Provider Change Status Packet

Thank you for remaining in StayWell's Provider Network. In order to make changes to the services you provide to StayWell Members, you must complete our "Change Status" process and be approved prior to beginning the added services. The Change Status process updates our records and evaluates the professional competency for the added services provided to our members and updates.

We will make every effort to process your application in a timely and efficient manner.

Change Status is a five-step process:

1. The applicant will receive the Change Status application packet.

2. The completed application along with all applicable documents must be returned directly to StayWell Provider Relations Department at 520 Route 8 Maite Guam 96910 or email: provider.relations@staywellguam.com or jmqcoronel@staywellguam.com within 30-days from the date the application was received. The applicant must contact StayWell Provider Relations Department if he or she is unable to complete and return the application within the 30-day timeframe.

3. The application will be reviewed by StayWell's Provider Relations Department to ensure all information and documents are complete and accurate.

4. The completed and verified application packet will be forwarded to the Credentialing Committee for applicable approval or acceptance.

5. The applicant will be notified of the approving authority's decision.

The Change Status process may take up to 90 days for verification, review, and final approval. To prevent any delay in the process, application should be filled out completely, without blanks or missing requested documents. In the event that the application is incomplete, the applicant will be notified in writing by the StayWell Provider Relations Department of the deficiency no later than 45 days following receipt of application. Please note, no part of the application may be completed by referring to or writing "See Curriculum Vitae" and/or "See Enclosed/Attached."

If you should have any questions, please contact the StayWell Provider Relations Department:
Edna Carbonell – Contracts & Provider Relations Manager at (671) 477-5091 ext 1181
Jan Marie Q Coronel –Provider Network Credentialing Specialist at (671) 477-5091 ext 1189

Provider Change Status Application

Instructions:

1. Information must be typed or legibly printed.

2. All questions must be answered and forms must be signed where indicated.
   Incomplete applications will result in a delay in the Change Status request.

3. Please initial the bottom of each page of this application.

4. Please attach the following documents with your application:
   - Copy of Board Certification(s), if adding a specialty or sub-specialty.
   - Copy of all current State Professional License(s), supported by original License Verification(s) from the approving Board, if adding a specialty or sub-specialty.
   - Copy of W-9 (if applicable; when adding a new practice facility)
   - Current Drug Enforcement Administration (DEA) License (if applicable or if any changes were made)
   - Current Controlled Substance Registration (CSR) License (if applicable or if any changes were made)
   - Copy of front sheet of current professional liability insurance policy including applicant's name, effective date, expiration date, and policy limits (if applicable or if any changes were made)

Section 1 – Application Type:		
Please check one: ☐ Group ☐ Individual		
Section 2 – Identification Information:		
Last Name (JR, SR, etc.):	First Name:	Middle Initial:
List other names by which you have been known: Last Name (JR, SR, etc.):	First Name:	Middle Initial:
Social Security Number:		
Date of Birth (mm/dd/yyyy):	Place of Birth: City State	
Mailing Address:	City State	Zip Code
Phone Number: Home	Mobile/Other	
Email Address:		
Specialty:	Subspecialty:	
Section 3 – Current Practice Affiliation: List all in chronological order.		
Practice Name:		
Practice Name:		
Practice Name:		
Practice Name:		
Practice Name:		

APPLICANT INITIALS:

Complete this section if adding or removing Practice Facility/Hospital Affiliation.

Section 4a – Practice Facility Affiliation:

☐ Not Applicable

Please check one:

☐ Add ☐ Remove

Practice Name:			
Physical Address:	City	State	Zip Code
☐ Mailing Address: Same as Physical Address	City	State	Zip Code

Phone Number:	Fax Number:
☐ Practice Email Address: None	Taxpayer Identification Number (TIN):
Effective Date (mm/dd/yyyy):	

Section 4b – Practice Facility Affiliation:

☐ Not Applicable

Please check one:

☐ Add ☐ Remove

Practice Name:			
Physical Address:	City	State	Zip Code
☐ Mailing Address: Same as Physical Address	City	State	Zip Code

Phone Number:	Fax Number:
☐ Practice Email Address: None	Taxpayer Identification Number (TIN):
Effective Date (mm/dd/yyyy):	

APPLICANT INITIALS:

Section 4c – Hospital Affiliation:	☐ Not Applicable
Please check one: ☐ Add ☐ Remove	
Name of Institution:	
Address: City State Zip Code	
Dates Affiliated (mm/dd/yyyy - mm/dd/yyyy):	
Membership Status (Active, Courtesy, Consulting, Adjunct, Suspended/Terminated/Resigned, Active Professional Staff, Senior Staff, Associate, Provisional, Affiliate, Pending, Other [specify]):	
Department/Division:	Name of Department Chief/Chair Person (First, Middle Initial, Last):
Do you currently have privileges? ☐ Yes ☐ No	If Yes, list type of Privileges granted: (Provisional, Limited, Conditional, etc.)

