PPO USA
THE PREFERRED NETWORK OF GEHA
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Provider Application

URAC ACCREDITED HEALTH NETWORK

General Information

PLEASE PRINT IN BLACK INK OR TYPE YOUR ANSWERS. THANK YOU.

Last Name ______________________ First Name ______________________ MI ______

Degree: ☐ MD ☐ DO ☐ DPM ☐ OD ☐ PhD ☐ EdD ☐ PsyD ☐ PT ☐ OT ☐ ST ☐ NP ☐ PA ☐ CRNA ☐ OTHER ________

SS#
__ __ __ /__ __ /__ __ __ __ Gender ☐ M ☐ F Date of Birth: ________________

License and Identification Numbers

Medical License Number ____________ State ________ Expiry Date __ __/__ __/__ __ Federal DEA Number ____________ Expiry Date __ __/__ __/__ __

Medical License Number ____________ State ________ Expiry Date __ __/__ __/__ __ State DEA Number ____________ State ________ Expiry Date __ __/__ __/__ __

____________ Medicaid # ____________ Medicare # ____________ NPI# ____________

Practice and Office Information

PLEASE LIST ALL OFFICE LOCATIONS WHERE YOUR PATIENTS ARE TREATED.
IF YOU HAVE MORE THAN TWO LOCATIONS, PLEASE ATTACH A SHEET GIVING THE OTHER LOCATIONS.

Location 1 **PROVIDER START DATE AT THIS LOCATION** ______ / ______ / ______ (MONTH / DAY / YEAR)

Name of Practice ______________________

Office Manager/Contact Name ______________________

Address ______________________

City ______________________ State ______________________

County ______________________ Zip Code __ __ __ __ __–__ __ __ __

Office Phone Number(s) (__ __ __) __ __ __–__ __ __ __ Tax ID# ______________________

Office Fax Number (__ __ __) __ __ __–__ __ __ __ Email Address ______________________

Billing Location 1

____

Address ______________________

City ______________________ State ______________________

County ______________________ Zip Code __ __ __ __ __–__ __ __ __

Phone Number (__ __ __) __ __ __–__ __ __ __ Tax ID# ______________________

Office Hours: **M**____ to _____ **T**____ to _____ **W**____ to ____ **TH**____ to _____ **F**____ to _____ **S**____ to _____ **SU**_____ to ____

Location 2 **PROVIDER START DATE AT THIS LOCATION** ______ / ______ / ______ (MONTH / DAY / YEAR)

Name of Practice ______________________

Office Manager/Contact Name ______________________

Address ______________________

City ______________________ State ______________________

County ______________________ Zip Code __ __ __ __ __–__ __ __ __

Office Phone Number(s) (__ __ __) __ __ __–__ __ __ __ Tax ID# ______________________

Office Fax Number (__ __ __) __ __ __–__ __ __ __ Email Address ______________________

Billing Location 2

____

Address ______________________

City ______________________ State ______________________

County ______________________ Zip Code __ __ __ __ __–__ __ __ __

Phone Number (__ __ __) __ __ __–__ __ __ __ Tax ID# ______________________

Office Hours: **M**____ to _____ **T**____ to _____ **W**____ to _____ **TH**____ to _____ **F**____ to _____ **S**____ to _____ **SU**_____ to ____

Do You Provide Services For:

New Patients	☐ Yes	☐ No
Medicare Patients	☐ Yes	☐ No
Medicaid Patients	☐ Yes	☐ No
Handicap Access	☐ Yes	☐ No
Schedule Same Day Appointments	☐ Yes	☐ No
Difficult To Schedule New Patients	☐ Yes	☐ No

Patient Age Limits: _____ Minimum Age
_____ Maximum Age

Languages Spoken In Office Other Than English: ______________________

Practice or Employment History

Please provide **last five years** history.(Your current practice is included.) If lapse in employment greater than 6 months, a written explanation is required.

Practice Name ______________________

Address ______________________

City ______________ State ______________

Zip Code __ __ __ __ __–__ __ __ __ Phone Number (__ __ __) __ __ __–__ __ __ __

____

From __ __ / __ __ (MO YR) To __ __ / __ __ (MO YR) Position Held ______________

Reason for leaving ______________________

Practice Name ______________________

Address ______________________

City ______________ State ______________

Zip Code __ __ __ __ __–__ __ __ __ Phone Number (__ __ __) __ __ __–__ __ __ __

____

From __ __ / __ __ (MO YR) To __ __ / __ __ (MO YR) Position Held ______________

Reason for leaving ______________________

Specialty Information

This information is needed for our paper and electronic directories. Please mark the applicable box(es) shown below.
Please indicate the corresponding location for each specialty by location number.

