MSO-CRE-PPT-106-120921-S

MSO | HOLDINGS

Working Instructions: Provider Application

CREDENTIALING TEAM

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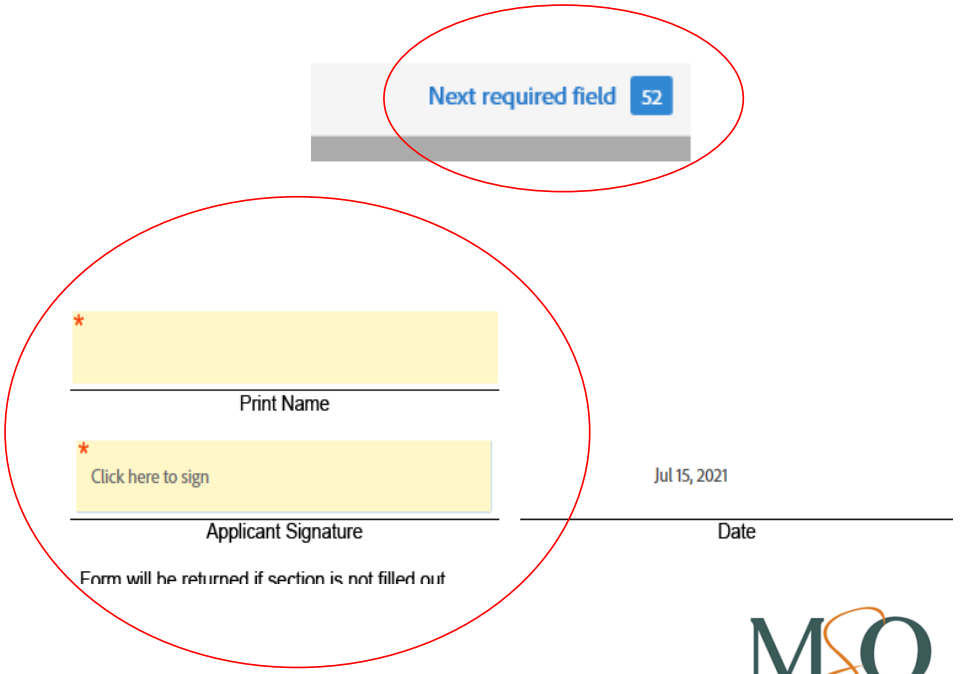
Important points

- If the application is closed before sending the information, the information will not be saved. Some probable reasons :
  - The time-out system closes the application after 15 minutes of inactivity.
  - Unstable internet connection
- Be sure to look up the requirements (under the applications option) to find out which documents you need before starting the process.
- Have all credentials available prior to the start of the event.
- Before you begin, confirm that you filled out the supplier application and not the facility application.
- The application will appear in the fields as you complete the document.

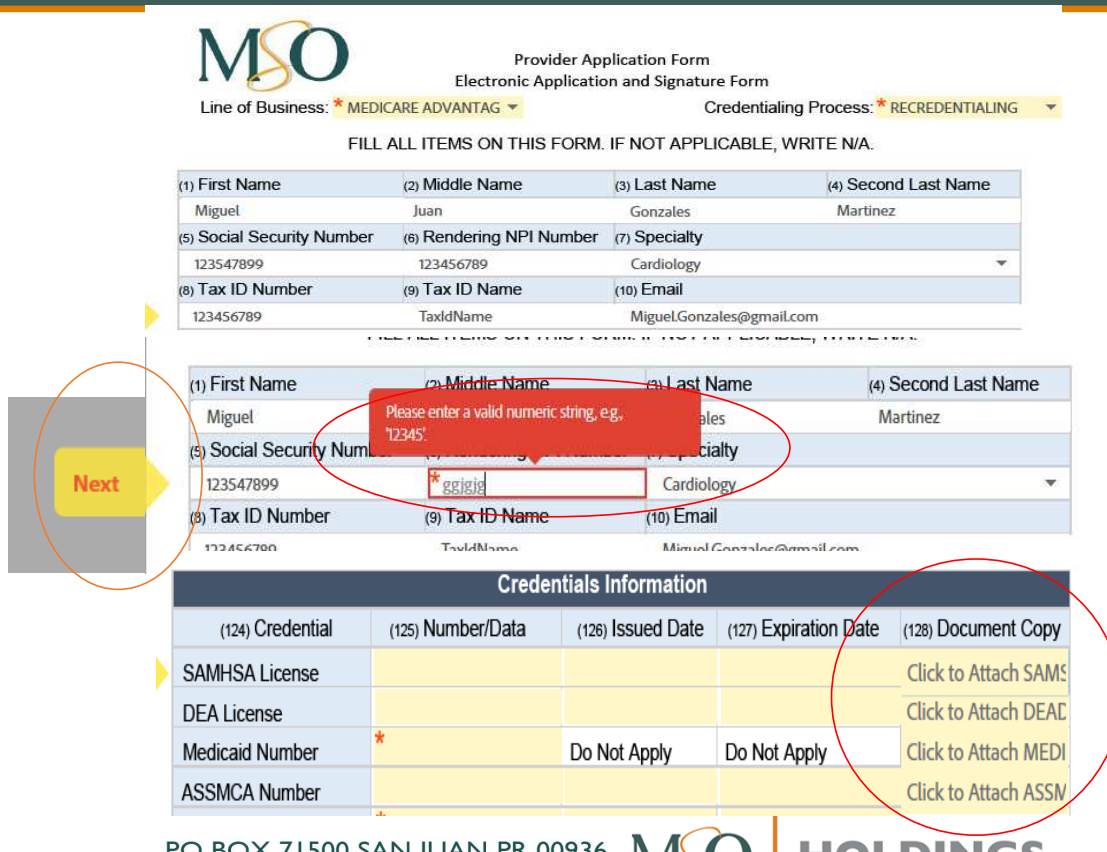
Important points

- If the Click to sign option does not appear at the end of the application, it means that the application has not been filled out completely.
  - In the upper right part of the screen, there is a button that will indicate errors in the application for quick troubleshooting.
- When you click to sign, the application will not be sent; you must first verify an email that Adobe will send you to complete the process.
- The application must be signed in the physician's name (page 11).
- The process of completing the application takes 20 to 30 minutes.



