Avēsis Provider Re-Credentialing Application

Please be sure to include the following **current** documents with your fully completed and signed application:

- Updated W-9, paying special attention to question 4
- Certificate of Professional Malpractice Liability
- Professional State License
- Federal DEA or CDS Certificate, if applicable
- Work History for past five years, with all gaps explained

Mail:
Avēsis
Attn: Vision Credentialing Dept
10324 South Dolfield Road
Owings Mills, MD 21117

*For Re-Credentialing applications,
Attn: Vision Re-Credentialing

Email: EyeCareServicesCredentialing@avesis.com

Fax: 855-591-3557

Avēsis does not discriminate against any provider applicant based on age, race, color, creed, religious affiliation, marital status, sexual orientation, disability status, or any other basis including the provider's practice being substantially comprised of patients requiring expensive or uncompensated care. Credentialing shall be based only upon the material facts contained in their application and subsequent information obtained. You have the right to request the status of your application and to provide us with updated information at any time during the credentialing process.

Version: 1 REV: 2/13/2019

Practice Information

Practice Information (check one): ☑ Sole Proprietorship ☐ Partnership ☐ Professional Corporation ☐ Other

Type of Practice (check one): ☑ Optometry ☐ Ophthalmology ☐ Dispensary ☐ Audiology

Are you part of a retail chain or affiliation? If so, please provide name and address of corporate office:

☑ National ☐ Regional ☐ Not Applicable

Provider's Name: _____

Corporation's Name (if applicable): _____

TIN: _____ NPI-2 (if applicable): _____

Practice Name: _____

Mailing Address: _____

Billing Address: _____

☑ Check here if multiple billing addresses (Please list on separate page)

Please indicate address where signed Provider Agreement and Welcome packet should be sent.

☑ Mailing Address ☐ Billing Address ☐ Primary Office Address ☐ Other

Business Contact: _____ Email Address: _____ Phone: _____

Practice Manager: _____ Email Address: _____ Phone: _____

Office Locations Please provide information for only those locations that will participate with Avēsis.

Primary Office Location

Practice Name: _____

Complete Address (Street, City, State, 9-digit zip): _____

Office Manager: _____ Phone: _____ Fax: _____

Services Provided: ☑ Exam Only ☐ Materials Only ☐ On-Site laboratory

☐ Exam and contact lenses only ☐ Full Service (exam, lenses, frames, contacts)

Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Name of Provider(s) at this Location, **including the applicant**. Please provide Medicaid numbers for each provider, as applicable.

1. _____ _____ 2. _____ _____

3. _____ _____ 4. _____ _____

Please complete if different from above Practice Information.

Billing Address for this Location: _____

TIN for this Location (if different, please submit additional W-9): _____

Patient Relation Services

Languages Spoken by Provider: ☑ English ☐ Spanish ☐ French ☐ Other: _____

Languages Spoken by Staff: ☑ English ☐ Spanish ☐ French ☐ Other: _____

Accepts Patients with Developmental Disabilities: ☑ Yes ☐ No TTY Available: ☑ Yes ☐ No Signing Available: ☑ Yes ☐ No

Handicap Accessible Office (ADA Compliant): ☑ Yes ☐ No Handicap Parking Available: ☑ Yes ☐ No

Provider or Staff CPR certified: ☑ Yes ☐ No Age of Patients: From _____ To _____

Office Locations 2 Please provide information for only those locations that will participate with Avēsis.

Primary Office Location

Practice Name: _____

Complete Address (Street, City, State, 9-digit zip): _____

Office Manager: _____ Phone: _____ Fax: _____

Services Provided: ☑ Exam Only ☐ Materials Only ☐ On-Site laboratory
☐ Exam and contact lenses only ☐ Full Service (exam, lenses, frames, contacts)

Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Name of Provider(s) at this Location, **including the applicant**. Please provide Medicaid numbers for each provider, as applicable.

1. _____ _____ 2. _____ _____

3. _____ _____ 4. _____ _____

Please complete if different from above Practice Information.

Billing Address for this Location: _____

TIN for this Location (if different, please submit additional W-9): _____

Patient Relation Services

Languages Spoken by Provider: ☑ English ☐ Spanish ☐ French ☐ Other: _____

Languages Spoken by Staff: ☑ English ☐ Spanish ☐ French ☐ Other: _____

Accepts Patients with Developmental Disabilities: ☑ Yes ☐ No TTY Available: ☑ Yes ☐ No Signing Available: ☑ Yes ☐ No

Handicap Accessible Office (ADA Compliant): ☑ Yes ☐ No Handicap Parking Available: ☑ Yes ☐ No

Provider or Staff CPR certified: ☑ Yes ☐ No Age of Patients: From _____ To _____

Office Locations 3 Please provide information for only those locations that will participate with Avēsis.

