MSO

Facility Request
Initial and Recredentialing Application

Line of Business:
☐ Medicare Advantage (MMM)
☐ MMM Multi Health (Vital)

Fill all items on this form. If not applicable, write N/A.

Provider Identification

(1) Tax ID Number

(2) Rendering NPI Number

(3) Billing NPI Number

Provider Demographic Data

(4) Provider Name

(5) E-mail

(6) Primary Location Address

City/State | Zip Code

(7) Telephone Number

(8) Fax Number

(9) Facility Hours
Opening Time

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Opening							
Closing							

(17) Accessibilty Questions

(17.1) Accepting New Patients for Medicare	(17.2) Accepting New Patients for Medicaid	(17.3) Gender Limitation	(17.4) Age Limitation		(17.5) Handicap Access
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Lowest Age: ________ months Highest Age: ________ years	☐ Yes ☐ No

(11) Billing Name

(12) Mailing / Billing Address

City/State | Zip Code

*Please fill out this section completely, following the guidelines established in the Program Integrity Plan established by MSO of Puerto Rico, LLC (MSO) in compliance with the PR Health Insurance Administration (PRHIA).

☐ Please check this box if the facility does not have a contracted Facility Director.

Facility Staff

(13) **Staff I**

☐ Administrator ☐ Biller ☐ Secretary ☐ Other Office Staff ☐ ________ ☐ ________

(14) Last Name

(15) Second Last Name

(16) First Name

(17) **Staff II**

☐ Administrator ☐ Biller ☐ Secretary ☐ Other Office Staff ☐ ________ ☐ ______

(18) Last Name

(19) Second Last Name

(20) First Name

(21) **Staff III**

☐ Administrator ☐ Biller ☐ Secretary ☐ Other Office Staff ☐ ________ ☐ ______

(22) Last Name

(23) Second Last Name

(24) First Name

(25) **Staff IV**

☐ Administrator ☐ Biller ☐ Secretary ☐ Other Office Staff ☐ ________ ☐ ______

(26) Last Name

(27) Second Last Name

(28) First Name

Ownership and Conflict of Interest (Discloser Questions) in compliance with the PR Health Insurance Administration (PRHIA-ASES).

	Question	Yes	No
(1)	Has any employee been convicted of a criminal offense under Medicare/Medicaid Programs?	☐ Yes	☐ No
	If yes, please explain:		
(2)	Has there been a business transaction involving $25,000 or more during the 12-month period ending the date of the submitted form?	☐ Yes	☐ No
	If yes, please explain:		
(3)	Has/Have the individual(s) or Organization under current or former name or bussiness identity, within the last ten years from the date of this statement, ever had a final adverse action/exclusion, revocation, suspension, conviction by any federal, state or local goverment program or agency (Ex. Medicare, Medicaid, Tittle V or XX)	☐ Yes	☐ No
	If yes, please explain:		
(4)	Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request	☐ Yes	☐ No
	If yes, please explain:		
(5)	Has there been any restriction denial of Federal Financial Participation (FFP)?	☐ Yes	☐ No
	If yes, please explain:		

OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION - (ORGANIZATIONAL)

☐ Please check this box if there is no ownership interest and/or managing control

***Please fill out this section completely, following the guidelines established in the Program Integrity Plan set by MSO of Puerto Rico, LLC (MSO) in compliance with the PR Health Insurance Administration (PRHIA-ASES).**

All organizations that have any of the following must report:
1) All persons who have a 5 percent or greater (direct or indirect) ownership interest in the supplier.
2) Applicant or provider ONLY IF the supplier, applicant or provider is a corporation (whether for-profit or non-profit).
3) All officers and directors of the supplier, applicant or provider.
4) All managing employees of the supplier, applicant or provider (including secretary, reception, among others).
5) Supplier, applicant or provider. All of those who have managing control.
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership the partner has; and Authorized delegate officials.

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In general, Owning/Managing organizations belong to one of the following categories:
1) Corporations (including non-profit corporations)
2) Partnerships and Limited Partnerships (as indicated above)
3) Limited Liability Companies
4) Charitable and/or Religious organizations
5) Governmental and/or Tribal organizations

* An owner may also be a managing employee 42 CFR § 455.104, 42 CFR § 455.105, 42 CFR § 455.106

Legal Business Name (As reported toDepartment of State)

"Doing Business As" - DBA Name (If Applicable)

Tax ID Number

NPI Number

Physical Address

Telephone Number

Fax Number

What is the above organization's relationship with the applicant or provider in section 1?

☐ 5% or more direct ownership interest
☐ 5% or more indirect ownership interest
☐ Partner
☐ Managing con
☐ Other Specify: ______________________

OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION - (INDIVIDUALS)

☐ Please check this box if there is no ownership interest and/or managing control

***Please fill out this section completely, following the guidelines established in the Program Integrity Plan set by MSO of Puerto Rico, LLC (MSO) in compliance with the PR Health Insurance Administration (PRHIA-ASES).**

All organizations that have any of the following must report:
1) All persons who have a 5 percent or greater (direct or indirect) ownership interest in the supplier.
2) Applicant or provider ONLY IF the supplier, applicant or provider is a corporation (whether for-profit or non-profit).
3) All officers and directors of the supplier, applicant or provider.
4) All managing employees of the supplier, applicant or provider (including secretary, reception, among others).
5) Supplier, applicant or provider. All those who have managing control.
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership the partner has; and authorized delegate officials.