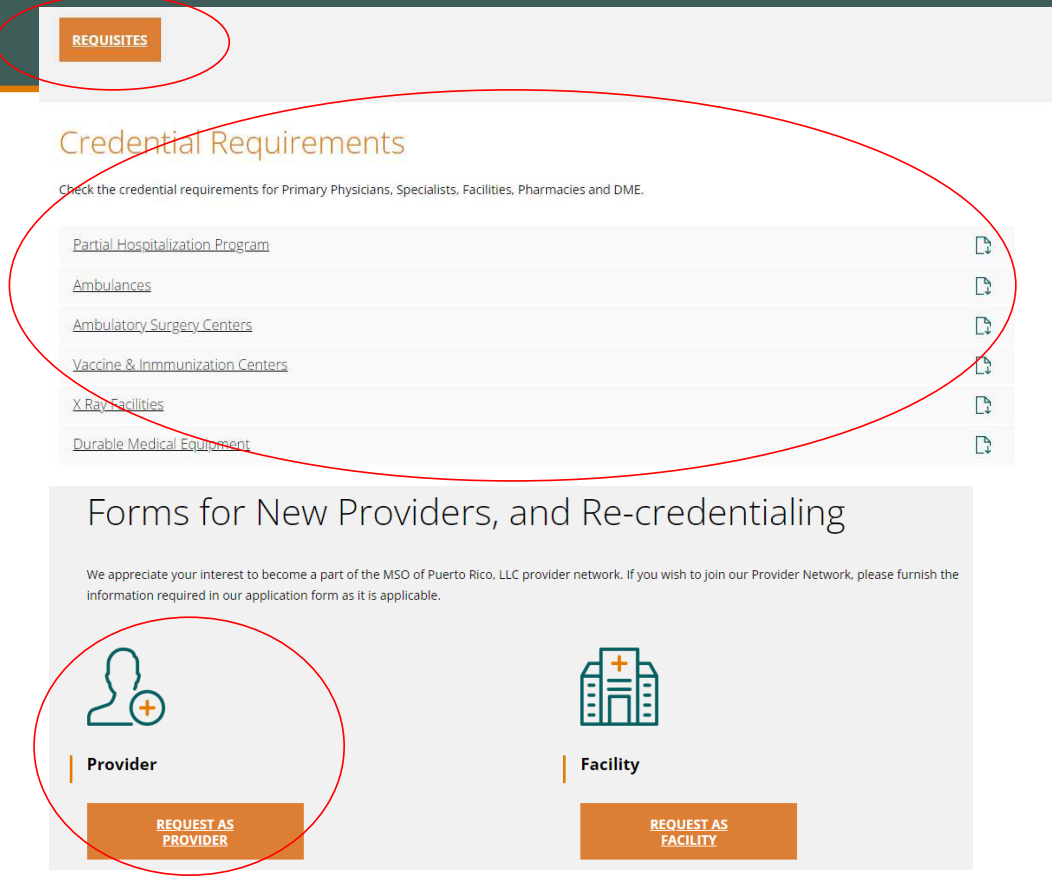
Important points

- The application has a bookmark that tells you what the next step is when filling out the application.
- Any information entered incorrectly will be highlighted and will include a note explaining the error.
- To attach a document, Click to Attach and select the required document. It will be attached to the application.



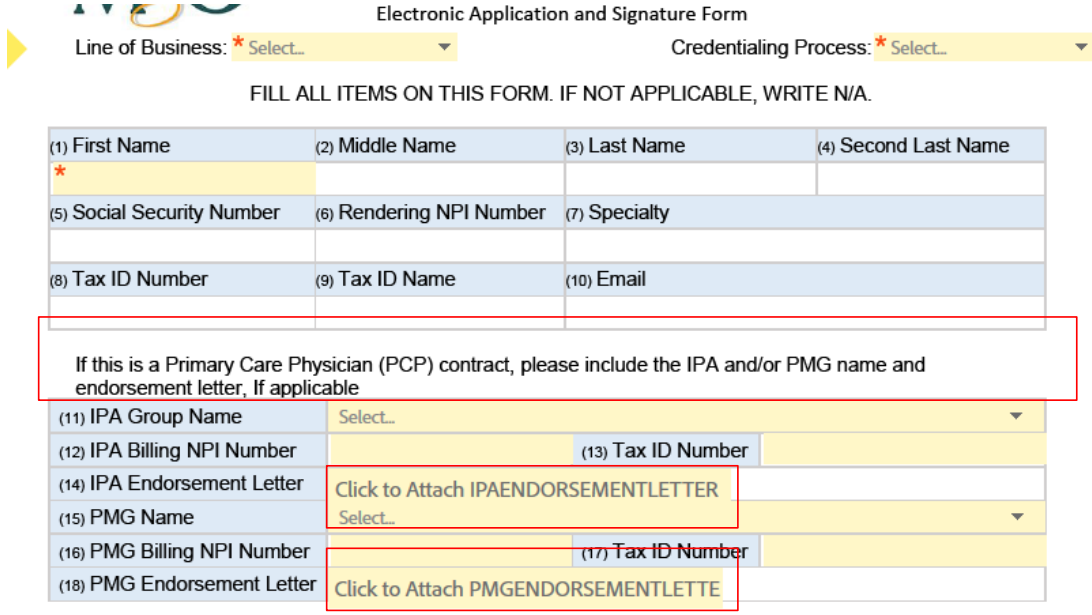
How is the process carried out?

- ✓ Visit this link : https://www.mso-pr.com/solicitudes/#
- ✓ Below, look for the option View Requirements and choose the option that applies to you.
- ✓ A new window will open with the requirements for your field. Make sure you read and have the required documents before starting the process.
- ✓ To get started, you will need to return to the previous window and scroll up until you reach the Request as Provider option.



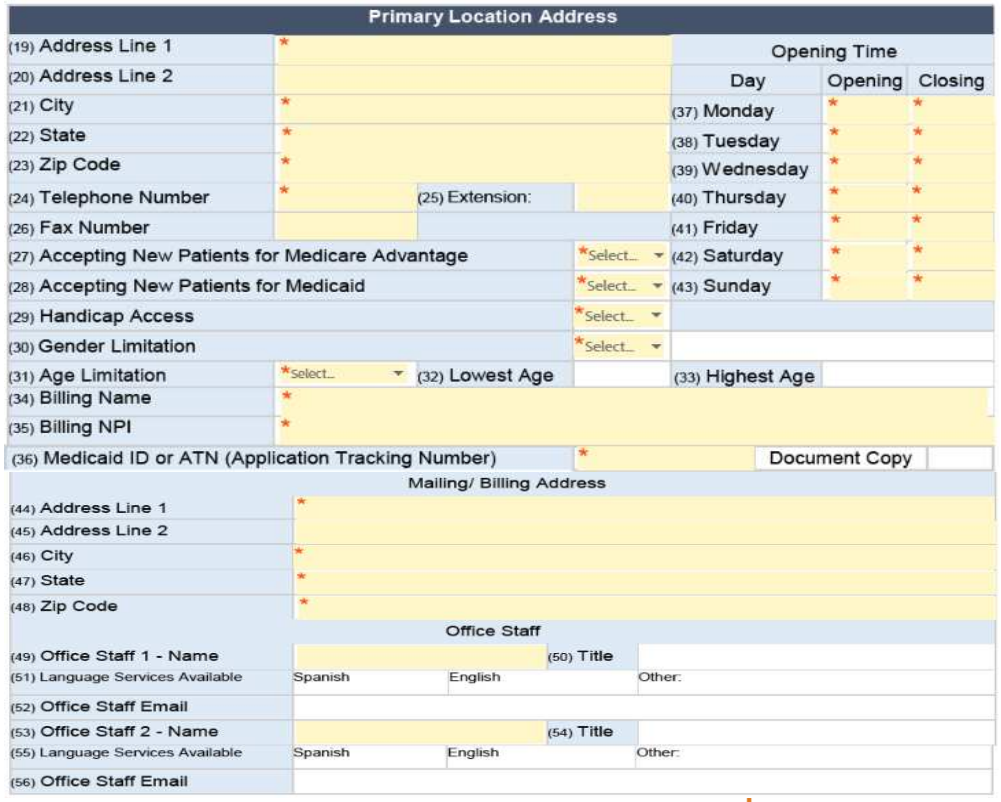
How is the process carried out? (Continued)

- ✓ Select **Line of Business**: Medicare Advantage, Vital, Medicare Advantage and Vital. And under Credentialing Process, select: Initial or Recredentialing.
- ✓ Then, include the supplier's name: first name, middle name, first last name and middle last name.
- ✓ Now, include the Social Security Number, Tax ID, Rendering NPI, Tax ID Name/Number, and Tax ID Name/Number.
- ✓ Primary physicians must include the IPA and/or PMG, and letter of endorsement if applicable.



