

JOIN STAYWELL'S PROVIDER NETWORK!

Thank you for your interest in becoming part of StayWell's Provider Network. In order to be a Participating Provider, applicants must submit the list of credentialing requirements below:

Credentialing Requirements

1. Letter of Intent
2. Copy of Business License
3. Signed copy of W-9
4. Accomplished StayWell Provider Application
5. Resume/Curriculum Vitae (CV)
6. Copy of Guam or CNMI Professional License
7. Copy of applicable Professional Certification and Education Certification
8. National Provider ID (NPI) Number
9. Drug Enforcement Administration (DEA) License (*if applicable for your practice*)
10. Controlled Substance Registration (CSR) License (*if applicable for your practice*)
11. Current National Practitioner Data Bank (NPDB) query result if you practiced in the United States (*NPDB must not be older than six (6) months*)
12. Copy of Medical Malpractice Insurance
13. Proposed Reimbursement Rates

For **Midlevel service providers** like Nurse Practitioners, Physician Assistants, and Counselors, we require **additional** supporting documents that would show:

14. Master's Degree with clinical practicum
15. Two (2) years of supervised clinical experience
16. For IMFTs and Counselors, course work for Master's Degree that includes courses in: psychopathology, human sexuality, marriage and family therapy and clinical practicum

You may find our Provider Application on the next page. Once completed, you may send all documents to the StayWell Provider Relations Department through the following:

Mail/Personal Delivery:

520 Route 8 Maite GU 96910
Attention: Provider Relations Department

Email:

provider.relations@staywellguam.com

Fax:

(671) 477-5096
Attention: Provider Relations Department



PARTICIPATING PROVIDER APPLICATION

- INSTRUCTIONS:**
1. This form must be typed or printed, fully completed, and signed.
 2. If more space is needed than provided on this application, attach additional sheet(s).
 3. Attach copies of all current licenses, registrations, certifications, and continuing medical education (CME) credits.

IDENTIFICATION INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOC. SEC. #
OFFICE ADDRESS (CITY, STATE, ZIP CODE)		OFFICE TELEPHONE NO.	TELEPHONE EXCHANGE
HOME ADDRESS (CITY, STATE, ZIP CODE)			TELEPHONE NO. /FAX NO.
U.S. CITIZENSHIP <input type="checkbox"/> YES <input type="checkbox"/> NO If no, do you have the right to remain permanently in the U.S.? <input type="checkbox"/> YES <input type="checkbox"/> NO			E-MAIL ADDRESS
PRESENT PRACTICE LIMITED TO			AVAILABLE DATE
PRESENT MEDICAL INTERESTS IN PRACTICE, RESEARCH, ETC.			NATIONAL PROVIDER IDENTIFIER (NPI)
PRACTICE WITH WHOM AND NATURE OF AFFLIATION			

PREMEDICAL EDUCATION

COLLEGE OR UNIVERSITY	DEGREE
ADDRESS	DATE OF GRADUATION

MEDICAL EDUCATION

MEDICAL SCHOOL	ADDRESS	DATE OF GRADUATION	DEGREE
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INTERNSHIP/RESIDENCIES

Indicate type of internship; Residencies; Fellowships; Preceptorship; Teaching appointments; Postgraduate Education (Chronological order, give dates, addresses, Chairman of Program)

PROGRAM	DATE (Month/Year)
ADDRESS	CHAIRMAN
PROGRAM	DATE (Month/Year)
ADDRESS	CHAIRMAN
PROGRAM	DATE (Month/Year)
ADDRESS	CHAIRMAN
PROGRAM	DATE (Month/Year)
ADDRESS	CHAIRMAN

FELLOWSHIP

AMERICAN COLLEGE OR ACADEMY	DATE (Month/Year)
OTHERS:	DATE (Month/Year)

BIBLIOGRAPHY

Please attach separate sheet.

