

Wellmark, Inc.

Iowa Universal Practitioner Application Addendum

To apply for participation in Wellmark networks, please complete this Addendum in addition to the *Iowa Statewide Universal Practitioner Application*. **You are only required to answer the questions that apply to your specialty.**

M.D./D.O., D.P.M., P.A., A.R.N.P. excluding allergy, anesthesiology, dermatology, emergency room, genetics, occupational medicine, pathology, psychiatry and radiology

Hospital Admitting Privileges

- I attest that I have hospital admitting privileges at the hospitals identified in Section E.
- I do not have hospital privileges but have the following arrangement for my patients to be admitted:
- Arrangement for admitting hospitals admissions by referral to a Wellmark participating physician or physician group.

Name of physician or physician group City/State

- Arrangement for hospital admissions by a Wellmark participating hospitalist or hospitalist group.

Name of physician or physician group City/State

Obstetrical Services (Family Practice, General Practice, Ob-Gyn, P.A., A.R.N.P. practicing in family or general practice or Ob-Gyn)

- If a Family or General Practitioner, do you perform Obstetrical services? Yes No
- If a Family or General Practitioner performing Obstetrical services, do you perform deliveries? Yes No
- If an Obstetrics/Gynecology Practitioner, do you perform obstetrical services? Yes No

Primary Care Providers (PCPs) PCPs are Family and General Practice Physicians, Internists, Pediatricians, and in some cases, Physician Assistants and Advanced Registered Nurse Practitioners.

Payment Options (Blue Advantage and Blue Choice)

PCPs participating in Blue Choice or Blue Advantage must choose to be paid capitation or fee-for-service. Please select one payment option below.

- Capitation on primary medical/surgical services
- Fee-for-service

M.D./D.O., P.A., and A.R.N.P. and D.P.M.

State or Federal Controlled Substance

Level of drugs you can prescribe: 2 3 4 5 2N 3N

If you do not have a current FDEA or CDS, please provide the name(s) of the practitioner(s) who will prescribe for your patients

Name	Title	NPI	Address	FDEA/CDS

M.D./D.O., P.A., and A.R.N.P. who work in urgent care clinics

Urgent Care - defined as a primary care walk-in clinic that is accessible by all patients and open extended hours beyond 8am - 5pm, Monday through Friday

Are you performing urgent care services at all practice locations? Yes No

If no, enter which locations are urgent care. (If you need more space, use the last page of this addendum.)

Clinic Name	Complete Address

Psychologists, Ph.D., Ed.D., Psy.D.

Licensing Information

Are you listed in the National Registry of Health Service Providers in Psychology? Yes No

If yes, please indicate Registrant Number _____

Original Issue Date ____/____/____
Mo Day Yr

Iowa HSP (Health Service Provider) Number _____

Date Issued ____/____/____ Exp. Date ____/____/____
Mo Day Yr Mo Day Yr

Licensed Dietitians/Nutritionists - for TRICARE only

_____/_____/_____
CDR Registration Number Registration Date Expiration Date

Provide the name and address of the diabetes education program where you work.

Name Street Address

City/State/Zip Phone Number

NPI of accredited program

Which organization accredits this diabetes education program? ADA AADE

Accreditation Effective Date ____/____/____ Expiration Date ____/____/____

Provide the name and NPI of the physician that oversees the ADA or AADE accredited diabetes education program.

Name NPI

Imaging Services Performed at your site

- | | | |
|---|---|---------------------------------|
| <input type="checkbox"/> CT | <input type="checkbox"/> MRI | <input type="checkbox"/> PET |
| <input type="checkbox"/> CTA | <input type="checkbox"/> Mammography | <input type="checkbox"/> PET/CT |
| <input type="checkbox"/> Echocardiography | <input type="checkbox"/> Nuclear Cardiology | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> MRA | | |

Clinic Authorization and Agreement

For clinics with two or more providers - Please sign the following authorization for payment if you are billing as a clinic and want payment to come to you in the name of the clinic.