How is the process carried out? (Continued)

- ✓ In the Primary Location Address section, include: *Primary Location Address (Address Line #2 is optional), Telephone, Extension, Fax, Office Hours, Accessibility Questions, Billing Name, Billing NPI and Medicaid ID*.
- ✓ In the Mailing Billing Address section, include: *Primary Location Address (Address Line #2 is optional), City, State and Zip Code*.
- ✓ In the Office Staff section, include *Office Staff 1 Name, your title, languages and email*; then Office Staff 2 *Name, your title, languages and email.*



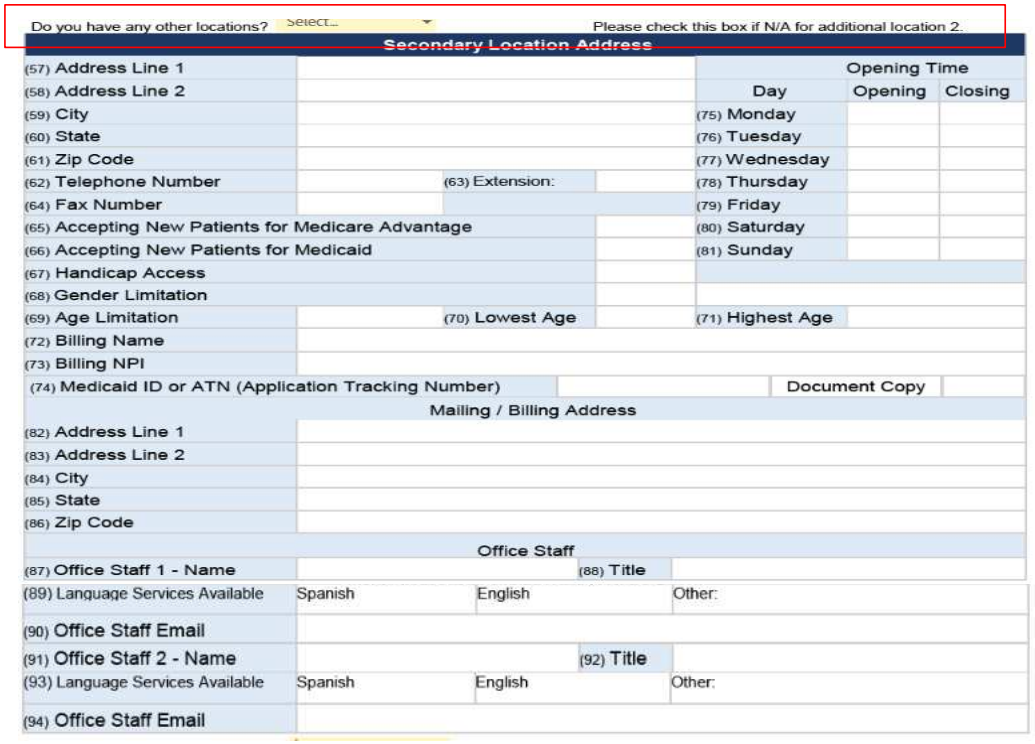
Primary Location Address						
(19) Address Line 1	*			Opening Time		
(20) Address Line 2				Day	Opening	Closing
(21) City	*			(37) Monday	*	*
(22) State	*			(38) Tuesday	*	*
(23) Zip Code	*			(39) Wednesday	*	*
(24) Telephone Number	*	(25) Extension:		(40) Thursday	*	*
(26) Fax Number				(41) Friday	*	*
(27) Accepting New Patients for Medicare Advantage			*Select...	(42) Saturday	*	*
(28) Accepting New Patients for Medicaid			*Select...	(43) Sunday	*	*
(29) Handicap Access			*Select...			
(30) Gender Limitation			*Select...			
(31) Age Limitation	*Select...	(32) Lowest Age		(33) Highest Age		
(34) Billing Name	*					
(35) Billing NPI	*					
(36) Medicaid ID or ATN (Application Tracking Number)	*		Document Copy			

Mailing/ Billing Address			
(44) Address Line 1	*		
(45) Address Line 2			
(46) City	*		
(47) State	*		
(48) Zip Code	*		

Office Staff			
(49) Office Staff 1 - Name		(50) Title	
(51) Language Services Available	Spanish	English	Other:
(52) Office Staff Email			
(53) Office Staff 2 - Name		(54) Title	
(55) Language Services Available	Spanish	English	Other:
(56) Office Staff Email			

How is the process carried out? (Continued)

- ✓ You can then add a second location, if necessary. Check the option Do you have any other locations? Yes or No. If you do not have any other locations, check Please check this box if N/A for additional location 2.
- ✓ Under Secondary Location Address, include Secondary Location Address (Address Line #2 is optional), Telephone, Extension, Fax, Office Hours, Accessibility Questions, Billing Name and Billing NPI.
- ✓ In the Mailing Billing Address section, include: Primary Location Address (Address Line #2 is optional), City, State, and Zip Code.
- ✓ In the Office Staff section, include Office Staff 1 Name, your title, languages and email; then Office Staff 2 Name, your title, languages and email.



Do you have any other locations?	Select...		Please check this box if N/A for additional location 2.		
Secondary Location Address					
(57) Address Line 1				Opening Time	
(58) Address Line 2				Day	Opening	Closing
(59) City				(75) Monday		
(60) State				(76) Tuesday		
(61) Zip Code				(77) Wednesday		
(62) Telephone Number		(63) Extension:		(78) Thursday		
(64) Fax Number				(79) Friday		
(65) Accepting New Patients for Medicare Advantage				(80) Saturday		
(66) Accepting New Patients for Medicaid				(81) Sunday		
(67) Handicap Access						
(68) Gender Limitation						
(69) Age Limitation		(70) Lowest Age		(71) Highest Age		
(72) Billing Name						
(73) Billing NPI						
(74) Medicaid ID or ATN (Application Tracking Number)			Document Copy			
Mailing / Billing Address						
(82) Address Line 1						
(83) Address Line 2						
(84) City						
(85) State						
(86) Zip Code						
Office Staff						
(87) Office Staff 1 - Name		(88) Title				
(89) Language Services Available	Spanish	English	Other:			
(90) Office Staff Email						
(91) Office Staff 2 - Name		(92) Title				
(93) Language Services Available	Spanish	English	Other:			
(94) Office Staff Email						