MEMBERSHIP IN PROFESSIONAL SOCIETIES

CERTIFICATION (Please provide copies of all certifications)

ECFMG	NUMBER	DATE
FLEX AND/OR NATIONAL BOARDS	NUMBER	DATE
BOARD STATUS		
<input type="checkbox"/> NOT ELIGIBLE (Please explain on separate sheet)		
<input type="checkbox"/> ELIGIBLE	WHICH BOARD	DATE
<input type="checkbox"/> CERTIFIED	CERTIFICATON NUMBER	WHICH BOARD
		DATE

LICENSING (Please provide copies of all current licenses & registrations)

Medical License Number, Expiration Date, Date Issued	DEA REGISTRATION NUMBER, EXPIRATION DATE		
Other State Medical Licenses (Current or inactive within the last 5 years)			
STATE	LICENSE NO.	EXPIRATION DATE	CURRENT STATUS
STATE	LICENSE NO.	EXPIRATION DATE	CURRENT STATUS
STATE	LICENSE NO.	EXPIRATION DATE	CURRENT STATUS
STATE	LICENSE NO.	EXPIRATION DATE	CURRENT STATUS
STATE	LICENSE NO.	EXPIRATION DATE	CURRENT STATUS

MEDICAL REFERENCES

List names, addresses, and telephone numbers of three professionals in your discipline who have supervised your clinical practice or have worked with you professionally and have personal knowledge of your professional competence and conduct.

DOCTOR	ADDRESS	PHONE #
		FAX #
DOCTOR	ADDRESS	PHONE #
		FAX #
DOCTOR	ADDRESS	PHONE #

		FAX#
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AFFILIATIONS

List all current and previous hospital affiliations, starting with most current (include assistantships and appointments) for the last 5 years.

NAME OF PRIMARY ADMITTING HOSPITAL	ADDRESS	TYPE OF PRIVILEGES/DEPT.	DATE

PREVIOUS PRACTICE

LIST IN CHRONOLOGICAL ORDER (Including military experience) ALL PREVIOUS PROFESSIONAL EXPERIENCE WITH CURRENT PRACTICE FOR THE LAST 5 YEARS.

	DATE
	DATE
	DATE
	DATE
	DATE

PROFESSIONAL LIABILITY

LIST INSURANCE CARRIERS FOR THE LAST FIVE (5) YEARS. LIST ADDRESS FOR EACH.

DATE	NAME OF INSURANCE CARRIER AND ADDRESS	POLICY NUMBER	<input type="checkbox"/> OCCURRENCE <input type="checkbox"/> CLAIMS MADE	LIMITS OF COVERAGE

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES", PLEASE GIVE FULL DETAILS ON SEPARATE SHEET OF PAPER

1. Has any disciplinary action (including voluntary and involuntary limitation, suspension, revocation or probation) been taken against your license to practice medicine in any jurisdiction?..... Yes No

2. Have your privileges voluntarily or involuntarily been suspended, diminished, revoked, Limited, or not renewed?..... Yes No

3. Have you ever been denied membership or renewal thereof, or been subject to disciplinary Action in any medical organization?..... Yes No

4. Have claims, judgements or settlements been made against you in professional liability cases?..... Yes No

5. Are there any claims, judgements or settlements pending?..... Yes No
 If "Yes" to any of the above, please describe circumstances on separate sheet.

6. Have you ever been convicted of a felony, or are any such charges pending?..... Yes No
 (A response in the affirmative will not necessarily bar you from appointment. Circumstances will be judged on its merit, time, situation, and severity.)

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 authorize the StayWell Health Plan Medical Director or its designee to consult with persons associated with other hospitals with which I have associated and to inspect any records of such hospitals, or of other organizations or individuals, that may be material to the evaluation of my professional qualifications, competence, personality, morality, ethics, or the adequacy of my professional liability protection. This includes authorization for release of information maintained by any professional liability insurance carrier and related to coverage provided to me and any claims, suits, and settlements naming me or made on my behalf.
4. I hereby release from any liability all representatives of the StayWell Health Plan 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 the StayWell Health Plan, including otherwise privileged or confidential information.
5. I understand that StayWell Health Plan 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 Health Plan of any change or modification to the information provided herein, so that at all times, StayWell Health Plan will accurate and current information.

_____ Date _____ SIGNATURE OF APPLICANT _____

CREDENTIALS COMMITTEE		
_____ CHAIRMAN	_____ DATE	<input type="checkbox"/> Recommended <input type="checkbox"/> Not Recommended <input type="checkbox"/> Deferred
ADMINISTRATOR		
_____ ADMINISTRATOR	_____ DATE	<input type="checkbox"/> Approved <input type="checkbox"/> Not Recommended <input type="checkbox"/> Deferred

REMARKS
