MSO-CRE-PPT-106-120921-S

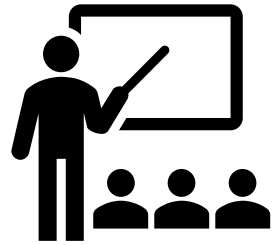
MSO | HOLDINGS

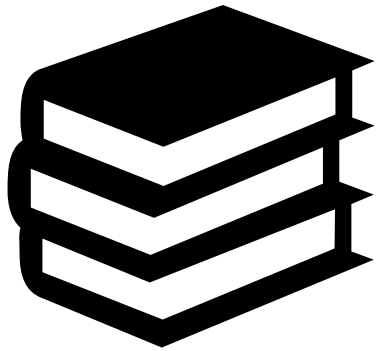
Working Instructions:
Aplicación de Proveedor

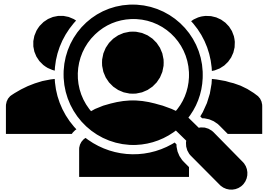
CREDENTIALING TEAM

Tabla de contenido

- Puntos importantes
- Cómo se realiza el proceso





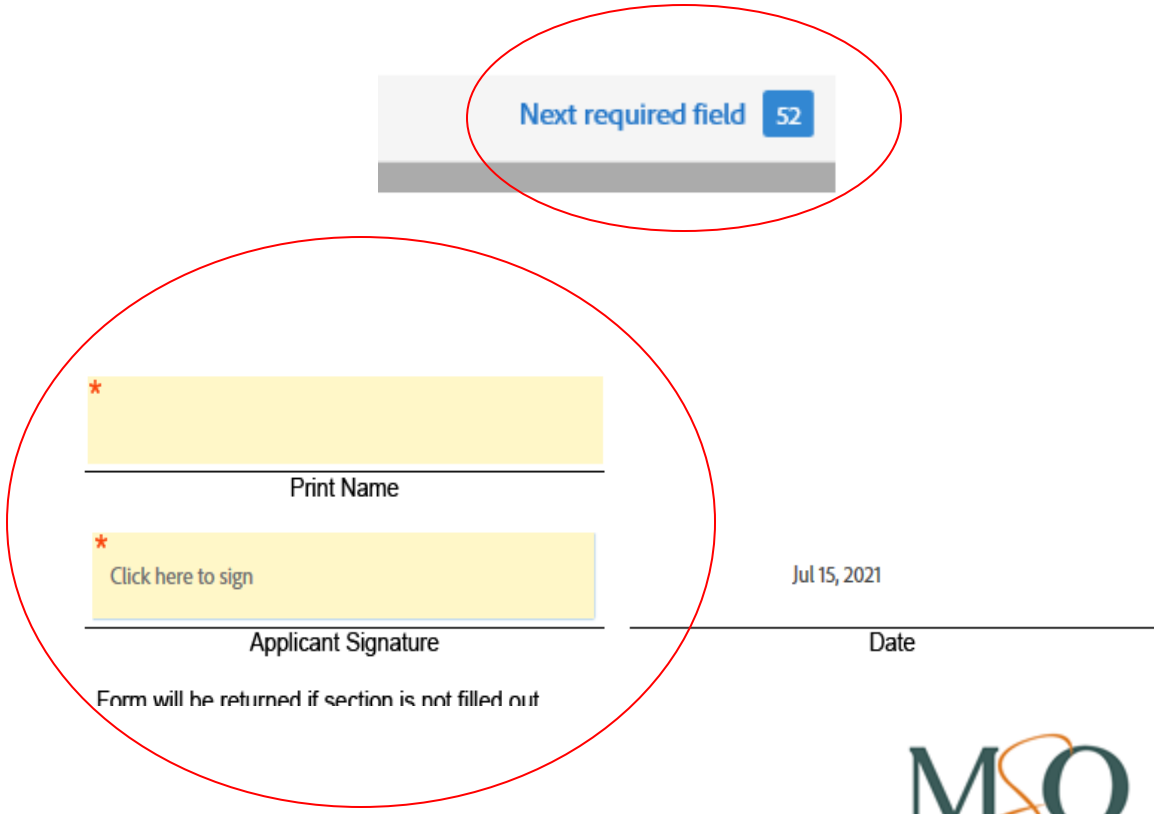


Puntos importantes

- Si la aplicación se cierra antes de enviar la información, esta no se guardará. Algunas razones probables:
  - El *time-out system* cierra la aplicación tras 15 minutos de inactividad.
  - Conexión inestable de internet
- Asegúrese de buscar los requisitos (bajo la opción de **aplicaciones**) para saber cuáles documentos necesita antes de comenzar el proceso.
- Tener todas las credenciales disponibles antes de comenzar el mismo.
- Antes de comenzar, confirme que llenó la aplicación de proveedores y **no** la de facilidad.
- La aplicación irá llenando los encasillados según usted vaya completando el documento.

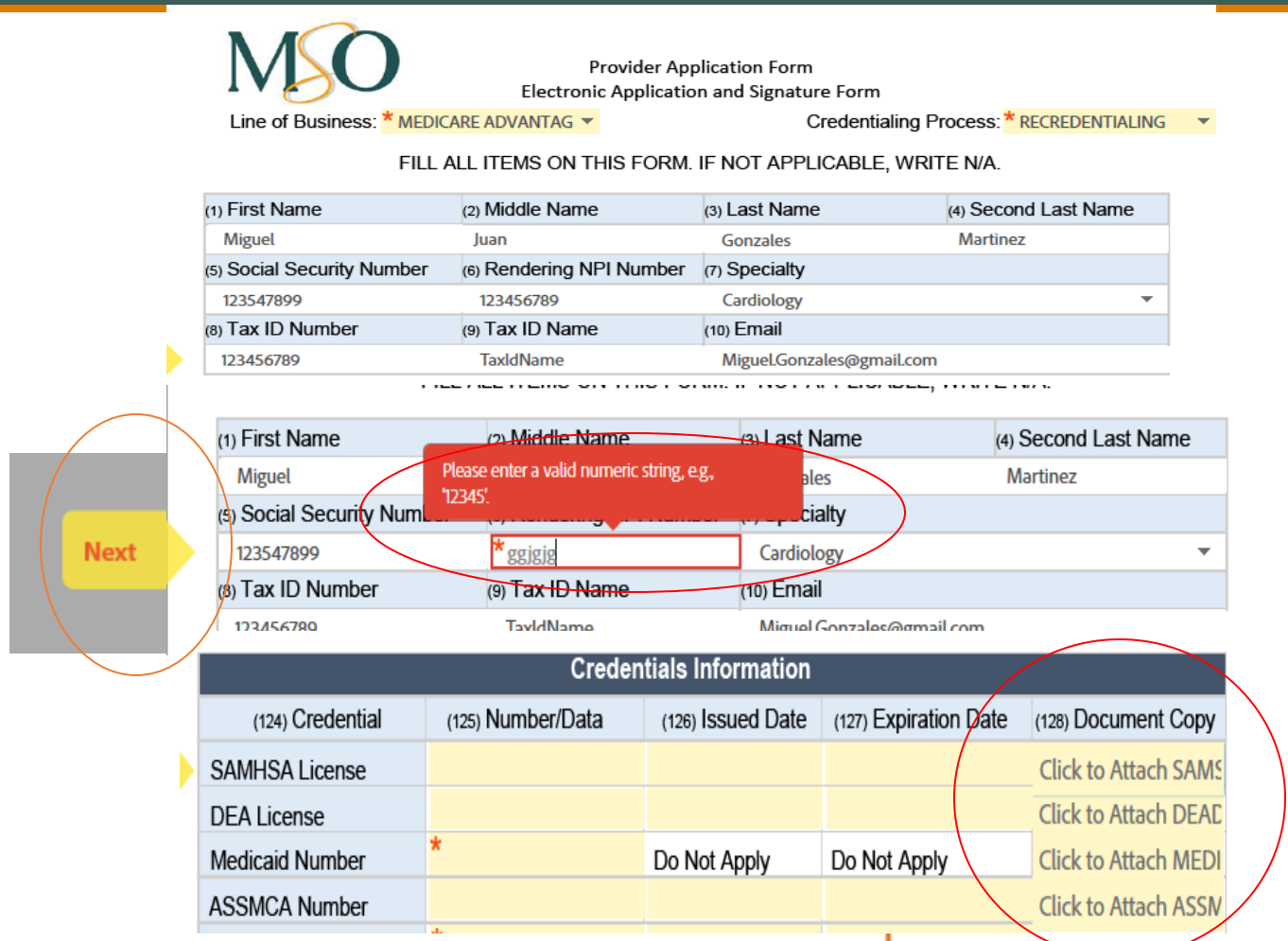
Puntos importantes

- Si no aparece la opción de *Click to sign* al llegar al final de la aplicación, significa que no se ha llenado en su totalidad.
  - En la parte superior derecha, aparece un botón que le indicará los errores en la aplicación para solucionarlos de manera rápida.
- Al pulsar *click to sign,* la aplicación **no** se enviará; primero tiene que verificar un correo electrónico que Adobe le enviará para completar el proceso.
- La aplicación debe firmarse a nombre del médico (pagina 11).
- El proceso de completar la aplicación toma de 20 a 30 minutos.