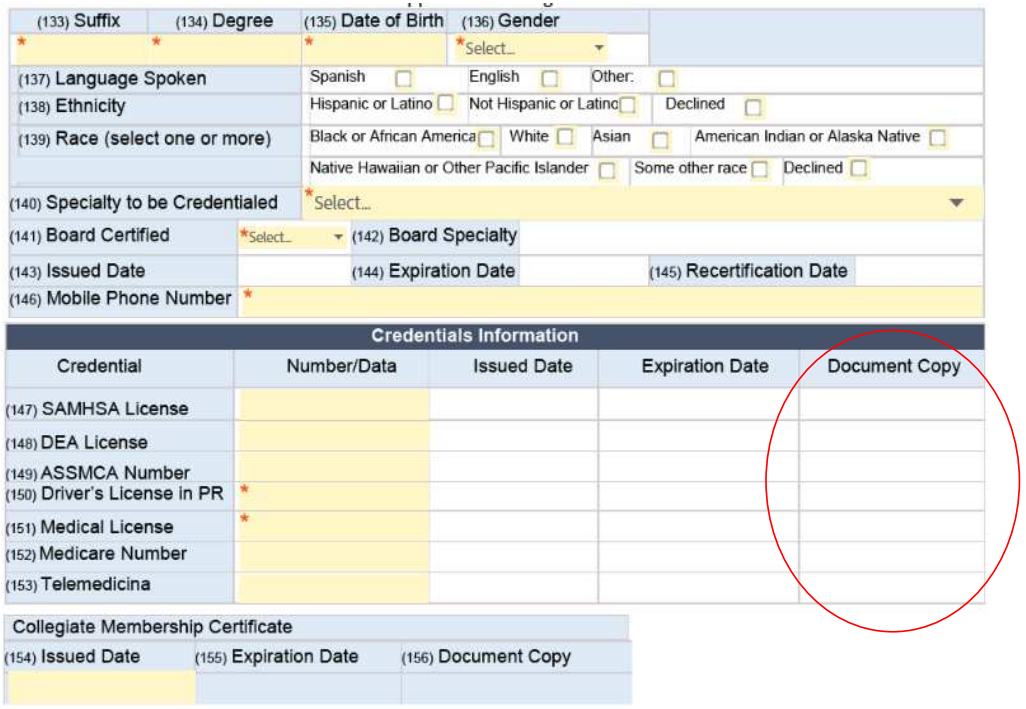
How is the process carried out? (Continued)

- ✓ You may also add an additional location, if needed. If so, in the Do you have any other locations? box, check Yes or No. If you do not have any other locations, check Please check this box if N/A for additional location 3.
- ✓ Under Other Location Address, include: Other Location Address (Address Line #2 is optional), Telephone, Extension, Fax, Office Hours, Accessibility Questions, Billing Name and Billing NPI.
- ✓ Under Mailing Billing Address, include: Primary Location Address (Address Line #2 is optional), City, State, and Zip Code.
- ✓ In the Office Staff section, include Office Staff 1 Name, your title, languages and email; then Office Staff 2 Name, your title, languages and email.

Do you have any other locations?	Select...			Please check this box if N/A for additional location 3.		
Other Location Address						
(95) Address Line 1				Opening Time		
(96) Address Line 2				Day	Opening	Closing
(97) City				(113) Monday		
(98) State				(114) Tuesday		
(99) Zip Code				(115) Wednesday		
(100) Telephone Number		(101) Extension:		(116) Thursday		
(102) Fax Number				(117) Friday		
(103) Accepting New Patients for Medicare Advantage				(118) Sunday		
(104) Accepting New Patients for Medicaid				(119) Saturday		
(105) Handicap Access						
(106) Gender Limitation						
(107) Age Limitation		(108) Lowest Age		(109) Highest Age		
(110) Billing Name						
(111) Billing NPI						
(112) Medicaid ID or ATN (Application Tracking Number)			Document Copy			
Mailing / Billing Address						
(120) Address Line 1						
(121) Address Line 2						
(122) City						
(123) State						
(124) Zip Code						
Office Staff						
(125) Office Staff 1 - Name			(126) Title			
(127) Language Services Available	Spanish	English	Other:			
(128) Office Staff Email						
(129) Office Staff 2 - Name			(130) Title			
(131) Language Services Available	Spanish	English	Other:			
(132) Office Staff Email						

How is the process carried out? (Continued)

- ✓ Under Credentialing Usage Information, include:
  - ✓ *Suffix, Degree, Date of Birth, Gender, Languages, Ethnicity, Race.*
  - ✓ *Specialty to be Credential*
  - ✓ *Board Certified* y *Specialty*
  - ✓ *Issued Date, Expiration Date* and recertification date
  - ✓ Mobile Phone Number
- ✓ In the Credentials Information section, include:
  - ✓ *SAMHSA, DEA License, ASSMCA Number, Drivers License in PR, Medical License, Medicare Number and Telemedicine (Include copy of these documents in the circulated section in the image*).
  - ✓ Include Issued Date, Expiration Date and copy of document in the Membership Certificate section.



(133) Suffix	(134) Degree	(135) Date of Birth	(136) Gender
*	*	*	*Select...

(137) Language Spoken	Spanish ☐	English ☐	Other: ☐		
(138) Ethnicity	Hispanic or Latino ☐	Not Hispanic or Latino ☐	Declined ☐		
(139) Race (select one or more)	Black or African America ☐	White ☐	Asian ☐	American Indian or Alaska Native ☐	
	Native Hawaiian or Other Pacific Islander ☐	Some other race ☐	Declined ☐		
(140) Specialty to be Credentialed	*Select...				
(141) Board Certified	*Select...	(142) Board Specialty			
(143) Issued Date		(144) Expiration Date		(145) Recertification Date	
(146) Mobile Phone Number	*				

Credentials Information

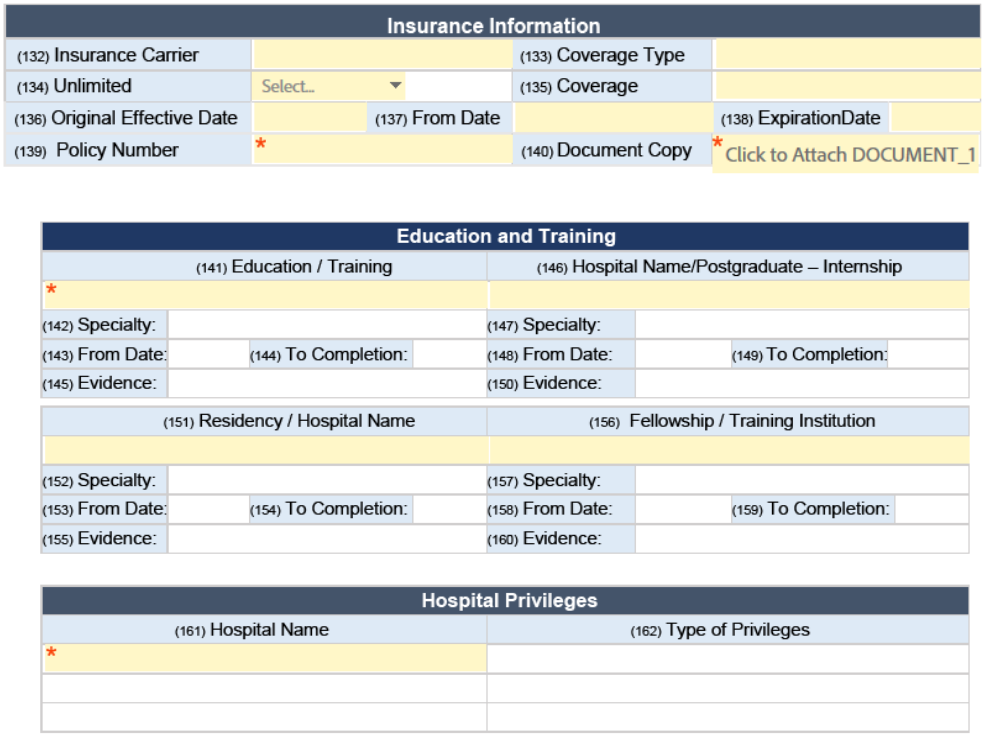
Credential	Number/Data	Issued Date	Expiration Date	Document Copy
(147) SAMHSA License				
(148) DEA License				
(149) ASSMCA Number				
(150) Driver's License in PR	*			
(151) Medical License	*			
(152) Medicare Number				
(153) Telemedicina				