Section 4d – Hospital Affiliation:	☐ Not Applicable
Please check one: ☐ Add ☐ Remove	
Name of Institution:	
Address: City State Zip Code	
Dates Affiliated (mm/dd/yyyy - mm/dd/yyyy):	
Membership Status (Active, Courtesy, Consulting, Adjunct, Suspended/Terminated/Resigned, Active Professional Staff, Senior Staff, Associate, Provisional, Affiliate, Pending, Other [specify]):	
Department/Division:	Name of Department Chief/Chair Person (First, Middle Initial, Last):
Do you currently have privileges? ☐ Yes ☐ No	If Yes, list type of Privileges granted: (Provisional, Limited, Conditional, etc.)

APPLICANT INITIALS:

Complete this section if adding a specialty or sub-specialty.

Section 5 – Board Certifications: ☐ Not Applicable
Please provide copies of all certification(s) with this application.

Specialty:		Issuing Board:	
Sub-specialty:		Issuing Board:	
Board Status:			
☐ Not Eligible	Please attach an explanation with this application.		
☐ Eligible	Current Status:	Date of exam: (mm/dd/yyyy)	
☐ Certified	Certificate Number:	Date Issued (mm/dd/yyyy):	Expiration Date (mm/dd/yyyy):

Complete this section if adding or making changes to Section 6, 7 and 8.

Section 6 – All current and past State Professional Licenses for any HealthCare discipline:
Please provide copies of all license(s) to include original License Verification(s) from the approving Board with this application.

State/Territory:	License Number:	Date Issued:	Expiration Date:	Status: ☐ Active ☐ Inactive
State/Territory:	License Number:	Date Issued:	Expiration Date:	Status: ☐ Active ☐ Inactive
State/Territory:	License Number:	Date Issued:	Expiration Date:	Status: ☐ Active ☐ Inactive
State/Territory:	License Number:	Date Issued:	Expiration Date:	Status: ☐ Active ☐ Inactive
State/Territory:	License Number:	Date Issued:	Expiration Date:	Status: ☐ Active ☐ Inactive

Section 7 – Controlled Substance: Not Applicable
Please provide copies of all certificate(s) with this application.

Do you administer or prescribe controlled substance? (Schedule II, III, or V medications) ☐ Yes ☐ No

If Yes, please complete the information below:

Drug Enforcement Administration (DEA) Certificate:	Certificate Number	Date Issued	Expiration Date
Controlled Substances Registration (CSR) Certificate:	Certificate Number	Date Issued	Expiration Date

APPLICANT INITIALS:

Section 8 – Professional Liability: Please provide copies of professional liability face sheet with this application.	☐ Not Applicable
Name of Insurance Carrier:	
Address: City State Zip Code	
Agent:	
Policy Number:	Type of Coverage: ☐ Claims Made ☐ Occurrence
Policy Effective Date (mm/dd/yyyy - mm/dd/yyyy):	Policy Expiration Date (mm/dd/yyyy - mm/dd/yyyy):
Policy Limits: Per Occurrence ($) Per Aggregate ($)	
Have any professional liability lawsuits been filed against you during the past ten years (including those closed)?	☐ Yes ☐ No
Are there any now still pending?	☐ Yes ☐ No
Has any judgment, payment of claim, or settlement ever been made against you in any professional liability cases?	☐ Yes ☐ No
Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?	☐ Yes ☐ No
Have you ever been denied professional insurance, or has your policy ever been cancelled?	☐ Yes ☐ No
If you answered "Yes" to any of the above, please provide full details/information on a separate sheet.	

APPLICANT INITIALS:

Section 9 – Testimonial and Release

PLEASE READ AND UNDERSTAND THE FOLLOWING BEFORE SIGNING THIS APPLICATION:

1. I fully understand that any significant misstatement in or omissions from this application constitute cause for denial.
2. All information submitted by me in this application is true to my best knowledge and belief.
3. I further declare that by submitting this application I hereby allow StayWell Insurance its affiliates and the employees, agents and representative thereof have permission to obtain information to access and verify my educational background and professional qualifications by authorizing StayWell Insurance to make inquiries and consult with all persons, places of employment, educational institutions, malpractice carriers, State or Territory licensing boards, or other similar government and non-government entities who have or may have information bearing on my moral, ethical, and professional qualifications and competence. This includes authorization for release of such information and copies of related records and/or documents to include not only the requested information for verification but information concerning each lawsuit, civil action, or other claim brought against me for malpractice or negligence; each disciplinary action under consideration or taken; any open or previously concluded investigations; and any changes in the status of a credential and all supporting documentation related to the information provided.
4. I hereby release from any liability all representatives of StayWell Insurance for acts performed in good faith in connection with evaluating my application and credentials and I release from liability all individuals and organizations which, in good faith, provide information to StayWell Insurance in response to such inquiries.
5. I understand that StayWell Insurance will rely upon the information given on this application form during the processing of my application to be a Participating Provider. A fully completed and signed application, and copies of necessary documents are essential for consideration.
6. I agree that I will immediately inform StayWell Insurance of any change or modification to the information provided herein, so that at all times, StayWell Insurance will have accurate and current information.

SIGNATURE OF APPLICANT: DATE:

PRINTED NAME OF APPLICANT:

REMARKS: