

Specialized Therapy Associates, LLC
83 Summit Avenue
Hackensack, NJ 07601
(201) 488-6678 / (201) 224-0599 fax

Preferred Provider Network Individual/Group Practitioner Application

(circle one)

Name: Last, First, M.I. (Jr., Sr., etc.)

Title/Degree

Any previous name(s)

Social Security # /NPI #

Date of Birth

Type of Business:

Medical Group _____

IPA _____

Solo Practice _____

PHO _____

Other (i.e. –sole proprietorship, corporation, professional corporation, and limited liability company)

Licensure

Discipline

State/License #

Year Granted

Expiration Date

DEA Narcotics License #

Year Granted

DEA Expiration Date

Mailing Address/Primary Office: Street Address

City, State, Zip Code

Telephone Number

Fax Number

Pager/Cell Number

Coverage

Do you have 24 hour telephone coverage? _____

If so, what arrangements have you made? _____

Is this office handicap accessible? _____

Office hours at this location:

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

Are there arrangements for urgent care (same day response)? _____

Are routine appointments offered within 3 days? _____

Billing Address: Street Address

City, State, Zip Code

Tax ID #

Office Administrator

Secondary Office Location/Street Address, if applicable

City, State, Zip Code

Telephone Number

Fax Number

Beeper Number

Coverage

Do you have 24 hour telephone coverage? _____

If so, what arrangements have you made? _____

Is this office handicap accessible? _____

Office hours at this location

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

Billing Address/Street Address

City, State, Zip Code

Tax ID #

Office Administrator

Adjunct Practitioners

If your business includes other practitioners, list them, including SS #s, NPI # and State / License #s:

(Attach additional information on a separate page if necessary.)

Name

<input type="text"/>
<input type="text"/>
<input type="text"/>

Social Security # /NPI # State / License

<input type="text"/>
<input type="text"/>
<input type="text"/>

<input type="text"/>
<input type="text"/>
<input type="text"/>

Covering Practitioners

List all covering practitioners:

Name	Telephone #	Emergency Telephone #
<input type="text"/>	<input type="text"/>	<input type="text"/>

Street Address, City, State, Zip Code

Name	Telephone #	Emergency Telephone #
<input type="text"/>	<input type="text"/>	<input type="text"/>

Street Address, City, State, Zip Code

Name	Telephone #	Emergency Telephone #
<input type="text"/>	<input type="text"/>	<input type="text"/>

Street Address, City, State, Zip Code

Education (Attach copies of all degrees earned.)

School/Program	Degree	Year Granted
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Continuing Education / Postgraduate Study / Board Certification

(Attach copies of certificates and any additional information.)

School or Board	Certification
<input type="text"/>	<input type="text"/>
Date Certification Granted	Expiration Date
<input type="text"/>	<input type="text"/>
School or Board	Certification
<input type="text"/>	<input type="text"/>
Date Certification Granted	Expiration Date
<input type="text"/>	<input type="text"/>
School or Board	Certification
<input type="text"/>	<input type="text"/>
Date Certification Granted	Expiration Date
<input type="text"/>	<input type="text"/>

Hospital Privileges

Name and Address

Privilege Type

Privilege Status

Name and Address

Privilege Type

Privilege Status

Name and Address

Privilege Type

Privilege Status

Any previous hospital affiliations:

Name and Address

Privilege Type

Privilege Status

Professional Memberships

Association

Dates of Active Membership

Malpractice Insurance

Company Name (not agency)

Street Address

City, State, Zip Code

Telephone #

Policy #

Date first obtained

Expiration Date

Coverage Limits: per occurrence

aggregate

Type of coverage: claims made _____, occurrence _____, tail _____

List all previous insurance carriers with active dates

Medicare/Medicaid

Do you accept Medicare assignment? _____

Do you accept Medicaid assignment? _____

Medicare UPIN #

Medicaid #

Medicare #

Self Identifying Information (voluntary)

Race

Gender

Sexual Orientation

Religion

Foreign Languages spoken

Completed applications require copies of licensure, malpractice insurance coverage, certifications, W-9, resume/CV Mail all supporting documents to STA PPO Network, 83 Summit Avenue, Hackensack, New Jersey 07601

