

Wellmark of South Dakota, Inc.

South Dakota Practitioner Application Addendum

To apply for participation in Wellmark networks, please complete this Addendum in addition to the *South Dakota 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

Have you ever voluntarily withdrawn an application for medical staff membership or an increase in clinical privileges? Yes No

Do you perform any procedures outside the hospital setting for which you have been denied hospital privileges? Yes No

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, Clinical Nurse Specialists, and Clinical 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., C.N.P., C.N.S., 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

Site Specific Information (cont.) - If the information is different by practice site, please make a copy of this section and complete by practice site

CLIA

Certification? Yes No

Name on CLIA certificate _____

Levels: Accreditation Waiver Compliance Registration Provider-Performed Microscopy Procedures

CLIA number _____ Date Issued ____/____/____ Expiration Date ____/____/____

Restrictions - mark the groups you want to see

Age? No age restrictions 0-5 6-12 13-17 18-65 65+

Gender? No gender restrictions Female only Male only

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 | | |

Billing Information (Billing Contact & Address)

Billing Person's Name _____

Business Name and Address _____

Phone Number _____ Fax Number _____

E-mail Address _____

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 South Dakota 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 ____/____/____

All Practitioners

Office Manager Information

Name _____

Phone Number _____

E-mail Address _____

Credentialing

Person's Title _____

Address _____

E-mail address _____

Fax Number _____

General Information

Do you store electronic medical records? Yes No

Do you prescribe medication electronically? Yes No

Organizational NPI _____

Office Hours

Days	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open							
Closed							

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 would like your name to appear in Wellmark's provider directory or if you practice at other site(s) outside the hospital, 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 *South Dakota 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 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.)

Education/Training

If there are any time gaps between each level of your *education*, please identify the time period (From/To) and the reason for the gap.

Time Period From ____/____/____ To ____/____/____

Explanation _____

If there are any time gaps between each level of *training*, any incomplete training, or any gaps between education and training, please provide the time period and the reason for the gaps or incomplete training.

Time Period From ____/____/____ To ____/____/____

Explanation _____

Licensure/Certification

License type (e.g., M.D., D.C., A.R.N.P.) _____

Name as it appears on the License _____

Board Certification Number _____

Have you been convicted of or pled no contest to a felony or grand jury indictment? Yes No

If yes, please explain _____

Malpractice

Next Policy Period:

Carrier Name _____

Policy Number _____ Aggregate Amount _____ Per Claim Amount _____

Effective Date (MM/DD/YY) ____/____/____ End Date (MM/DD/YY) ____/____/____

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	Medical Services:	Nurse Practitioners and Physician Assistants:
Surgery: <input type="checkbox"/> Gastric <input type="checkbox"/> Breast <input type="checkbox"/> Oncology <input type="checkbox"/> Mastectomy <input type="checkbox"/> Reconstructive <input type="checkbox"/> Gynecological Oncology <input type="checkbox"/> Other (Specify) _____	<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"/> Allergy/Immunology <input type="checkbox"/> Cardiology <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Other (Specify) _____
	<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	

All Practitioners (cont.)

Medical/Surgical (cont.)

<p>Dental Surgery:</p> <input type="checkbox"/> TMJ Surgery	<p>Ophthalmology:</p> <input type="checkbox"/> Cataract Laser Surgery <input type="checkbox"/> Cornea Specialist <input type="checkbox"/> Glaucoma Specialist	<p>Transplant:</p> <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
<p>Dermatology:</p> <input type="checkbox"/> MOHS Surgery	<p>Orthopedics:</p> <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"/> Oculoplastics <input type="checkbox"/> Orbit Specialist <input type="checkbox"/> Retinal Specialist <input type="checkbox"/> Strabismus Specialist <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
	<p>Orthopedics:</p> <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Knee Surgery <input type="checkbox"/> Shoulder Surgery <input type="checkbox"/> Wrist	