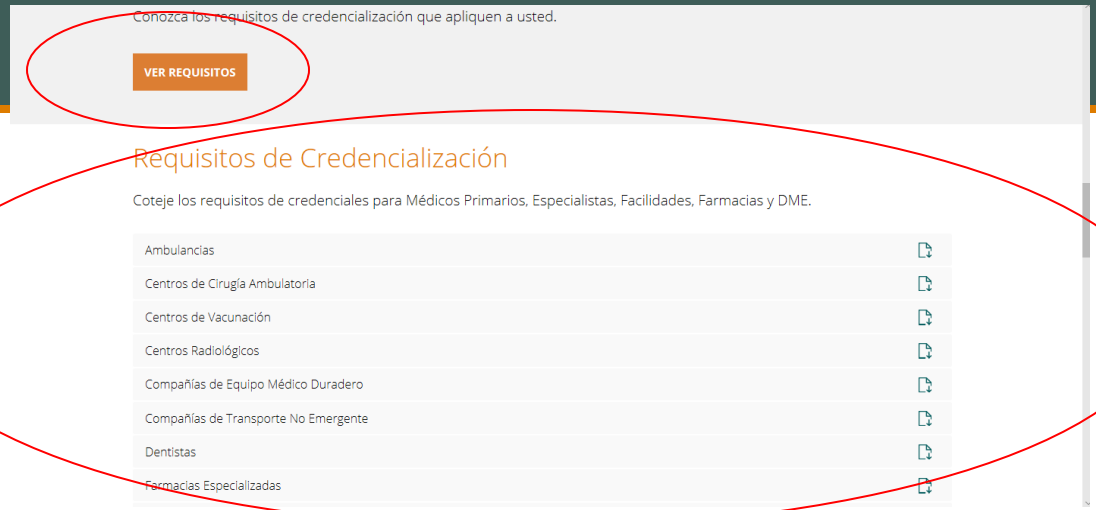
Puntos importantes

- La aplicación cuenta con un marcador que le indica cuál es el siguiente paso al llenar la aplicación.
- Cualquier información ingresada incorrectamente será resaltada e incluirá una nota que explica el error.
- Para anejar un documento, presione *Click to Attach* y seleccione el documento requerido. Este se anejará a la aplicación.