Collegiate Membership Certificate

(154) Issued Date	(155) Expiration Date	(156) Document Copy

How is the process carried out? (Continued)

- ✓ Under Insurance Information, include:
  - ✓ *Insurance Carrier* y *Coverage Type*
  - ✓ *Unlimited* and *Coverage*
  - ✓ *Original Effective Date, From Date and Expiration Date*
  - ✓ *Policy Number* y *Document Copy* (attached)
- ✓ In Education and Training, include:
  - ✓ *Speciality*
  - ✓ *From Date and To Completion*
  - ✓ *Evidence*
    - ✓ *Aplican a *Education/Training, Hospital Name/Postgraduate-Internship, Residency/Hospital name and Fellowship/Training Institution**
- ✓ At Hospital Privileges, include:
  - ✓ Hospital name and type of privilege



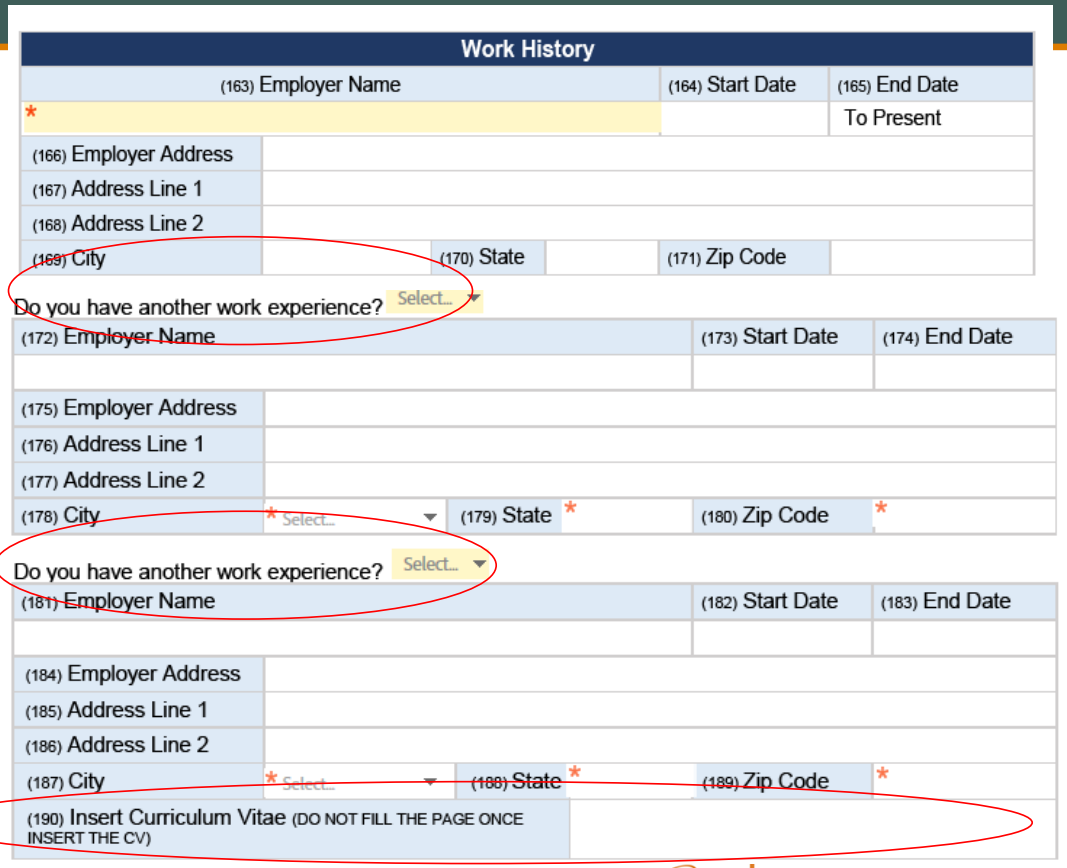
Insurance Information			
(132) Insurance Carrier		(133) Coverage Type	
(134) Unlimited	Select...	(135) Coverage	
(136) Original Effective Date	(137) From Date		(138) ExpirationDate
(139) Policy Number	*	(140) Document Copy	* Click to Attach DOCUMENT_1

Education and Training			
(141) Education / Training		(146) Hospital Name/Postgraduate – Internship	
*			
(142) Specialty:		(147) Specialty:	
(143) From Date:	(144) To Completion:	(148) From Date:	(149) To Completion:
(145) Evidence:		(150) Evidence:	
(151) Residency / Hospital Name		(156) Fellowship / Training Institution	
(152) Specialty:		(157) Specialty:	
(153) From Date:	(154) To Completion:	(158) From Date:	(159) To Completion:
(155) Evidence:		(160) Evidence:	

