Print Form

CONFIDENTIAL/PROPRIETARY

California Participating Physician Application

Addendum A

Health Plans and IPA's/Medical Groups

This Addendum is submitted to: MDI herein, this Healthcare Organization. [1]

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:

Medical Group (s) /IPA(s) Affiliation:

Do you intend to serve as a primary care provider? ☐ Yes ☐ No
Do you intend to serve as a specialist? ☐ Yes ☐ No (If yes, please list specialty(s))

Please check all that apply:
☐ Solo Practice ☐ Single Specialty
☐ Group Practice ☐ Multi specialty

II. BILLING INFORMATION

Billing Company:

Street Address:	City:	
	State:	ZIP:
Contact:	Telephone Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

III. PRACTICE INFORMATION

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? ☐ Yes ☐ No
If so, please list:

Name: Type of Provider: License Number:

_____
_____
_____
_____
_____

If you are a Physician Assistant Supervisor, please include State License Number: _____
Do you personally employ any physicians (do not include physicians that are employed by the medical group)? ☐ Yes ☐ No
If so, please list:

Name: California Medical License Number:

_____ _____
_____ _____

Please list any clinical services you perform that are not typically associated with your specialty: _____

Please list any clinical services you **do not** perform that are typically associated with your specialty: _____

Is your practice limited to certain ages? ☐ Yes ☐ No
If yes, specify limitations: _____

[1] The term "this Healthcare Organization" shall refer to the entity to which this Addendum is submitted as identified above.

Physician Name: _____

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council?	☐ Yes	☐ No
Do you participate in EDI (electronic data interchange)?	☐ Yes	☐ No
If so, which Network? _____		
Do you use a practice management system/software:	☐ Yes	☐ No
If so, which one? _____		

What type of anesthesia do you provide in your group/office?
☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other (please specify) _____

Has your office received any of the following accreditations, certifications or licensures?
- ☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- ☐ California Department of Health Services Licensure
- ☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
- ☐ Medicare Certification
- ☐ The Medical Quality Commission (TMQC)
- ☐ Other _

IV. OFFICE HOURS - Please indicate the hours your office is open:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holidays

V. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary)

Answering Service Company:	Phone Number: ( )	Fax Number: ( )
Mailing Address:	City:	
	State:	ZIP:
Covering Physician's Name:	Telephone Number: ( )	
Covering Physician's Name:	Telephone Number: ( )	
Covering Physician's Name:	Telephone Number: ( )	
Covering Physician's Name:	Telephone Number: ( )	

If you do not have hospital privileges, please provide written plan for continuity of care:

VI. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:	Fluently by Staff:

VII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

Tax ID #:	Billing Name:	Type of Service Provided:
Do you have a CLIA certificate?	☐ Yes	☐ No
Do you have a CLIA waiver?	☐ Yes	☐ No
Certificate Number:		Certificate Expiration Date:

VIII. PROFESSIONAL ORGANIZATIONS

Please list country, state or national medical societies, or other professional organizations or societies of which you are a member or applicant.

Organization Name	Applicant	Member
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

I certify that the information in this document and any attached documents is true and correct.

Print Name Here: _____

Physician Signature: _____ Date: _____

(Stamped Signature Is Not Acceptable)