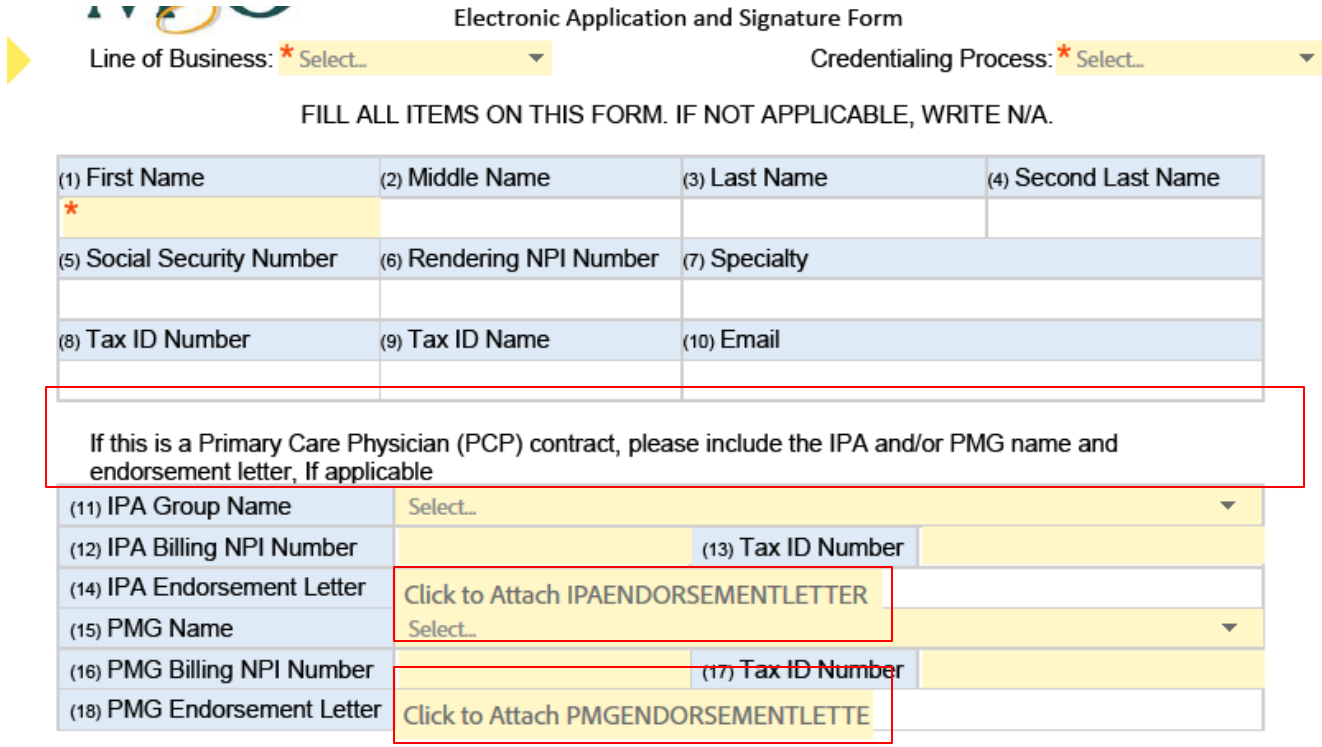
¿Cómo se realiza el proceso?

- ✓ Visite este enlace: https://www.mso-pr.com/solicitudes/#
- ✓ Abajo, busque la opción de **Ver Requisitos** y escoja la opción que le corresponda.
- ✓ Se abrirá una ventana nueva con los requisitos de su campo. Asegúrese de leer y tener los documentos requeridos antes de comenzar el proceso.
- ✓ Para comenzar, tendrá que volver a la ventana previa y desplazarse hacia arriba hasta llegar a la opción de **Solicite como Proveedor.**



¿Cómo se realiza el proceso? (Continuación)

- ✓ Seleccione **Line of Business**: Medicare Advantage, Vital, Medicare Advantage and Vital. Y en *Credentialing Process,* seleccione: *Initial* o *Recredentialing*.
- ✓ Luego, incluir el nombre del proveedor: primer nombre, segundo nombre, primer apellido y segundo apellido.
- ✓ Ahora, incluya el número de seguro social, Tax ID, Rendering NPI, Tax ID Name/Number.
- ✓ Médicos primarios deben incluir el IPA y/o el PMG, y la carta de endoso si aplica.



Electronic Application and Signature Form

Line of Business: * Select...

Credentialing Process: * Select...

FILL ALL ITEMS ON THIS FORM. IF NOT APPLICABLE, WRITE N/A.