Behavioral Health Practitioners Only

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Pain Management
<input type="checkbox"/> Addictions	<input type="checkbox"/> Dual Diagnosis	<input type="checkbox"/> Panic Disorder
<input type="checkbox"/> Adjustment Disorder	<input type="checkbox"/> EMDR	<input type="checkbox"/> Parenting Skills
<input type="checkbox"/> Adoption Issues	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Pastoral Counseling
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Electro-Convulsive Therapy (ECT)	<input type="checkbox"/> Personality Disorder
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Faith-based Counseling	<input type="checkbox"/> Pervasive Developmental Disorders
<input type="checkbox"/> Applied Behavioral Analysis	<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Phobias
<input type="checkbox"/> Asperger's Syndrome	<input type="checkbox"/> Forensic/Sex Offenders	<input type="checkbox"/> Physical Abuse/Violence
<input type="checkbox"/> Autism	<input type="checkbox"/> Gay/Lesbian	<input type="checkbox"/> Physically Impaired Patients
<input type="checkbox"/> Behavior Modification	<input type="checkbox"/> Grief Counseling	<input type="checkbox"/> Play Therapy
<input type="checkbox"/> Bi-Polar Disorder	<input type="checkbox"/> Gender Identity	<input type="checkbox"/> Police Personnel
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Post Partum Depression
<input type="checkbox"/> Child Abuse	<input type="checkbox"/> Head Injury Patients	<input type="checkbox"/> Post Traumatic Stress Disorder
<input type="checkbox"/> Christian Counseling	<input type="checkbox"/> Hearing Impaired Issues	<input type="checkbox"/> Psych. Disability Eval/Mgmt
<input type="checkbox"/> Chronic Mental Illness	<input type="checkbox"/> HIV Positive/AIDS Patients	<input type="checkbox"/> Psychological Testing
<input type="checkbox"/> Chronic Physical Illness	<input type="checkbox"/> Home Based Services	<input type="checkbox"/> Psychosomatic
<input type="checkbox"/> Co-Dependency	<input type="checkbox"/> Home Care/Home Visits	<input type="checkbox"/> Psychotic Disorders
<input type="checkbox"/> Cognitive Behavioral Therapy	<input type="checkbox"/> Hypnosis	<input type="checkbox"/> Rape Victims
<input type="checkbox"/> Combat Related Post Traumatic Stress Disorder	<input type="checkbox"/> Infertility	<input type="checkbox"/> Schizophrenic Disorders
<input type="checkbox"/> Compulsive Gambling	<input type="checkbox"/> Inpatient Therapy	<input type="checkbox"/> Sex Offender
<input type="checkbox"/> Conduct/Disruptive Disorders	<input type="checkbox"/> Learning Disabilities	<input type="checkbox"/> Sexual Abuse/Violence
<input type="checkbox"/> Couples/Marriage Therapy	<input type="checkbox"/> Medical Stress/Behavioral Med	<input type="checkbox"/> Sexual Dysfunction
<input type="checkbox"/> Crisis Diversionary Services	<input type="checkbox"/> Medication Management	<input type="checkbox"/> Sexual Harassment
<input type="checkbox"/> Crisis Intervention Services	<input type="checkbox"/> Men's Issues	<input type="checkbox"/> Sleep Disorders
<input type="checkbox"/> Critical Incident Debriefing	<input type="checkbox"/> Mood Disorders	<input type="checkbox"/> Somatoform Disorders
<input type="checkbox"/> Depressive Disorder	<input type="checkbox"/> Multicultural Issues	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Developmental Disabilities	<input type="checkbox"/> Neuropsych Assessment	<input type="checkbox"/> Terminally Ill Patients
<input type="checkbox"/> Dialectical Behavior Therapy	<input type="checkbox"/> Nursing Home Services	<input type="checkbox"/> Visually Impaired Patients
<input type="checkbox"/> Disability Evaluation	<input type="checkbox"/> Obesity Assessment & Counseling	<input type="checkbox"/> Women's Issues
<input type="checkbox"/> Dissociative Disorder	<input type="checkbox"/> Obsessive Compulsive Disorder	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Divorce	<input type="checkbox"/> Organic Brain Syndrome	
	<input type="checkbox"/> Organic Disorders	

All Practitioners (cont.)

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 email 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.

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.