* An owner may also be a managing employee

42 CFR § 455.104
42 CFR § 455.105
42 CFR § 455.106

Individual having ownership interest and/or managing control

First Name | Middle Name

Last Name | Second Last Name

Rendering NPI Number

Check all applicable to those having Ownership Interest and/or Managing Control with the applicant or provider:

- ☐ 5% or more direct ownership interest
- ☐ Managing Employee (W-2)
- ☐ Directly exercises operational control over day-to-day operations
- ☐ Indirectly exercises operational control over day-to-day operations
- ☐ Indirectly has managerial control over day-to-day operations
- ☐ 5% or more indirect ownership interest
- ☐ Partner
- ☐ Contracted Managing Employee
- ☐ Director/Officer
- ☐ Directly has managerial control over day-to-day operations
- ☐ Other specify: ___________________

Individual having ownership interest and/or managing control

First Name | Middle Name

Last Name | Second Last Name

Rendering NPI Number

Check all applicable to those having Ownership Interest and/or Managing Control with the applicant or provider:

- ☐ 5% or more direct ownership interest
- ☐ Managing Employee (W-2)
- ☐ Directly exercises operational control over day-to-day operations
- ☐ Indirectly exercises operational control over day-to-day operations
- ☐ Indirectly has managerial control over day-to-day operations
- ☐ 5% or more indirect ownership interest
- ☐ Partner
- ☐ Contracted Managing Employee
- ☐ Director/Officer
- ☐ Directly has managerial control over day-to-day operations
- ☐ Other specify: _________________

Individual having ownership interest and/or managing control

First Name	Middle Name

Last Name	Second Last Name

Rendering NPI Number

Check all applicable to those having Ownership Interest and/or Managing Control with the applicant or provider:

- ☐ 5% or more direct ownership interest
- ☐ Managing Employee (W-2)
- ☐ Directly exercises operational control over day-to-day operations
- ☐ Indirectly exercises operational control over day-to-day operations
- ☐ Indirectly has managerial control over day-to-day operations
- ☐ 5% or more indirect ownership interest
- ☐ Partner
- ☐ Contracted Managing Employee
- ☐ Director/Officer
- ☐ Directly has managerial control over day-to-day operations
- ☐ Other specify: ___________________

☐ Please check this box of there is no ownership interest and/or managing control

Individual having ownership interest and/or managing control

First Name	Middle Name

Last Name	Second Last Name

Rendering NPI Number

Check all applicable to those having Ownership Interest and/or Managing Control with the applicant or provider:

- ☐ 5% or more direct ownership interest
- ☐ Managing Employee (W-2)
- ☐ Directly exercises operational control over day-to-day operations
- ☐ Indirectly exercises operational control over day-to-day operations
- ☐ Indirectly has managerial control over day-to-day operations
- ☐ 5% or more indirect ownership interest
- ☐ Partner
- ☐ Contracted Managing Employee
- ☐ Director/Officer
- ☐ Directly has managerial control over day-to-day operations
- ☐ Other specify: _________________

Insurance Company Information - Enclose a Copy of Certificate

(29) Insurance Carrier	(30) Coverage Type	(31) Unlimited Coverage?	(32) Coverage
		☐ Yes ☐ No	

(33) Policy Number	(34) Original Effective Date	(35) Effective Date	(36) Expiration Date
	M D Y	M D Y	M D Y

Other Provider Information

(37) **Hospital Only - Check all that apply**

☐ Anesthesiology	☐ Laboratory (Pathology) CLIA # ___________ Exp. Date ____/____/____
☐ Emergency Room	
☐ Inpatient	☐ Physical Therapy
☐ Outpatient	☐ Transportation
☐ Inpatient and Outpatient	☐ Radiology
If Outpatient and Inpatient services total, # of Medicare Beds __________	*DOH Radiology Machine License Expiration Date* _____/______/___

Do you serve as a provider in the Medicaid Program?	☐ Yes	☐ No
Is your office computerized?	☐ Yes	☐ No
Does your facility have Internet access?	☐ Yes	☐ No

(38) **Clinical/Pathological Laboratory - Skilled Nursing Facility**

☐ Laboratory (Pathology)	CLIA # _______________	Exp. Date ______/_____/_____

Do you serve as a provider in the Medicaid (Vital) Program?	☐ Yes	☐ No
Do you make appointments? If so, in what manner (day only, no set hours)?		
Do you perform Home Visits?	☐ Yes	☐ No

(39) **Town list**

(40) **Radiology Facility with Mammogram Only**

☐ DOH Radiology Machine License Exp. Date ______/_____/_____

(41) **DME & DMEPOS**

☐ DOH License Number to dispense Medications (If applicable) Exp. Date ______/_____/_____