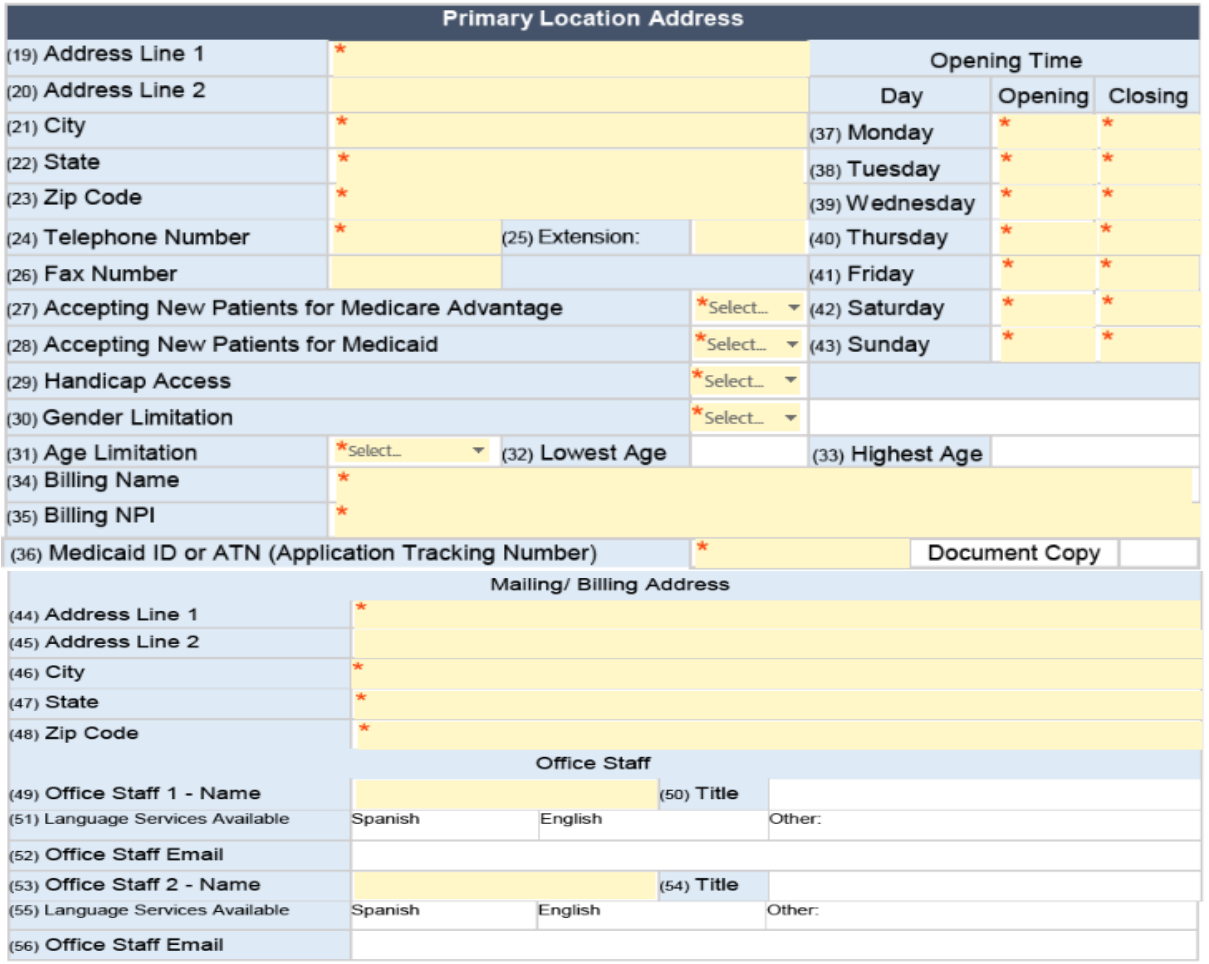
(1) First Name	(2) Middle Name	(3) Last Name	(4) Second Last Name
*			
(5) Social Security Number	(6) Rendering NPI Number	(7) Specialty	
(8) Tax ID Number	(9) Tax ID Name	(10) Email	

If this is a Primary Care Physician (PCP) contract, please include the IPA and/or PMG name and endorsement letter, If applicable

(11) IPA Group Name	Select...		
(12) IPA Billing NPI Number		(13) Tax ID Number	
(14) IPA Endorsement Letter	Click to Attach IPAENDORSEMENTLETTER		
(15) PMG Name	Select...		
(16) PMG Billing NPI Number		(17) Tax ID Number	
(18) PMG Endorsement Letter	Click to Attach PMGENDORSEMENTLETTE		

¿Cómo se realiza el proceso? (Continuación)

- ✓ En la sección de *Primary Location Address*, incluya: *Primary Location Address (Address Line #2 is optional), Telephone, Extension, Fax, Office Hours, Accessibility Questions, Billing Name, Billing NPI y Medicaid ID*.
- ✓ En la sección de *Mailing Billing Address*, incluya: *Primary Location Address (Address Line #2 is optional), City, State y Zip Code*.
- ✓ En la sección de *Office Staff*, incluya *Office Staff 1 Name,* su título, idiomas y email; luego el *Office Staff 2 Name,* su título, idiomas y 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