Hospital Privileges	
(161) Hospital Name	(162) Type of Privileges
*	

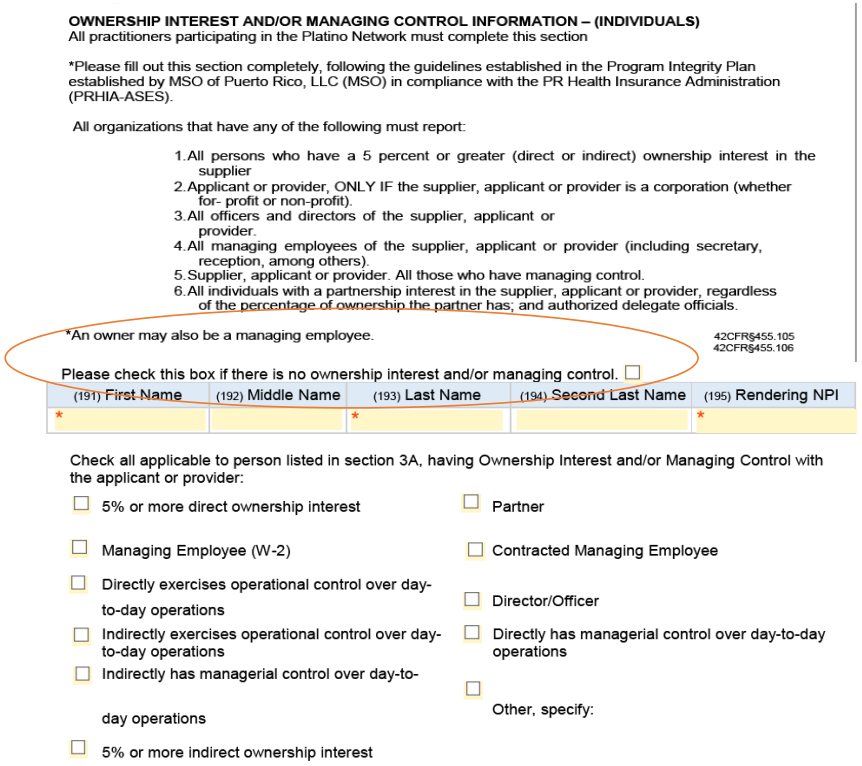
How is the process carried out? (Continued)

- ✓ In *Work History*, include:
  - ✓ *Employer Name, Start Date and End Date*
  - ✓ *Employer Address, Address line 1* and *2* (opcional)
  - ✓ *City, State and Zip Code*
- ✓ If you have more work experience, check Yes or No to the Do you have another work experience? question, add:
  - ✓ *Employer Name, Start Date* and *End Date*
  - ✓ *Employer Address, Address line 1 and 2* (optional)
  - ✓ *City, State and Zip Code*
  - ✓ *Include a CV or Resume*



How is the process carried out? (Continued)

- ✓ *In Ownership Interest and/or Managing Control Information*:
  - ✓ Please read and follow the stipulated guidelines..
  - ✓ Si no aplica, marque *Please check this box if there is no ownership interest and/or managing control.*
  - ✓ If applicable, include :
    - ✓ First name, middle name, first name, last name, middle name and Rendering NPI
    - ✓ Check what applies to persons listed in the 3rd section with Ownership Interest and/or Managing Control with the applicant or Provider.



OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION – (INDIVIDUALS)
All practitioners participating in the Platino Network must complete this section

*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-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.

42CFR§455.105
42CFR§455.106

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

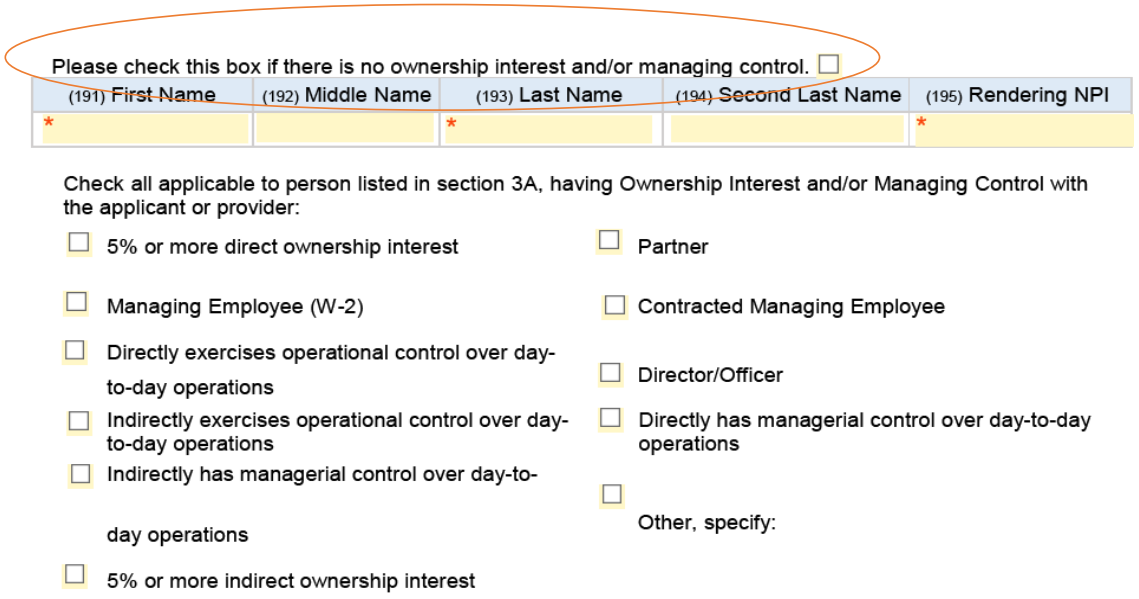
(191) First Name	(192) Middle Name	(193) Last Name	(194) Second Last Name	(195) Rendering NPI
*		*		*

Check all applicable to person listed in section 3A, 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:

How is the process carried out? (Continued)

- ✓ If applicable, include:
  - ✓ First name, middle name, first name, last name, middle name and Rendering NPI
  - ✓ Check what applies to persons listed in the 3rd section with *Ownership Interest and/or Managing Control with the applicant or Provider*.



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

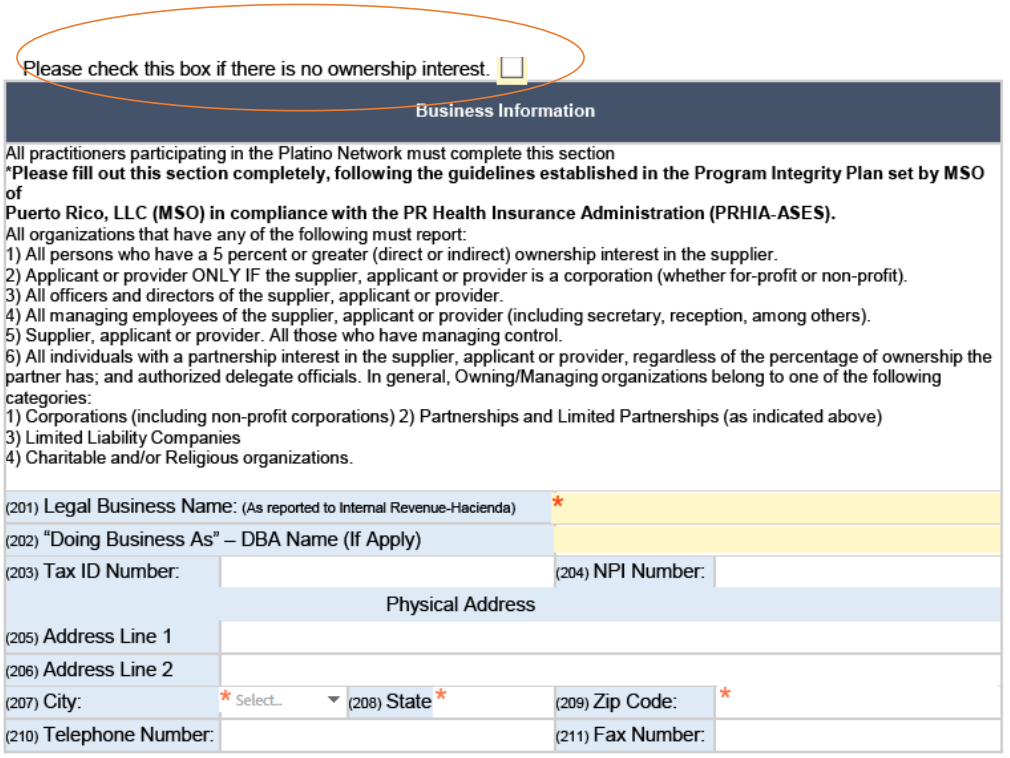
(191) First Name	(192) Middle Name	(193) Last Name	(194) Second Last Name	(195) Rendering NPI
*		*		*

