Provider Credentialing Packet

Thank you for your interest in becoming part of StayWell's Provider Network. Prior to beginning your service with StayWell Insurance, you must complete our credentialing process and be approved in our Network. The credentialing process evaluates a professional's eligibility and competency for providing services to StayWell Members.

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

Credentialing is a five-step process:

1. The applicant will receive the initial application packet. Provider Credentialing Packets are available for download through StayWell's web portal: https://www.staywellguam.com/health/providers-corner and/or can be obtained at the StayWell Insurance office: 520 Route 8 Maite Guam 96910.

2. The applicant will return the completed application along with requested documents within 30 days from the date application was signed directly to the StayWell Provider Relations Department at 520 Route 8 Maite Guam 96910 or email: provider.relations@staywellguam.com or jmqcoronel@staywellguam.com

3. The application will be reviewed by StayWell's Provider Relations Department to make sure all information is complete and accurate.

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

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

The credentialing process may take up to 90 to 180 days to verify, review, and obtain final approval. To expedite the process, your application should be without blanks or missing requested documents; if in the event 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 Coronel – Provider Network Credentialing Specialist at (671) 477-5091 ext 1189

Provider Credentialing 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 Credentialing Process.

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

4. Please attach the following documents with your application:
   - Letter of Intent
   - Copy of Business License (if applicable)
   - Copy of signed W-9 (if applicable)
   - Proposed Reimbursement Rates
   - Government Issued Picture ID (Valid Driver's License, Passport, etc.)
   - Resume/Curriculum Vitae (CV)
   - Copy of all current State Professional License(s), supported by original License Verification(s) from the approving Board
   - Current Drug Enforcement Administration (DEA) License (if applicable)
   - Current Controlled Substance Registration (CSR) License (if applicable)
   - Copy of professional school/diploma, residency certificates and fellowship certificates
   - Copy of Board Certification(s) (if applicable)
   - Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate (if applicable)
   - Copy of front sheet of current professional liability insurance policy including applicant's name, effective date, expiration date, and policy limits (if applicable)

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:	National Provider Identifier (NPI) Number:
Medicaid Number:	Medicare Unique Provider ID Number:
Specialty:	Subspecialty:

Are you a citizen of the United States? ☐ Yes ☐ No

If No, do you have the right to remain permanently in the United States? ☐ Yes ☐ No

Section 2a – Languages Spoken / Well-Women Care:

Any other language(s) spoken? ☐ Yes ☐ No
(For Provider Directory Information only)

If Yes, please specify:

Do you perform Well-Women Care Exams including Cervical Cancer Screening? ☐ Yes ☐ No ☐ Not Applicable

If Yes, please specify:

☐ Well-Women Care Exam only

☐ Well-Women Care Exam with Pap smear

☐ Pap smear only

APPLICANT INITIALS:

Section 3 – Current Practice/Primary Affiliation Information: Use Form SW-PCP 1 for additional Practice Affiliations			
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):		
Start Date (mm/dd/yyyy):			

Section 3.1 – General Hours:		
Day	Start (HH:MM)	End (HH:MM)
Sunday Closed	AM PM	AM PM
Monday Closed	AM PM	AM PM
Tuesday Closed	AM PM	AM PM
Wednesday Closed	AM PM	AM PM
Thursday Closed	AM PM	AM PM
Friday Closed	AM PM	AM PM
Saturday Closed	AM PM	AM PM

Section 4 – 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

APPLICANT INITIALS:

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

Section 5 – Controlled Substance:
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

Section 6 - Education:
Please provide copies of all degree, diploma and/or certificate(s) with this application.

Name of college or university which corresponds with the professional degree indicated:

Address:	City	State	Zip Code

Professional Degree: (Ex. MD, MA, DMD)	Date of Graduation (mm/dd/yyyy):

Section 7 – Internship: ☐ **Not Applicable**
Please provide copies of all degree, diploma and/or certificate(s) with this application.

Name of Institution:

Address:	City	State	Zip Code

Type:	Kind (Medical, Surgical, etc.):

Dates Attended (mm/dd/yyyy - mm/dd/yyyy):

Name of Program Director or Department Chair (First, Middle Initial, Last):

Program successfully completed? Yes ☐ No ☐
If No, please attach an explanation with this application.

