StayWell INSURANCE

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. Accomplished StayWell Provider Application Form (you may download it below)
3. Resume/CV
4. Copy of CNMI or Guam Professional License
5. Copy of applicable Professional Certification and Education Certification
6. NPI (National Provider ID) Number
7. DEA License (if applicable for your practice)
8. National Provider Data Bank (NPDB) query result if you practiced in the United States

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

9. Master's Degree with a clinical practicum
10. Two years of supervised clinical experience
11. Course work for master's degree that includes courses in: psychopathology, human sexuality, marriage and family therapy and clinical practicum (IMFT Counselors)

You may find our Provider Application on the next page. Once all documents are completed, you may send it through email at provider.relations@staywellguam.com or via fax at 1.671.477.5096, Attention to Provider Relations.

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 ☐ YES ☐ NO If no, do you have the right to remain permanently in the U.S.? ☐ YES ☐ 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

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		
☐ NOT ELIGIBLE (Please explain on separate sheet)		
☐ ELIGIBLE	WHICH BOARD	DATE
☐ 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 your professionally and have personal knowledge of your professional competence and conduct.

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

		FAX#

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 ADDRESSPOLICY	NUMBER	☐ OCCURRENCE	LIMITS OF COVERAGE
			☐ OCCURRENCE ☐ CLAIMS MADE	

F 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	❑ Recommended ❑ Not Recommended ❑ Deferred
ADMINISTRATOR		
______________________ ADMINISTRATOR	______________ DATE	❑ Approved ❑ Not Recommended ❑ Deferred

REMARKS

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