Primary Office Location

Practice Name: _____

Complete Address (Street, City, State, 9-digit zip): _____

Office Manager: _____ Phone: _____ Fax: _____

Services Provided: ☑ Exam Only ☐ Materials Only ☐ On-Site laboratory
☐ Exam and contact lenses only ☐ Full Service (exam, lenses, frames, contacts)

Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Name of Provider(s) at this Location, **including the applicant**. Please provide Medicaid numbers for each provider, as applicable.

1. _____ _____ 2. _____ _____

3. _____ _____ 4. _____ _____

Please complete if different from above Practice Information.

Billing Address for this Location: _____

TIN for this Location (if different, please submit additional W-9): _____

Patient Relation Services

Languages Spoken by Provider: ☑ English ☐ Spanish ☐ French ☐ Other: _____

Languages Spoken by Staff: ☑ English ☐ Spanish ☐ French ☐ Other: _____

Accepts Patients with Developmental Disabilities: ☑ Yes ☐ No TTY Available: ☑ Yes ☐ No Signing Available: ☑ Yes ☐ No

Handicap Accessible Office (ADA Compliant): ☑ Yes ☐ No Handicap Parking Available: ☑ Yes ☐ No

Provider or Staff CPR certified: ☑ Yes ☐ No Age of Patients: From _____ To _____

For additional locations, please copy this page and complete and return with completed application.

Provider Information

Provider's Name: _____ Suffix (Jr., Sr., etc.): _____

Maiden/Other Name(s) (if applicable): _____ ☑ Owner ☐ Assoc. ☐ Employee

SSN: _____ TIN (if different): _____ DOB (MM/DD/YY): _____ ☑ Male

Medicaid Number (if applicable): _____ NPI-1: _____ ☐ Female

Do you submit claims under your TIN or the Practice? ☑ TIN ☐ Practice ☐ Not Applicable Email: _____

Professional Training

Professional School: _____

Degree: _____ Year Graduated: _____ Years of Practice: _____

If trained outside of the United States, check here and attach copy of ECFMG D

Residency Program (if applicable): _____ From: _____ To: _____

Advanced Training (if applicable): _____ From: _____ To: _____

Board Certified: ☑ Yes ☐ No ☐ Not Applicable Board Eligible: ☑ Yes ☐ No ☐ Not Applicable

Name and Address of Board: _____

Licensing Information

State Licenses: Please attach copies of current license(s) and certificate(s)	State: _____	License Number: _____	Effective Date: _____	Expiration Date: _____
	State: _____	License Number: _____	Effective Date: _____	Expiration Date: _____
	State: _____	License Number: _____	Effective Date: _____	Expiration Date: _____
DEA Certificate	Number: _____	Effective Date: _____	Expiration Date: _____	☐ Not Applicable
Controlled Substance Certificate (CDS)	Number: _____	Effective Date: _____	Expiration Date: _____	☐ Not Applicable

Hospital Privileges If not applicable, check here. ☐

Hospital Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Contact Name: _____

Date Privileges Granted: _____ Type of Privileges: _____

Professional Liability Insurance Information

Please attach a copy of your Insurance Declaration page or Certificate of Insurance.

Professional Liability Insurance Carrier: _____ Policy #: _____

Limits of Coverage: Individual: _____ Aggregate: _____

Effective Date (MM/DD/YY): _____ Expiration Date (MM/DD/YY): _____

Work History In lieu of completing the section below, you may attach a resume or Curriculum Vitae.

Has your work history changed in the past five years? If yes, provide information below. Please include **current employment**. Explain any gaps of six months or more on a separate piece of paper. GA and PA applicants only, please explain any gaps of 30 days or more. ☑ Yes ☐ No

Dates To/From (MM/YY - MM/YY)	Employer	Address	Phone	Can Can Employer be Contacted?
				☑ Yes ☐ No
				☑ Yes ☐ No
				☑ Yes ☐ No
				☑ Yes ☐ No
				☑ Yes ☐ No

Attestation

(Please complete a separate form for each provider)