Check all applicable to person listed in section 3A, 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:

How is the process carried out? (Continued)

- ✓ Continue to *Business Information*:
- ✓ If not applicable, check *Please check this box if there is no ownership interest*
  - ✓ Read and follow the stipulated guidelines.
  - ✓ Include:
    - ✓ *Legal Business Name*
    - ✓ *Doing Business As - DBA Name*
    - ✓ *Tax ID Number*
    - ✓ *NPI Number*
    - ✓ *Physical Address (Address line 1 and 2(optional)) City, State, Zip Code, Telephone Number and Fax Number*



Please check this box if there is no ownership interest. ☐

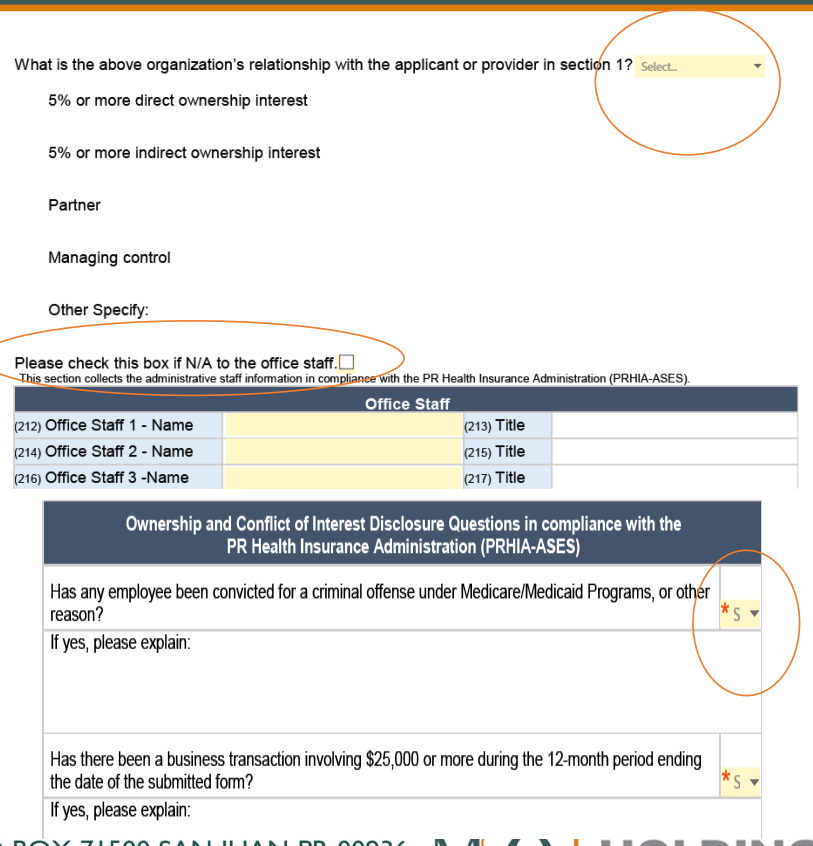
Business Information

All practitioners participating in the Platino Network must complete this section
***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. 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.

(201) Legal Business Name: (As reported to Internal Revenue-Hacienda) *			
(202) "Doing Business As" – DBA Name (If Apply)			
(203) Tax ID Number:		(204) NPI Number:	
Physical Address			
(205) Address Line 1			
(206) Address Line 2			
(207) City:	* Select... (208) State *	(209) Zip Code:	*
(210) Telephone Number:		(211) Fax Number:	

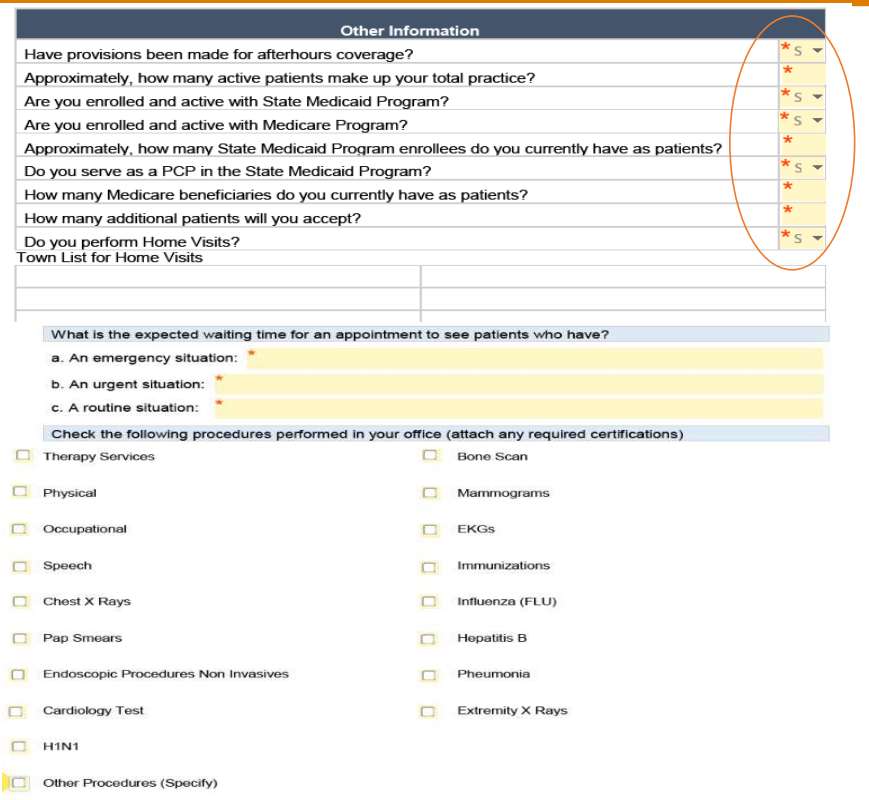
How is the process carried out? (Continued)

- ✓ Check Yes or No for What is the above organization's relationship with the applicant or provider in section 1? If Yes, check all that apply.
- ✓ In the following section, include administrative information, according to PR Health Insurance Administration.
- ✓ If not applicable, check *Please check this box if N/A to the office staff*
  - ✓ Include:
    - ✓ Office Staff Name 1, 2 and 3, and their respective titles.
- ✓ In *Ownership and Conflict of Interest Disclosure Questions in compliance with the PR Health Insurance Administration:*
  - ✓ Check Yes or No to the right of the questions (17 in total)
  - ✓ If the answer is Yes, provide an explanation



How is the process carried out? (Continued)

- ✓ In *Other Information*:
  - ✓ Please answer with the options provided to the right of each question.
  - ✓ When checking Yes in Do you perform home visits?, you must list in the boxes the towns where you perform them.
  - ✓ Answer the questions on patient waiting time.
  - ✓ Check all procedures that are carried out in your office.