License # ______________________ (Please include copy of license, must not be expired)

☐ DOH License Number to Operate Practice Exp. Date ______/_____/_____

License # ______________________ (Please include copy of license, must not be expired)

☐ Check if DME Manufactures own Products and Malpractice coverage includes General Liability including products, operations, Professional Liability and limits of at least $300,000. (Policy must not be expired)

☐ Surety Bond ($50,000 or over according with CMS rule, must not be expired) Exp. Date ______/_____/_____

☐ Joint Commission Accreditation - JCAHO (must not be expired) Exp. Date ______/_____/_____

(42) **Ambulance**

List Vehicle Identification Number (VIN), license plate number and expiration date for each transportation vehicle from Department of Health (DOH) Certificate

VIN#	License Plate #	Exp. Date _____/____/_____
VIN#	License Plate #	Exp. Date _____/____/_____
VIN#	License Plate #	Exp. Date _____/____/_____
VIN#	License Plate #	Exp. Date _____/____/_____
VIN#	License Plate #	Exp. Date _____/____/_____
VIN#	License Plate #	Exp. Date _____/____/_____
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VIN#	License Plate #	Exp. Date _____/____/_____
VIN#	License Plate #	Exp. Date _____/____/_____
VIN#	License Plate #	Exp. Date _____/____/_____

(43)

Please provide the following information for certified vehicles: License, expiration date for each transportation vehicle		
Authorization Num:	Exp. Date ______/_____/_____	
Authorization Num:	Exp. Date ______/_____/_____	
Authorization Num:	Exp. Date ______/_____/_____	
Authorization Num:	Exp. Date ______/_____/_____	
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Authorization Num:	Exp. Date ______/_____/_____	
Authorization Num:	Exp. Date ______/_____/_____	
Authorization Num:	Exp. Date ______/_____/_____	
Authorization Num:	Exp. Date ______/_____/_____	
Does your company provide Non emergency transportation services?	☐ Yes	☐ No
SPACE AVAILABLE FOR ANY ADDITIONAL INFORMATION		

Disclosure Questions

	Question	Yes	No
(1)	Has your license and/or certifications ever been revoked or have any restrictions or modifications ever been assessed against it/them?	☐ Yes	☐ No
	If yes, please explain:		
(2)	Has your facility ever had a malpractice suit?	☐ Yes	☐ No
	If yes, please explain:		
(3)	Has your malpractice coverage ever been restricted or limited?	☐ Yes	☐ No
	If yes, please explain:		
(4)	Has your facility ever been found to have quality measure deficiencies?	☐ Yes	☐ No
	If yes, please explain:		
(5)	Has your facility ever been found to have healthcare deficiencies?	☐ Yes	☐ No
	If yes, please explain:		
(6)	Does the company currently have a malpractice suit filed against it?	☐ Yes	☐ No
	If yes, please explain:		
(7)	Have you ever been the subject of an investigation or have you ever been suspended or otherwise restricted from participating in any private, state or federal health insurance program, such as Medicare or Medicaid?	☐ Yes	☐ No
	If yes, please explain:		

Provider Attestation & Information Release

I hereby certify that all information provided on this application and its attachments is correct and current to the best of my knowledge. I acknowledge that I have been informed of my right to review primary source verification information obtained by MSO of Puerto Rico, LLC (MSO) in compliance with regulatory requirements, and to correct erroneous information submitted in support of this credentialing application. I understand that MSO will notify me of any information obtained during the credentialing process that varies substantially from the information provided herein. I understand that falsification of information from this application may result in rejection of my request for initial/continued participation in the Provider Network (the "Network") administered by MSO, and Payers that contract with the Network.

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance (“credentialing information”) by and between MSO of Puerto Rico, LLC (MSO), and other Healthcare Organizations. These organizations include: hospitals, medical associations, professional associations, medical school faculty positions, training programs, professional liability insurance companies, and licensing authorities. This information shall be used for the sole purpose of evaluating my credentialing information. In this regard, MSO will take the utmost care to safeguard the privacy and confidentiality of my credentialing information and will protect it from further disclosure. I am aware and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all people and entities providing credentialing information to MSO from any liability they might incur for their acts and/or communications in connection with my credentialing information. I understand and agree that I have the obligation of producing adequate information for proper evaluation of my credentialing information and for resolving any uncertainty regarding said information. I am also aware, that I can receive the status of my credentialing or recredentialing application, upon request by contacting the Provider Contact Center Department at 1-866-787-6060.
I recognize that the MSO will not consider my application complete unless it is submitted with at least the following documents: medical license, DEA license, malpractice insurance and ASSMCA license, as applicable.

______________________ Authorized Name

______ / ______ / ______ Date*

______________________ Authorized Signature*

______________________ Title (Print)

*Form will be returned if section is not filled out

If you need to verify the documents in your file, or you wish to check on the status of your application, feel free to contact our Credentialing Department at credentialinghelpdesk@mso-pr.com

Please mail application to the following address:
Credentialing Department
PO Box 71500
San Juan, PR 00936
Fax: 787-625-3374