liable for fraud or abuse involving a government program in any civil proceeding? ***If "Yes"****, please provide date of final judgment (mm/dd/yyyy)* **Yes** ☐ **No** ☐

8) (DHS 6207 11/11: K3) **Within ten years of the date of this statement,** have you, the applicant/provider, entered into a settlement in lieu of conviction for fraud or abuse involving a government program? *If "Yes", please provide date of final settlement (mm/dd/yyyy)* **Yes** ☐ **No** ☐

9) (DHS 6207 11/11: K4) Do you, the applicant/provider, currently participate or have you ever participated as a provider in the Medi-Cal program or in another state's Medicaid program? **Yes** ☐ **No** ☐

If "Yes"*, please provide the following information:*

Name(s) (Legal and DBA) | NPI AND/OR Provider Numbers(s) | State

10) (DHS 6207 11/11: K5) Have you, the applicant/provider, ***ever*** been suspended from a Medicare, Medicaid, or Medi-Cal program? **Yes** ☐ **No** ☐

If "Yes", *please attach a verification of reinstatement and provide the following information:*

a) Check Applicable Program: Medi-Cal ☐ Medicaid ☐ Medicare ☐

NPI and/or Provider Number(s) | *Effective Date(s) of Suspension* | *Date(s) of Reinstatement(s) as Applicable*

11) (DHS 6207 11/11: K6) Has the individual license, certificate, or other approval to provide health care of the applicant/provider **ever** been suspended or revoked? **Yes** ☐ **No** ☐

If yes, *include copies of licensing authority decisions(s) for each decision and written confirmation from them that your professional privileges have been restored and provide the following information:*

Were Action(s) was taken | Action(s) Taken | Effective date(s) of licensing authority's action(s)

12) (DHS 6207 11/11: K7) Have you, the applicant/provider, ever lost or surrendered your license, certificate, or other approval to provide health care **while a disciplinary hearing was pending**? **Yes** ☐ **No** ☐

If yes, *attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:*

Were Action(s) was taken | Action(s) Taken | Effective date(s) of licensing authority's action(s)

13) (DHS 6207 11/11: K8) Has the license, certificate, or other approval to provide health care of the applicant/provider **ever** been disciplined by any licensing authority? **Yes** ☐ **No** ☐

If yes, *include copies of licensing authority decision(s) including any terms and conditions for each decision and provide the following information:*

Were Action(s) was taken | Action(s) Taken | Effective date(s) of licensing authority's action(s)

14) (DHS 6207 11/11: *I) List below fines/debts due and owing by applicant/provider to any federal, state, or local government that relate to Medicare, Medicaid and ***all*** other federal and state health care programs that have not been paid and what arrangements have been made to fulfill the obligation(s). ***Submit copies of all documents*** pertaining to the arrangements including terms and conditions. See California Code of Regulations (CCR), Title 22, Section 51000.50(a)(6). N/A ☐

Fine/Debt | Agency | Date Issued | Date to be Paid In Full

Psychologists

15) Do you have a doctoral degree in psychology? If "Yes", what field of Psychology do you hold your degree in? **Yes** ☐ **No** ☐

16) Do you inform each Medicare patient of the desirability of conferring with the patient's attending or primary care physician to consider potential medical conditions contributing to the patient's condition? **Yes** ☐ **No** ☐

17) Contingent upon the patient's consent, do you consult with the patient's designated attending or primary care physician in accordance with accepted professional ethical norms, taking into consideration the patient confidentiality? **Yes** ☐ **No** ☐

18) If the patient assents to the consultation, do you attempt to consult with the patient's physician within a reasonable time after receiving consent? **Yes** ☐ **No** ☐

UCSF MEDICAL GROUP MEMBERSHIP APPLICATION

Name

Last | First | Middle | Title

Address

Mailing Address | City | State | Zip

Phone

Office | Home | Pager/Cell

Email

Department	**Specialty**	**Subspecialty**	**Start Date**

I hereby consent to the disclosure and copying of information and documents relating to my credentials and qualifications by and between the UCSF Medical Group, and contracted commercial and government healthcare organizations and individuals acting as their agents. In this regard the utmost care shall be taken to safeguard the privacy of the applicant and the confidentiality of applicant records.

I hereby acknowledge that there shall be no liability on the part of, and no cause of action shall arise against any representative of the UCSF Medical Group for their acts performed in connection with evaluating my credentials and qualifications, and negotiating on my behalf *only* as a member of the UCSF Medical Group.

I release the UCSF Medical Group, and representatives of, from liability that the UCSF Medical Group may incur as a result of disclosing such information in accordance with the foregoing to the fullest extent provided under state or federal law.

I understand that I shall be afforded fair procedures with respect to my participation in the UCSF Medical Group in accordance with applicable state and federal regulation, including but not limited to, California Business and Professions Code Section 809 et seq.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) mandate I affirm that my National Provider Identifier (NPI) is _____ . If an NPI has not been procured by me or on my behalf, I authorize the UCSF Medical Group to procure one for me in accordance with the terms stated herein.

I hereby affirm that the information submitted in this application and any addenda thereto, is true to the best of my knowledge, is furnished in good faith. I also affirm that I will notify the UCSF Medical Group promptly should any changes occur to any of the information I have furnished during or after the health plan enrollment process with the UCSF contracted health plans.

I understand that significant omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or participation agreement. A photocopy of this document shall be as effective as the original.