I authorize Wellmark Blue Cross and Blue Shield of Iowa to make payment to

Clinic Name _____

Clinic Address _____

_____ for services that I perform. I agree that charges for my services will be uniform with all other physicians or health care providers that practice in the clinic named above.

Practitioner's Signature _____ Date ____/____/____

Military

Are you subject to mobilization as a member of a reserve or guard unit? Yes No

Which Branch? Army Air Force Navy Coast Guard Air National Guard Marine Corps

Hospital-Based Practitioners

If you practice exclusively in a hospital setting, you are considered hospital-based. However, if you practice at other site(s) outside the hospital and would like your name to appear in Wellmark's provider directory, you will need to be credentialed.

Do you see patients outside of the hospital? Yes No

Do you want to be listed at the other site(s) identified in the *Iowa Statewide Practitioner Universal Application*, in the Wellmark provider directory? Yes No

Ownership - If you have multiple affiliations please copy page and complete for each affiliation.

Document current affiliations with other health care or health related organizations.

Organization Name _____

Address _____ City _____ State _____ Zip _____

Start Date ____/____/____ End Date ____/____/____

Position Held _____ Compensated Yes No

Do you own or a family member own or have ownership interest in a healthcare facility or organization that provides health or medical services (lab, nursing home, pharmacy, radiology/imaging center, rehab, HMO, medical equipment supplier, etc.)?

Yes No

If yes, then provide the following:

Name of Facility _____

Address _____

Percent of Ownership _____ Owned By _____

Name of Organization _____

All Practitioners (cont.)

Med/Surg & Behavioral Health Practice Focus

Please check those capabilities in which you focus your practice. These may or may not be a covered benefit. The information provided may be used to direct members to providers that practice in the areas indicated below.

Medical/Surgical

MD/DO's Only Surgery: <input type="checkbox"/> Bariatric <input type="checkbox"/> Breast <input type="checkbox"/> Gastric <input type="checkbox"/> Oncology <input type="checkbox"/> Mastectomy <input type="checkbox"/> Reconstructive <input type="checkbox"/> Gynecological Oncology <input type="checkbox"/> Other (Specify) _____	Medical Services: <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS) <input type="checkbox"/> Autism (speech) <input type="checkbox"/> Developmental Disabilities (speech) <input type="checkbox"/> EMG <input type="checkbox"/> Epilepsy <input type="checkbox"/> HIV <input type="checkbox"/> Huntington's Disease <input type="checkbox"/> Memory Loss <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Short Term Pain Management <input type="checkbox"/> Sleep Studies <input type="checkbox"/> Sleep Studies - Prosthetics <input type="checkbox"/> Telemedicine Services <input type="checkbox"/> Ultrasound only <input type="checkbox"/> Urodynamics <input type="checkbox"/> Venous Closures	Nurse Practitioners and Physician Assistants: <input type="checkbox"/> Allergy/Immunology <input type="checkbox"/> Cardiology <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Other (Specify) _____ Orthopedics: <input type="checkbox"/> Arthroscopic <input type="checkbox"/> Back Surgery <input type="checkbox"/> Elbow <input type="checkbox"/> Foot and Ankle <input type="checkbox"/> Hip Surgery <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Knee Surgery <input type="checkbox"/> Shoulder Surgery <input type="checkbox"/> Wrist	Ophthalmology: <input type="checkbox"/> Cataract Laser Surgery <input type="checkbox"/> Cornea Specialist <input type="checkbox"/> Glaucoma Specialist <input type="checkbox"/> Oculoplastics <input type="checkbox"/> Orbit Specialist <input type="checkbox"/> Retinal Specialist <input type="checkbox"/> Strabismus Specialist Transplant: <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Cornea <input type="checkbox"/> Heart <input type="checkbox"/> Heart/Lung <input type="checkbox"/> Kidney <input type="checkbox"/> Liver <input type="checkbox"/> Liver/Kidney <input type="checkbox"/> Pancreas/Kidney <input type="checkbox"/> Small Intestine <input type="checkbox"/> Small Intestine/Liver <input type="checkbox"/> Tissue
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Behavioral Health Practitioners Only