Rotating ☐ Straight ☐	If Straight, list specialty:

Were you the subject of any disciplinary actions during your attendance at this institution? ☐ Yes ☐ No
If Yes, please attach an explanation with this application.

APPLICANT INITIALS:

Section 8 – Residency Programs: ☐ **Not Applicable**
Please provide copies of all degree, diploma and/or certificate(s) with this application.

Name of Institution:

Address: City State Zip Code

Type:

Dates Attended (mm/dd/yyyy - mm/dd/yyyy):

Name of Program Director or Department Chair (First, Middle Initial, Last):

Program successfully completed? ☐ Yes ☐ No

If No, please attach an explanation with this application.

Section 9 – Training, Fellowships, Preceptorships, Postgraduate Education: ☐ **Not Applicable**
Give complete school or hospital name and address, including ZIP code, beginning and ending dates, and name of your immediate superior. Please provide copies of degree, diploma and/or certificate(s) with this application.

Name of Institution:

Address: City State Zip Code

Type:

Dates Attended (mm/dd/yyyy - mm/dd/yyyy):

Name of Program Director or Department Chair (First, Middle Initial, Last):

Program successfully completed? ☐ Yes ☐ No

If No, please attach an explanation with this application.

Were you the subject of any disciplinary actions during your attendance at this institution? ☐ Yes ☐ No

If Yes, please attach an explanation with this application.

APPLICANT INITIALS:

Section 10a – Educational Commission for Foreign Medical Graduates (ECFMG): ☐ **Not Applicable** Please provide copies of all certification(s) with this application.	
Certificate Number:	Date Issued (mm/dd/yyyy):

Section 10b – Board Certifications: ☐ **Not Applicable** Please provide copies of all certification(s) with this application.			
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):

Section 11 – Hospital Affiliations: ☐ **Not Applicable** List all present and past affiliations in chronological order. Indicate “Membership Status” as: Active/Courtesy, etc., or Academic Title. Use an additional sheet if necessary.			
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:

Section 11 – Hospital Affiliations: ☐ **Not Applicable**

List all present and past affiliations in chronological order.
Indicate "Membership Status" as: Active/Courtesy, etc., or Academic Title. Use an additional sheet if necessary.

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 12 – Previous Group / Medical Practice:

List in chronological order all previous professional experience (including military experience) with current practice within the last five (5) years.

Name of Organization / Office Practice:			
Address:	City	State	Zip Code
Dates Practiced (mm/dd/yyyy - mm/dd/yyyy):			
Name of Organization / Office Practice:			
Address:	City	State	Zip Code
Dates Practiced (mm/dd/yyyy - mm/dd/yyyy):			
Name of Organization / Office Practice:			
Address:	City	State	Zip Code
Dates Practiced (mm/dd/yyyy - mm/dd/yyyy):			

APPLICANT INITIALS:

Section 13 – Professional Peer References:
List names, addresses and telephone numbers of three (3) professionals' references in your discipline who have supervised your clinic practice or have worked with you professionally and have personal knowledge of your professional competence and conduct. One professional peer reference must be an immediate supervisor where the applicant last furnished professional services.

Please complete Attachment A - "Applicant Peer-Reference Request Form" in this application.

Name (First, Middle Initial, Last):			
Address:	City	State	Zip Code
Phone Number:	Fax Number:		
Email Address:			
Name (First, Middle Initial, Last):			
Address:	City	State	Zip Code
Phone Number:	Fax Number:		
Email Address:			
Name (First, Middle Initial, Last):			
Address:	City	State	Zip Code
Phone Number:	Fax Number:		
Email Address:			

Section 14 – Professional Liability:
Please provide copies of professional liability face sheet with this application.

Name of Insurance Carrier:			
Address:	City	State	Zip Code
Agent:			
Policy Number:	Type of Coverage: ☐ Claims Made ☐ Occurrence		

APPLICANT INITIALS:

Section 14 – Professional Liability: Please provide copies of professional liability face sheet with this application.	
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.	