By signing below, I acknowledge that I am aware that the SFHP Summary of Key Information is available for my review on the UCSF Medical Group website. http://medschool2.ucsf.edu/medgroup/san-francisco-health-plan

Printed/Typed Name of Applicant | Signature of Applicant

Date Signed

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:

   Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.

2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS *(Continued)*

FINAL ADVERSE LEGAL ACTION HISTORY

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed on page 12 of this application imposed against you?

☐ YES–Continue Below	☐ NO–Skip to Section 4

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

First Name	Middle Initial	Last Name	M.D., D.O., etc.

Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*

Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. For changes, only submit documents that are applicable to the change requested. The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. In addition, the Medicare fee-for-service contractor may also request documents from you, other than those identified in this section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

☐ Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
NOTE: If a supplier already receives payments electronically and is not making a change to his/her banking information, the CMS-588 is not required. (Moreover, physicians and non-physician practitioners who are reassigning all of their payments to another entity are not required to submit the CMS-588.)

☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2. (**NOTE:** This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)

MANDATORY, IF APPLICABLE

☐ Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit.

☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).

☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.

☐ Completed Form CMS-855R, Individual Reassignment of Medicare Benefits.

☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.

☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity (e.g., Form 8832). (**NOTE:** A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.)

☐ Copy of current CLIA and FDA certification for each practice location reported.

SECTION 4: AUTHORIZATION STATEMENTS

The signatures below authorize the reassignment of benefits to a supplier or the termination of a reassignment of benefits to a supplier, as indicated in Section 1.

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or supplier unless the individual practitioner who provided the services specifically authorizes another individual or supplier (employer, facility, or health care delivery system) to receive said payments in accordance with 42 C.F.R. 424.73 and 42 C.F.R. 424.80. By signing this Reassignment of Benefits Statement, you are authorizing the supplier identified in Section 2 to receive Medicare payments on your behalf.

Your employment or contract with this individual or supplier must be in compliance with CMS regulations and you must be in compliance with applicable Medicare program safeguard standards described in 42 C.F.R. 424.80. All individual practitioners who allow another supplier (employer, facility, or health care delivery system) to receive payment for their services must sign the Reassignment of Benefits Statement.

The signatures below acknowledge that you will abide by all laws and regulations pertaining to the reassignment of benefits.

A. Individual Practitioner

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Individual Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

B. Authorized or Delegated Official of Group Practice/Clinic

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Authorized or Delegated Official's Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

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Authorized or Delegated Official's Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

PROVIDER AGREEMENT

I declare under penalty of perjury under the laws of the State of California that the foregoing information and the information on all attachments is true, accurate, and complete to the best of my knowledge and belief and that I am authorized to sign this application pursuant to CCR, Title 22, Section 51000.30(a)(2)(B).

I understand that the failure to disclose the required information, or the disclosure of false information, shall, prior to any hearing, result in the denial of the application for enrollment or shall be grounds for termination of enrollment status and suspension from the Medi-Cal program, which shall include deactivation of all provider numbers used to obtain reimbursement from the Medi-Cal program. I understand that I must report changes in the foregoing information within 35 days to the Department of Health Care Services ("DHCS"), Provider Enrollment Division.

I hereby further declare that I will abide by all Medi-Cal laws and regulations and the Medi-Cal program policies and procedures as published in the Medi-Cal Provider Manual, including the requirements for record keeping and the disclosure of information. I understand that compliance with all Medi-Cal laws and regulations is a condition for participation as a provider in the Medi-Cal program.

I agree to make available, during regular business hours, all pertinent financial records, all records of the requisite insurance coverage, and all records concerning the provision of health care services to Medi-Cal beneficiaries to any duly authorized representative of DHCS, the California Attorney General's Medi-Cal Fraud Unit ("AG"), and the Secretary of the United States Centers for Medicare and Medicaid Services. I further agree to provide if requested by any of the above, copies of the records and documentation, and that failure to comply with any request to examine or receive copies of such records shall be grounds for immediate suspension of Applicant/Provider from participation in the Medi-Cal program. Applicant/Provider will be reimbursed for reasonable copy costs as determined by DHCS or AG.

I also agree that DHCS and/or AG may make unannounced visits to Applicant/Provider, at any of Applicant's/Provider's business locations, before, during or after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program, to investigate complaints of abuse and neglect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as necessary for the administration of the Medi-Cal program and/or the fulfillment of the AG's powers and duties under Government Code Section 12528. Premises subject to inspection include billing agents, as defined in Welfare and Institutions Code Section 14040.1. Failure to permit inspection by DHCS or AG, or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of Applicant/Provider from participation in the Medi-Cal program.

Printed legal name of applicant (last) (first) (middle)

Original signature of applicant

X

Executed at: San Francisco (City), CA (State) on / / (Date)

Notary Public:

Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ***ARE NOT REQUIRED*** to have this form notarized. If notarization is required, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

10. Contact Person's Information

☐ Check here if you are the same person identified in item 1. If you checked the box, provide only the e-mail address and telephone number below.

Contact Person's Name (Last)	(First)	(Middle)
DeLane	Michael	P

Title/Position	E-mail address	Telephone number
Director of Credentialing	delanem@ucsfmg.ucsf.edu	(415) 476-4029

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Care Services, Provider Enrollment Division, by the authority of Welfare and Institutions Code, Section 14043.2(a) and California Code of Regulations, Title 22, Section 51536. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Division at (916) 323-1945 or Denti-Cal at (800) 423-0507.