<input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Addictions <input type="checkbox"/> Adjustment Disorder <input type="checkbox"/> Adoption Issues <input type="checkbox"/> Anger Management <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Applied Behavioral Analysis <input type="checkbox"/> Asperger's Syndrome <input type="checkbox"/> Autism <input type="checkbox"/> Behavior Modification <input type="checkbox"/> Bi-Polar Disorder <input type="checkbox"/> Biofeedback <input type="checkbox"/> Child Abuse <input type="checkbox"/> Christian Counseling	<input type="checkbox"/> Chronic Mental Illness <input type="checkbox"/> Chronic Physical Illness <input type="checkbox"/> Co-Dependency <input type="checkbox"/> Cognitive Behavioral Therapy <input type="checkbox"/> Combat Related Post Traumatic Stress Disorder <input type="checkbox"/> Compulsive Gambling <input type="checkbox"/> Conduct/Disruptive Disorders <input type="checkbox"/> Couples/Marriage Therapy <input type="checkbox"/> Crisis Diversionary Services <input type="checkbox"/> Crisis Intervention Services <input type="checkbox"/> Critical Incident Debriefing <input type="checkbox"/> Depressive Disorder <input type="checkbox"/> Developmental Disabilities	<input type="checkbox"/> Dialectical Behavior Therapy <input type="checkbox"/> Disability Evaluation <input type="checkbox"/> Dissociative Disorder <input type="checkbox"/> Divorce <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Dual Diagnosis <input type="checkbox"/> EMDR <input type="checkbox"/> Eating Disorders <input type="checkbox"/> Electro-Convulsive Therapy (ECT) <input type="checkbox"/> Faith-based Counseling <input type="checkbox"/> Family Therapy <input type="checkbox"/> Forensic/Sex Offenders <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Grief Counseling
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All Practitioners (cont.)

Behavioral Health Practitioners Only (cont.)

<input type="checkbox"/> Gender Identity	<input type="checkbox"/> Obesity Assessment & Counseling	<input type="checkbox"/> Psychological Testing
<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Obsessive Compulsive Disorder	<input type="checkbox"/> Psychosomatic
<input type="checkbox"/> Head Injury Patients	<input type="checkbox"/> Organic Brain Syndrome	<input type="checkbox"/> Psychotic Disorders
<input type="checkbox"/> Hearing Impaired Issues	<input type="checkbox"/> Organic Disorders	<input type="checkbox"/> Rape Victims
<input type="checkbox"/> HIV Positive/AIDS Patients	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Schizophrenic Disorders
<input type="checkbox"/> Home Based Services	<input type="checkbox"/> Panic Disorder	<input type="checkbox"/> Sex Offender
<input type="checkbox"/> Home Care/Home Visits	<input type="checkbox"/> Parenting Skills	<input type="checkbox"/> Sexual Abuse/Violence
<input type="checkbox"/> Hypnosis	<input type="checkbox"/> Pastoral Counseling	<input type="checkbox"/> Sexual Dysfunction
<input type="checkbox"/> Infertility	<input type="checkbox"/> Pervasive Development Disorders	<input type="checkbox"/> Sexual Harassment
<input type="checkbox"/> Inpatient Therapy	<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Sleep Disorders
<input type="checkbox"/> Learning Disabilities	<input type="checkbox"/> Phobias	<input type="checkbox"/> Somatoform Disorders
<input type="checkbox"/> Medical Stress/Behavioral Med	<input type="checkbox"/> Physical Abuse/Violence	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Medication Management	<input type="checkbox"/> Physically Impaired Patients	<input type="checkbox"/> Terminally Ill Patients
<input type="checkbox"/> Men's Issues	<input type="checkbox"/> Play Therapy	<input type="checkbox"/> Visually Impaired Patients
<input type="checkbox"/> Mood Disorders	<input type="checkbox"/> Police Personnel	<input type="checkbox"/> Women's Issues
<input type="checkbox"/> Multicultural Issues	<input type="checkbox"/> Post Partum Depression	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Neuropsych Assessment	<input type="checkbox"/> Post Traumatic Stress Disorder	_____
<input type="checkbox"/> Nursing Home Services	<input type="checkbox"/> Psych. Disability Eval/Mgmt	