Areas of expertise and training-must be listed on CV and must provide documentation of training. Choose areas of expertise and specialized training from the following list. Indicate years of experience in treating that disorder.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> adjustment disorders | <input type="checkbox"/> anxiety disorders | <input type="checkbox"/> bereavement/grief counseling | <input type="checkbox"/> chemical dependency |
| <input type="checkbox"/> depression | <input type="checkbox"/> eating disorders | <input type="checkbox"/> sexual identity orientation | <input type="checkbox"/> gay/lesbian issues |
| <input type="checkbox"/> HIV | <input type="checkbox"/> incest survivors | <input type="checkbox"/> men's issues | <input type="checkbox"/> multiple personality disorder |
| <input type="checkbox"/> personality disorders | <input type="checkbox"/> parenting | <input type="checkbox"/> post-traumatic stress disorder | <input type="checkbox"/> somatoform disorders |
| <input type="checkbox"/> women's issues | <input type="checkbox"/> ACOA | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> borderline personality disorder |
| <input type="checkbox"/> child abuse | <input type="checkbox"/> elder abuse | <input type="checkbox"/> dissociative disorders | <input type="checkbox"/> domestic violence |
| <input type="checkbox"/> forensics | <input type="checkbox"/> geriatrics | <input type="checkbox"/> stage of life adjustments | <input type="checkbox"/> infertility |
| <input type="checkbox"/> learning disabilities | <input type="checkbox"/> mood disorders | <input type="checkbox"/> pain management | <input type="checkbox"/> phobias |
| <input type="checkbox"/> sexual abuse | <input type="checkbox"/> sexual dysfunction | <input type="checkbox"/> stress management | <input type="checkbox"/> neuropsychological disorders |
| <input type="checkbox"/> developmental delays | <input type="checkbox"/> multicultural issues | | |
| <input type="checkbox"/> other _____ | | | |
-

Populations Served

- Infant Toddler Child Adolescent Adult Geriatric

Treatment Modalities

- | | | | | | |
|--|--|---|------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Group | <input type="checkbox"/> Marital | <input type="checkbox"/> Family | <input type="checkbox"/> wellness | <input type="checkbox"/> biofeedback |
| <input type="checkbox"/> medication management | <input type="checkbox"/> psychological testing | <input type="checkbox"/> neuropsychological testing | | | |
| <input type="checkbox"/> hypnosis | <input type="checkbox"/> workplace evaluation | <input type="checkbox"/> forensic evaluation | <input type="checkbox"/> mediation | <input type="checkbox"/> employee assistance | |
| <input type="checkbox"/> critical incident stress debriefing | <input type="checkbox"/> analysis | | | | |

IMPORTANT. Please read carefully and completely before signing.

I hereby certify that the information provided in this application is accurate and true. I understand that any information entered into this application which subsequently is found to be false could result in immediate dismissal from the STA PPO Network.

In order to evaluate my application for inclusion and continuing participation status in the STA PPO Network, in the event my application is accepted, I hereby give my permission to STA PPO, its affiliates, employees and agents to solicit information regarding my professional credentials and qualifications. Specifically included, but not limited to, in this consent are the following informational sources: professional state licensing boards, Medicare regulating agencies, and colleagues or chiefs of departments of a facility where I have practiced.

Release and Authorization

I authorize STA, LLC and its subsidiaries, affiliates, successors, employees and agents, to consult with hospitals, members of hospital medical staffs, professional liability carriers, managed care organizations and other persons or entities to obtain information concerning my qualifications, including without limitation my professional competence and conduct. I consent to the release to STA, LLC of any and all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions and information that might otherwise be considered confidential or privileged. I authorize STA, LLC to release this information, as well as quality assurance data relating to me, to health benefit plans owned, managed or administered by STA, LLC to medical groups, independent practice associations and similar entities contracting with said health plans, or as authorized under state or federal law or regulation. I release STA, LLC and any and all persons or entities providing information about me to STA, LLC from any and all liability connected with or arising from the release of such information, provided that such party(ies) was acting in good faith and without malice in evaluating my application and any decisions related to my application or credentialing status.

I understand that I have the burden of providing adequate information to STA, LLC to demonstrate my qualifications. I understand and agree that any misstatement or material omission in this application will constitute grounds for rejection of my application or summary dismissal as a participating provider in any and all networks maintained by STA, LLC. If any material changes occur in the information I have provided in this application making such information no longer correct and complete or affecting my professional status, I understand and agree that it is my obligation to notify STA, LLC, its subsidiaries, affiliates, successors employees and agents within 10 days of said occurrence. Failure to comply with this obligation may constitute grounds of rejection of my application or summary dismissal as a participating provider in any and all networks maintain or managed by STA, LLC.

I attest that the information contained in this application is true, correct and complete.

Signature of Provider

Date

PRACTICE ATTESTATION FORM

Write your responses to each question.

Have you ever had any adverse action taken or is any adverse action pending with respect to:

- state license, certificate, or registration?
- DEA registration or other applicable narcotic registration?
- hospital or other health care facility staff membership or privileges?
- professional organization membership?
- Medicare, Medicaid, or any other governmental health program participations?
- HMO, PPO, pho, phc, IPA or any prepaid health plan or managed care participation?
- educational or training institution or program?
- professional society or association?