Section 15a – Attestation Questions: Professional Sanctions Please answer “Yes” or “No” to the following questions. If you answered “Yes” to any of the following, please provide full details/information on a separate sheet.	
1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled, and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn?	☐ Yes ☐ No
2. Have you ever been reprimanded and/or fined, been the subject of a complaint, and have you been notified in writing that you have been investigated as the possible subject of a criminal, civil, or disciplinary action by any state or federal agency that licenses providers?	☐ Yes ☐ No
3. Have you lost any board certification(s), and/or failed to rectify?	☐ Yes ☐ No
4. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank?	☐ Yes ☐ No
5. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended, or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?	☐ Yes ☐ No
6. Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation, or non-renewed?	☐ Yes ☐ No
7. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason?	☐ Yes ☐ No
8. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license?	☐ Yes ☐ No
9. Have you ever been reprimanded, censured, excluded, suspended, and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS, and/or any other governmental health-related programs?	☐ Yes ☐ No

APPLICANT INITIALS:

Section 15a – Attestation Questions: Professional Sanctions Please answer "Yes" or "No" to the following questions. If you answered "Yes" to any of the following, please provide full details/information on a separate sheet.	
10. Have Medicare, Medicaid, CHAMPUS, PRO authorities, and/or any other third-party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues?	☐ Yes ☐ No
11. Have you been denied membership and/or been subject to probation, reprimand, sanction, or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any healthcare organization, e.g., hospital, HMO, PPO, IPA, professional group or society, licensing board or certification board?	☐ Yes ☐ No
12. Have you withdrawn an application or any portion or an application for appointment or reappointment for clinical privileges or staff appointment or for license or membership in an IPA, PHO, professional group or society, healthcare entity, or healthcare plan prior to a final decision to avoid a professional review or an adverse decision?	☐ Yes ☐ No
13. Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country?	☐ Yes ☐ No
14. Have you been the subject of a civil or criminal or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, or elder abuse?	☐ Yes ☐ No
Section 15b – Attestation Questions: Health Status Please answer "Yes" or "No" to the following questions. If you answered "Yes" to any of the following, please provide full details/information on a separate sheet.	
1. Do you have a medical condition, physical defect, or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety?	☐ Yes ☐ No
2. Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation?	☐ Yes ☐ No
Section 15c – Attestation Questions: Chemical Substances or Alcohol Abuse Please answer "Yes" or "No" to the following questions. If you answered "Yes" to any of the following, please provide full details/information on a separate sheet.	
1. Are you currently engaged in illegal use of any legal or illegal substances?	☐ Yes ☐ No
2. 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

APPLICANT INITIALS:

Section 16 – 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:

Attachment A

Applicant Peer-Reference Request Form

NAME OF APPLICANT:
SPECIALTY:
Dear Sir / Madam: I have submitted an application for credentialing/recredentialing to StayWell Insurance. Please complete the information attached and return it directly to the StayWell Provider Relations Department at 520 Route 8 Maite Guam 96910 or email provider.relations@staywellguam.com or jmqcoronel@staywellguam.com. My signature authorizes you to complete the form at my request. Thank you for your prompt attention to this. PRINTED NAME OF APPLICANT: DATE:
SIGNATURE OF APPLICANT:

Malpractice Insurance Waiver Form

(Clinic Name) understands that Island Home Insurance Company (StayWell) will not be held liable in the event of any malpractice lawsuit brought against below-named provider of (Clinic Name)

(Clinic Name) understands that as part of Credentialing requirements and Provider Responsibilities, the facility must post information in the clinic or notify StayWell Members that the facility/provider does not possess Malpractice insurance.

This waiver is only valid for the duration of below-named provider's employment or business relationship with (Clinic Name) that is not insured with any malpractice insurance. This waiver will no longer be valid in the event that proof of malpractice insurance is submitted to StayWell.

PROVIDER NAME _____

_____

PROVIDER SIGNATURE Date

OFFICE MANAGER/OWNER (Print): _____

_____

OFFICE MANAGER/OWNER SIGNATURE Date