CONNECT
Transitional Care Management

801-820-0085

Connect Transitional Care Management ® Provider Network Application Checklist

To apply for the CONNECT Panel, please return the following items:

COMPLETED AND SIGNED

- ☐ Connect Transitional Care Management Provider Network Application
- ☐ Non-Disclosure Agreement

INCLUDE A COPY

- ☐ Informational Brochures of Entity
- ☐ Insurance List of Entity

RETURN ALL MATERIALS TO:
Connect Transitional Care Management
Email: connect@conecttcm.org

PERSONAL ENTITY INFORMATION

General Instructions:
Please complete the application in full, including addresses where indicated. Incomplete applications will be returned.

Date of Application: _____ Individual NPI# _____

Contact Person: _____

Phone: _____ Email: _____

Entity Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

SPECIALTY / AREA OF FOCUS

- ☐ Home Health
- ☐ Hospice
- ☐ DME
- ☐ Specialty Pharmacy
- ☐ Medical Practice: _____
- ☐ ALF / SNF
- ☐ Other Specialty: _____

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ADDITIONAL INFORMATION

The following information is collected for provider directories and customer service use.

	OFFICE HOURS / ADDITIONAL HOURS	OFFICE MANAGER NAME	INTAKE / APPOINTMENT CONTACT INFORMATION	AFTER HOURS CONTACT INFORMATION
MAIN OFFICE				
OFFICE 1				
OFFICE 2				

Foreign Language(s) Spoken: _____

Handicap Access: ☐ Yes ☐ No

Accepting New Patients: ☐ Yes ☐ No

Patient Age Restrictions: ☐ Yes ☐ No If restrictions, explain: _____

Hospital Privileges (if applicable): _____

Accepted Patient Payment Methods: ☐ Cash ☐ Check ☐ Credit Card ☐ Payment Plan ☐ Medicare / Medicaid

ENTITY ATTESTATION INFORMATION

A. PROFESSIONAL SANCTIONS

1.	Have you ever been, or are you now in the process of being denied, revoked terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?	
	a. License to practice stated profession in any jurisdiction	☐ Yes ☐ No
	b. Other professional registration or certification in any jurisdiction	☐ Yes ☐ No
	c. Specialty or sub-specialty board certification	☐ Yes ☐ No
	d. Membership on any hospital medical staff	☐ Yes ☐ No
	e. Clinical privileges at any facility, including hospitals	☐ Yes ☐ No
	f. Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	☐ Yes ☐ No
	g. Professional society membership or fellowship	☐ Yes ☐ No
	h. Participation/membership in an HMO, PPO, IPA, PHO or other(s)	☐ Yes ☐ No
	i. Academic Appointment	☐ Yes ☐ No
	j. Authority to prescribe controlled substances (DEA or other authority)	☐ Yes ☐ No
	k. Is your Medical Director associated with a Clinic? If yes , please specify? _____	☐ Yes ☐ No

2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, and professional association or education/training institution?	☐ Yes ☐ No
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?	☐ Yes ☐ No
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?	☐ Yes ☐ No

B.	**CRIMINAL HISTORY**	
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community services or other obligation?	☐ Yes ☐ No
	a. Do you have notice of any such anticipated charges?	☐ Yes ☐ No
	b. Are you currently under governmental investigation?	☐ Yes ☐ No

C.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY**	
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?	☐ Yes ☐ No
2.	Are there any such claims being asserted against you now?	☐ Yes ☐ No
3.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?	☐ Yes ☐ No
4.	Are you currently involved in any claims that may be considered detrimental to the Connect Transitional Care Management network? If yes, please describe in detail below:	
5.	On a scale of 1-10, how do you rank your financial stability as an entity? Please explain in detail below: *Enter score of 1 - 10 here*	

STATEMENT

In the space provided, please provide a brief statement as to why you feel your entity should participate as in an in-network provider of Connect Transitional Care Management and what your entity has to offer:

SIGNATURES

I hereby certify that the information in this application is true and complete and that is fairly and accurately discloses all matters requested. I understand that any omissions, misrepresentations, or inaccuracies in this application constitute cause for denial of my application and/or may be cause for my summary dismissal from Connect Transitional Care Management network participation.

I agree to report any malpractice claims filed against me to Connect Transitional Care Management. I have read, understand, and have signed the document entitled Non-Disclosure Agreement. I intend and agree that all the consents, releases, waivers, and other provisions in that document will apply both to the process of considering and evaluating this application and to my panel participation, if approved and granted.

Signature:_____ Date:_____

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FOR OFFICE USE ONLY

Date of Review: _____ Review Board: _____

☐ Approved ☐ Denied

COMMENTS:

Signature(s): _____