Other Information

Have provisions been made for afterhours coverage?	* S
Approximately, how many active patients make up your total practice?	*
Are you enrolled and active with State Medicaid Program?	* S
Are you enrolled and active with Medicare Program?	* S
Approximately, how many State Medicaid Program enrollees do you currently have as patients?	*
Do you serve as a PCP in the State Medicaid Program?	* S
How many Medicare beneficiaries do you currently have as patients?	*
How many additional patients will you accept?	*
Do you perform Home Visits?	* S

Town List for Home Visits

What is the expected waiting time for an appointment to see patients who have?

a. An emergency situation: *

b. An urgent situation: *

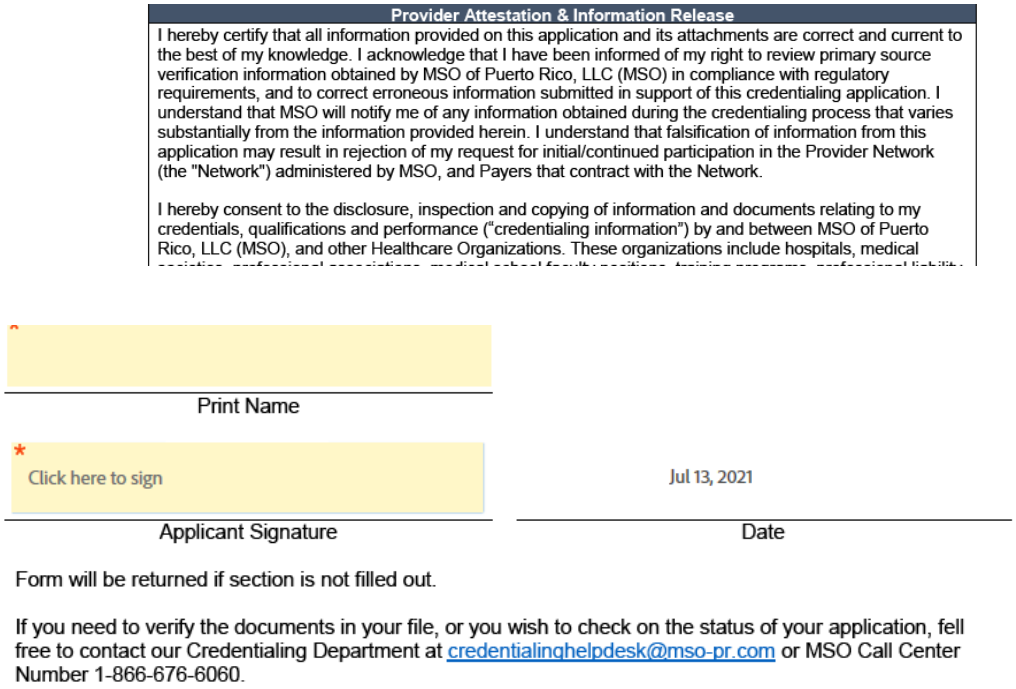
c. A routine situation: *

Check the following procedures performed in your office (attach any required certifications)

Therapy Services	Bone Scan
Physical	Mammograms
Occupational	EKGs
Speech	Immunizations
Chest X Rays	Influenza (FLU)
Pap Smears	Hepatitis B
Endoscopic Procedures Non Invasives	Pheumonia
Cardiology Test	Extremity X Rays
H1N1	
Other Procedures (Specify)	

How is the process carried out? (Continued)

- ✓ In the last section, you will find the Provider Attestation & Information Release, which you should read completely before completing the process.
- ✓ Write the physician's name and include his/her signature, as well as the date.
- ✓ Remember, when you click to sign, you will receive an email from Adobe to confirm and submit the completed application.



Provider Attestation & Information Release

I hereby certify that all information provided on this application and its attachments are 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

Print Name

Click here to sign

Jul 13, 2021

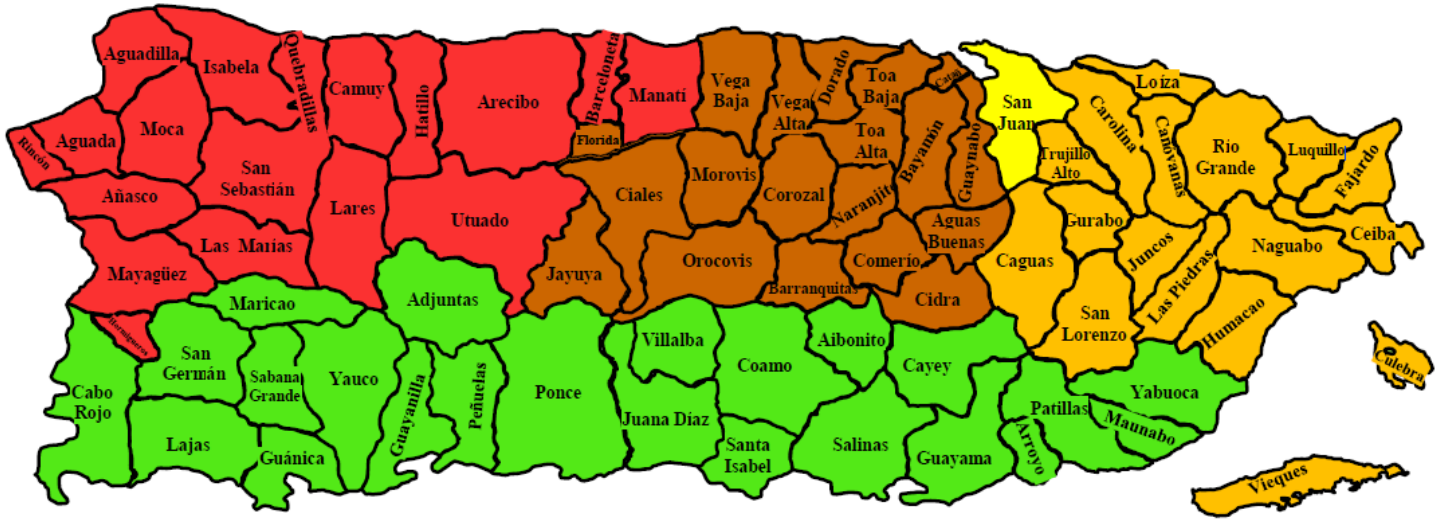
Applicant Signature

Date

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, fell free to contact our Credentialing Department at credentialinghelpdesk@mso-pr.com or MSO Call Center Number 1-866-676-6060.

Credentialing Staff



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787-460-4518

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787-918-5623

Yaislin Ruiz Ramos
787-309-6181

Luis Sierra Rosado
Cel. 787-309-8128

Cathyana Ortega Sierra
787-370-1432

Still have doubts about the process?

- If you need to update an expired credential to keep your file up to date, please send the information to: **CredentialingUpdates@mso-pr.com**.
- If you need additional information, please call Provider Services a:
  - **787-993-2317 (Metro Area)**
  - **1-866-676-6060 (Free of charge)**


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HOLDINGS