Do you have a medical condition, which in any way impairs or limits your ability to practice with reasonable skill and safety?

If yes, are the limitations or impairments reduced or ameliorated due to receiving ongoing treatment, with or without medication, or participation in a monitoring program?

If yes, are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice?

Do you have any chronic communicable disease or other medical conditions that would pose a risk to the safety or well being of you patients?

If you use chemical substances, does your use in any way impair or limit your ability to practice with reasonable skill and safety?

Are you currently engaged in illegal use of controlled dangerous substances?

Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you?

Are you now or have you been involved in any malpractice action(s), including litigation, arbitration or mediation, regardless of the method or amount of the resultant outcome?

Has payment to resolve or avoid any allegation(s) concerning your competence, conduct or quality of care (including but not limited to those which did not involve litigation, arbitration or mediation) ever been paid by you or on your behalf?

If yes, attach the following information for each allegation, claim, suit, action, or settlement, whether open or closed, regardless of whether payment was made. Please obtain this information from your insurer or attorney, if necessary.

-date and clinical details of the incident(s) leading to the allegation, claim, suit, action or settlement. Be specific.

-date of filing, date of resolution and outcome (for example, settlement or award by an arbitrator, mediator, panel, judge, or jury) or, if not resolved, current status (for example, open, closed, in arbitration, etc.)

-professional liability insurer involved

-your status (for example, primary defendant, co-defendant, other) and the names of any other co-defendants

Has your professional liability insurance or coverage been denied, suspended, canceled, lapsed, not renewed, special rated or experienced gaps?

Have you been convicted of a crime or are you under indictment for an alleged crime?

Have you been the subject of an administrative, civil or criminal complaint or investigation regarding sexual misconduct or child abuse?

If yes, provide full details (including the plaintiff and court caption of any pending lawsuit).

Are you presently a defendant in a malpractice, discrimination or professional liability lawsuit or proceeding or have you been placed on notice of such a potential lawsuit or proceeding yet to be filed which has not been reported in writing to STA, LLC?

If you have been employed by or served as a clinician or other health care provider for military service, a hospital, a managed care plan or any other health care organization, was such relationship terminated by anyone other than yourself?

PRINT NAME _____

SIGNATURE AND DATE _____

***Mail the original PRACTICE ATTESTATION FORM with all supporting documents to STA PPO Network,
83 Summit Avenue, Hackensack, New Jersey 07601***

Specialized Therapy Associates, LLC
PPO Network

Authorization to Release Records and Other Information

I hereby authorize STA, LLC to request all of my records, personal recommendations, and other pertinent information with respect to my hospital privileges or my performance in medical school or as an intern, resident, or physician. I hereby authorize the hospital or institution or other institution or individual receiving such request to release such records and information to STA, LLC.

I understand that all of the records and information provided will be available to the staff and to the administrations of STA, LLC in connection with consideration of my application.

I understand and agree that all recommendations and disclosures or records of information will be privileged to the full extent permitted by law. I further agree not to bring any administrative proceeding or take any judicial action against STA, LLC or any person, hospital or institution providing, receiving or using any such material.

Name (Print clearly)

Signature

Date

Mail the original release form with all supporting documents to STA PPO Network, 83 Summit Avenue, Hackensack, New Jersey 07601

Specialized Therapy Associates, LLC
PPO Network

Authorization to Obtain Certificate of Insurance

Name of Insured

Office Address

Policy Number

Insurance Company (not Agent)

Street Address

City

State

Zip Code

I hereby authorize the above-named insurance company to annually provide STA, LLC, 83 Summit Avenue, Hackensack, NJ 07601 with a copy of my Certificate of Insurance of professional liability coverage. In the event of any material change in, cancellation of, or failure to renew said coverage, I also authorize the above-named company to give written notice to STA, LLC. I hereby release from liability and agree to hold harmless said company and its representatives for the provision of such information to STA, LLC.

Signature

Date

Mail the original authorization form with all supporting documents to STA PPO Network, 83 Summit Avenue, Hackensack, New Jersey 07601

Specialized Therapy Associates, LLC
PPO Network

Authorization to Obtain Proof of Licensure

Name

Address

License Number

Licensing Board/State

Street Address

City

State

Zip Code

I hereby authorize the above-named licensing board to provide STA, LLC, 83 Summit Avenue, Hackensack, NJ 07601 with proof of licensure. In the event of any material change in, cancellation of, or failure to renew said license, I also authorize the above-named licensing board to give written notice to STA, LLC. I hereby release from liability and agree to hold harmless said licensing board and its representatives for the provision of such information to STA, LLC.

Signature

Date

Mail the original authorization form with all supporting documents to STA PPO Network, 83 Summit Avenue, Hackensack, New Jersey 07601