Professional Questions and Attestation			
1. In the last five years, have you had any gaps of six months or greater, where you did not work as a practitioner in this current discipline? If "YES," please explain the reason(s) for any gap(s) on a separate page.	☑ Yes	☐ No	☐ N/A
2. Has your license(s) to practice in any jurisdiction(s), whether completed or still pending, ever been denied, limited, suspended, revoked, not renewed; or have you ever been placed under probation, subjected to disciplinary action, or have you voluntarily relinquished any license in anticipation of any actions?	☑ Yes	☐ No	☐ N/A
3. Has your professional liability insurance ever been denied, suspended, revoked, canceled, or not renewed?	☑ Yes	☐ No	☐ N/A
4. Have any of your DEA or State Drug Certificate registrations ever been denied, suspended, canceled, or subjected to any disciplinary action?	☑ Yes	☐ No	☐ N/A
5. Has your status as a provider, or membership with any professional organization, ever been denied, suspended, disciplined, canceled, sanctioned; or are you currently under investigation by any municipal, state, federal or any other governmental agency, HMO, PPO, or other prepaid health plan? (e.g., Medicare, Medicaid).	☑ Yes	☐ No	☐ N/A
6. Are your privileges or memberships at any hospital or institution (Military service) currently under investigation or have they ever been denied, suspended, reduced, disciplined, or not renewed?	☑ Yes	☐ No	☐ N/A
7. Are you able to perform any procedures within the scope of privileges and duties as a healthcare provider with or without reasonable accommodation?	☑ Yes	☐ No	☐ N/A
8. Do you currently, or did you in the last two years, engage in the unlawful use of drugs, including the improper use of prescription drugs?	☑ Yes	☐ No	☐ N/A
9. Do you have any felony or misdemeanor charges pending against you, other than traffic violations, or have you ever been convicted or pleaded "nolo contendere" to a felony?	☑ Yes	☐ No	☐ N/A
10. Have you been involved, within the last ten years, or are you currently involved in **any** claims/lawsuits, settlements, or judgments (other than divorce or custody)? If yes, please provide detailed information on a separate sheet of paper including: docket number of the case, location of the court, the names of the plaintiff(s) and defendant(s), description and date(s) of the incident(s), your involvement, current disposition, and the amount of settlement, if any.	☑ Yes	☐ No	☐ N/A
11. Are you currently practicing **without**, or with an **expired**, Professional Liability/Malpractice Insurance?	☑ Yes	☐ No	☐ N/A
12. Has your diagnostic/therapeutic certificate ever been suspended or otherwise limited?	☑ Yes	☐ No	☐ N/A
If you answered "yes" to any of the above questions, please explain, in detail, on an additional page.			
13. Providers participating with certain programs are mandated by the government to annually train staff on fraud, waste and abuse. (A presentation, if needed, is available on the Avēsis website.) Are you and your staff annually trained on fraud, waste, and abuse?	☑ Yes	☐ No	☐ N/A

I understand that acceptance of my application for participation in the Avēsis Vision Network may require Avēsis or its designee to review information listed above. I hereby authorize the release of such information to Avēsis and its authorized designee. I further understand that all information provided in this document will be held in confidence by Avēsis, to the extent permitted by law. I agree that Avēsis and its agents shall not be liable for any action or omission related to the evaluation or verification of information provided in this document. I further agree to notify Avēsis within thirty (30) days of any change to the information requested herein. I understand that submission of this application does not constitute approval or acceptance as an Avēsis participating provider.

I hereby acknowledge that I have read, and understood each of the questions contained herein and that I certify that the responses I have provided herein are accurate, complete, and the truth, to the best of my knowledge and belief.

Provider's Name (Print): _____

Signature: _____ Date: _____

Patients often express preferences for providers of a particular ethnic background or gender. Your completion of the information below will allow us to meet these patients' needs when a referral is requested. If you **volunteer** to provide this information it will be used only when a patient indicates that such information is important in selecting a provider and it will be held in the strictest confidence.

Ethnic Background: ☑ Asian/Pacific Islander ☐ Black/African American ☐ Caucasian ☐ Hispanic/Latino
☐ American Indian/Alaska Native American ☐ Other

Credential Verification Release

I, the undersigned provider, acknowledge and agree that Avēsis Incorporated and its subsidiaries have a valid interest in obtaining and verifying information concerning my professional competence for the sole purpose of evaluating my credentials and qualifications as a provider. Avēsis agrees to keep this information confidential and may use such confidential information only in the furtherance of the purposes and obligations of the Provider Agreement. Accordingly,

1. I represent and warrant to Avēsis that the information contained herein is true and complete, to the best of my knowledge and belief.

2. I authorize Avēsis or its authorized agents to consult with previous employers, members of medical or other professional staffs, malpractice carriers, hospital administrators and other persons to obtain and verify my credentials and qualifications as a provider. I release Avēsis and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and evaluating my application.

3. I consent to the release by any person to Avēsis or its authorized agents all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical stature. This information is to include any information relating to any disciplinary action; suspension or curtailment of surgical/medical privileges; and/or any malpractice actions. I hereby release any such person providing such information from any and all liability for doing so.

4. I agree to immediately notify Avēsis upon any investigation, revocation, reduction, termination, denial, limitation or suspension of my professional license, professional liability insurance, participation in Medicare or Medicaid Programs or other certification programs, DEA certification or other credentialing programs authorizing me to practice optometry or ophthalmology. I also agree to notify Avēsis upon termination, suspension or revocation of my staff privileges at any hospital or health care facility. I understand that the NPDB will be reviewed.

5. I agree to inform Avēsis promptly if any material change in the information submitted herein occurs whether before or after entering into an Agreement with Avēsis for the provision of professional services.

Provider Signature: _____ Date: _____

Printed Name: _____

Address: _____

Phone: _____

A photocopy of this consent shall be as effective as the original when so presented.