- ☐ Allergy/Immunology
- ☐ Anesthesiology
- ☐ Cardiology
- ☐ Cardiovascular Surgery
- ☐ Colon/Rectal Surgery
- ☐ Critical Care Medicine
- ☐ Critical Care Surgery
- ☐ Dermatology
- ☐ Emergency Medicine
- ☐ Endocrinology
- ☐ Family Practice
- ☐ Gastroenterology
- ☐ General Practice
- ☐ General Surgery
- ☐ Gerontology
- ☐ Gynecology (no OB)
- ☐ Gynecological Oncology
- ☐ Hand Surgery
- ☐ Head & Neck Surgery
- ☐ Hematology
- ☐ Hematology/Oncology
- ☐ Infectious Diseases
- ☐ Internal Medicine
- ☐ Maxillofacial Surgery
- ☐ Neonatology/Perinatology
- ☐ Nephrology
- ☐ Neurology
- ☐ Neuropsychiatry
- ☐ Neurosurgery
- ☐ Nuclear Medicine
- ☐ Obstetrics/Gynecology
- ☐ Oncology
- ☐ Ophthalmology
- ☐ Oral Surgery
- ☐ Orthopedic Surgery
- ☐ Otolaryngology/ENT
- ☐ Pathology
- ☐ Pediatrics
- ☐ Pediatric Allergy/Immunology
- ☐ Pediatric Cardiology
- ☐ Pediatric Critical Care Medicine
- ☐ Pediatric Endocrinology
- ☐ Pediatric Hematology/Oncology
- ☐ Pediatric Infectious Diseases
- ☐ Pediatric Nephrology
- ☐ Pediatric Neurology
- ☐ Pediatric Pulmonology
- ☐ Pediatric Surgery
- ☐ Perinatology
- ☐ Physical/Rehab. Medicine
- ☐ Plastic/Reconstructive Surgery
- ☐ Podiatry
- ☐ Psychiatry
- ☐ Psychiatry, Child
- ☐ Psychology
- ☐ Pulmonology
- ☐ Radiation Oncology
- ☐ Radiology/Rad. Subspecialties
- ☐ Reproductive Endocrinology
- ☐ Rheumatology
- ☐ Thoracic Surgery
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Other ______________ ______________

Please provide the additional information requested below concerning board status.

Board Certified Yes ☐ No ☐ Eligible ☐
Specialty ______________________

Name of Certifying Board ______________________

Date Certified __ __/__ __/__ __ Valid Until __ __/__ __/__ __

Board Certified Yes ☐ No ☐ Eligible ☐
Specialty ______________________

Name of Certifying Board ______________________

Date Certified __ __/__ __/__ __ Valid Until __ __/__ __/__ __

Educational Background

Medical / Specialty School Name

Address

City State

Zip Code ______–_____ From __/__/__ To __/__/__

Residency Facility

Address

City State

Zip Code ______–_____ From __/__/__ To __/__/__

Internship Facility

Address

City State

Zip Code ______–_____ Graduation Date __/__/__

Fellowship Facility

Address

City State

Zip Code ______–_____ From __/__/__ To __/__/__

If applicable: Foreign Medical Graduate Number ______________________________

Hospital Affiliations

Please list all hospitals where you have admitting privileges. Please attach separate sheet if needed.

Hospital Name

Address

City State

Zip Code ______–_____

Hospital Name

Address

City State

Zip Code ______–_____

Hospital Name

Address

City State

Zip Code ______–_____

Hospital Name

Address

City State

Zip Code ______–_____

Professional Liability Insurance Information

Name of Insurance Carrier and Phone Number

Address

City State

Zip Code ______–_____

Policy Number

Date Insured __/__/__ Expiry Date __/__/__

Per Occurrence $______________________ Aggregate $ ______________________

Malpractice Litigation Information: AN EXPLANATION OF EACH MALPRACTICE ACTION WITH THE DATE OF OCCURRENCE IS REQUIRED. PLEASE DO NOT LEAVE BLANKS.

Number of cases currently open: ____________________ Number of cases closed with payment: ____________________

Number of cases closed without payment: ____________________

Professional and Health Status AN EXPLANATION OF EACH YES ANSWER IS REQUIRED.

Are you or have you been subject to:

Suspension or limitation of hospital privileges? ☐ Yes ☐ No
Suspension as a Medicare or Medicaid provider? ☐ Yes ☐ No
Professional liability insurance denied, cancelled or not renewed? ☐ Yes ☐ No
State licensing investigation or action? ☐ Yes ☐ No
Revoked or suspended license? ☐ Yes ☐ No
DEA licensing investigation or action? ☐ Yes ☐ No
Plead guilty or convicted of a felony? ☐ Yes ☐ No
Chronic illness, physical defects or substance abuse that would impair your ability to practice? ☐ Yes ☐ No
Do you currently use illegal drugs? ☐ Yes ☐ No

IMPORTANT INFORMATION

We must have the following information in order for us to process your Application.

☐ Completed Application (Please include all separate sheets and any requested written explanations)
☐ Original Signed Participating Physician Agreement
☐ Copy of Your Current State License
☐ Copy of Your Board Certification or, if not Board Certified, a copy of your most recently completed school certificate
☐ Copy of Your DEA Certificate
☐ Proof of Malpractice Coverage (Copy of the Certificate of Insurance or policy fact sheet which reflects expiry date, insured's name, and malpractice limits)
☐ Copy of Your W-9

IF ALL REQUIRED INFORMATION/COPIES ARE NOT RETURNED WITH THIS APPLICATION, YOUR CREDENTIALING PROCESS WILL BE SIGNIFICANTLY DELAYED.

Credentialing Information (If different than practice location, please list.)

____
Address

____
City State Zip Code

Office Phone Number(s)(___) ___–____

Office Fax Number (___) ___–____

Contact ____________________

Authorization

I hereby certify that the information provided on this Application is true and correct to the best of my knowledge. I hereby authorize GEHA to contact individuals and organizations to obtain information pertaining to my qualifications. I agree that GEHA, its subsidiaries, employees or representatives, and individuals or organizations providing information to GEHA shall not be liable for any act or omission related to the verification of information provided in this Application. GEHA will treat information in this Application which is not publicly available as confidential, unless disclosure is required by law. I agree to advise GEHA of any changes in the information provided on this Application. I understand that submission of this Application does not guarantee participation in the PPO USA Network. A photocopy of this authorization shall be considered valid.

Provider Signature ____________________ Date ____________________
(original signature required)

If we have any questions about your Application, please give us a contact name: ____________________ Phone: ____________

If you have any questions about this Application, just call toll free 800-821-4991.

www.pplousanetwork.com

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Lee's Summit, MO 64064-6707
(800) 821-4991