Confirmation of Practitioner Enrollment *(Print Legibly)*

For an electronic summary of the practitioner's network participation status resulting from this application, complete the following fields. If you would like others to receive this information, such as billing staff, include e-mail addresses on the lines provided.

Primary Contact _____

Primary Contact Phone Number _____

Primary Contact E-mail Address _____

Other E-mail Address(es) _____

Note: If a contract is being signed as part of this application process, this option is not available. Contract(s) and participation status will be sent by mail.

Certification and Release

Applicants have the following rights:

- You may request to review the information submitted in support of your credentialing application
- You may correct any erroneous information found in your credentialing files
- You will be notified if any information collected during the credentialing process varies substantially from the information you submitted

You must sign and date this section for all Wellmark networks. Please do not back date it. It will be returned if signature date is older than 60 days.

All Practitioners (cont.)

CONFLICT OF INTEREST STATEMENT - TRICARE NETWORK PROVIDERS ONLY

By signing this document you are agreeing that if you are called up for active duty or you are employed by a government agency you will not be reimbursed for medical services provided above your normal pay.

Federal law (5 U.S.C. 5536) prohibits medical personnel, who are active duty members or civilian employees of the government, compensation above their normal pay and allowances for medical care rendered. This prohibition applies to TRICARE benefits whether the claim for reimbursement is filed by the individual who provided the care, the facility in which the care was rendered, or by the sponsor/beneficiary. Claims for TRICARE benefits will be denied in any situation where either a uniform member or civilian employee of the uniform services has the opportunity to exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries to one or more providers on a selective basis.

As part of the credentialing and contracting process, if the provider has included any information that they are an Active Duty Service Member (ADSM), or employed by the MTF they are not eligible to bill TRICARE for any services provided inside or outside of the Military Treatment Facility. These providers should not be contracted as a network provider. Provider agreements for ADSMs that are currently contracted as a network provider should be terminated.

WELLMARK/TRICARE CERTIFICATION AND RELEASE

I understand that any information entered on this application and any Wellmark, Inc. addenda appropriate to my specialty, which subsequently is found to be false could result in immediate dismissal from any Wellmark Blue Cross and Blue Shield of Iowa program.

I hereby certify that the information contained in this application is correct and complete. I authorize release of information as may be required by Wellmark Blue Cross and Blue Shield of Iowa to process this application and understand and agree Wellmark Blue Cross and Blue Shield of Iowa may communicate with me through various means, including but not limited to telephone, mail, and/or e-mail over the internet, regarding my application.

My signature on this application does not constitute a contract with Wellmark Blue Cross and Blue Shield of Iowa. By signing this application, I authorize Wellmark Blue Cross and Blues Shield of Iowa to release this information to Wellmark subsidiaries and affiliates.

Practitioner's Signature _____ Date ____/____/____

Practitioner's Name (Please type or print) _____

Complete this section if this application has been prepared by someone other than the applicant.

I, _____, hereby attest that the information included on this application is correct and complete and can be retrieved from the files located at:

Clinic Name _____

Clinic Address _____

Preparer's Signature _____ Date ____/____/____

Instructions: Once you have completed the application, go to www.wellmark.com (Provider>Credentialing & Enrollment>Apply for Participation>Step 3: Obtaining Your Participation Agreements) to access contracts. Please send the completed contract(s) *with* this application to the address given on the application instruction sheet.