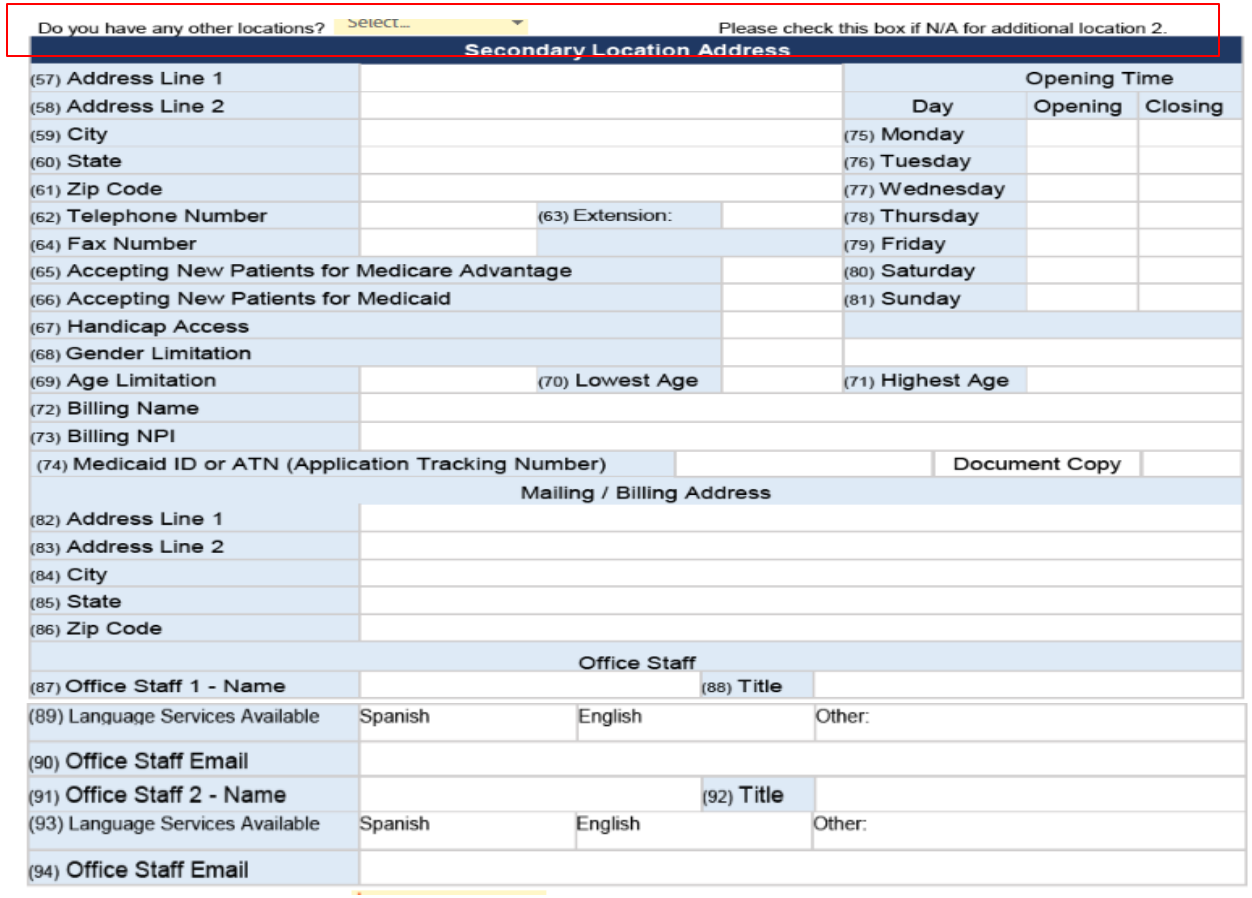
(44) Address Line 1	*		
(45) Address Line 2			
(46) City	*		
(47) State	*		
(48) Zip Code	*		

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			

¿Cómo se realiza el proceso? (Continuación)

- ✓ Luego, podrá añadir una segunda localidad, de ser necesario. Marque la opción *Do you have any other locations? Yes* o *No*. Si no tiene otra localidad, marque *Please check this box if N/A for additional location* 2.
- ✓ En *Secondary Location Address*, incluya *Secondary Location Address (Address Line #2 is optional), Telephone, Extension, Fax, Office Hours, Accessibility Questions, Billing Name* y *Billing NPI.*
- ✓ En la sección de *Mailing Billing Address*, incluya: *Primary Location Address (Address Line #2 is optional), City, State* y *Zip Code*.
- ✓ En la sección de *Office Staff*, incluya *Office Staff 1 Name,* su título, idiomas y email; luego el *Office Staff 2 Name,* su título, idiomas y email.



Do you have any other locations? Select... Please check this box if N/A for additional location 2.

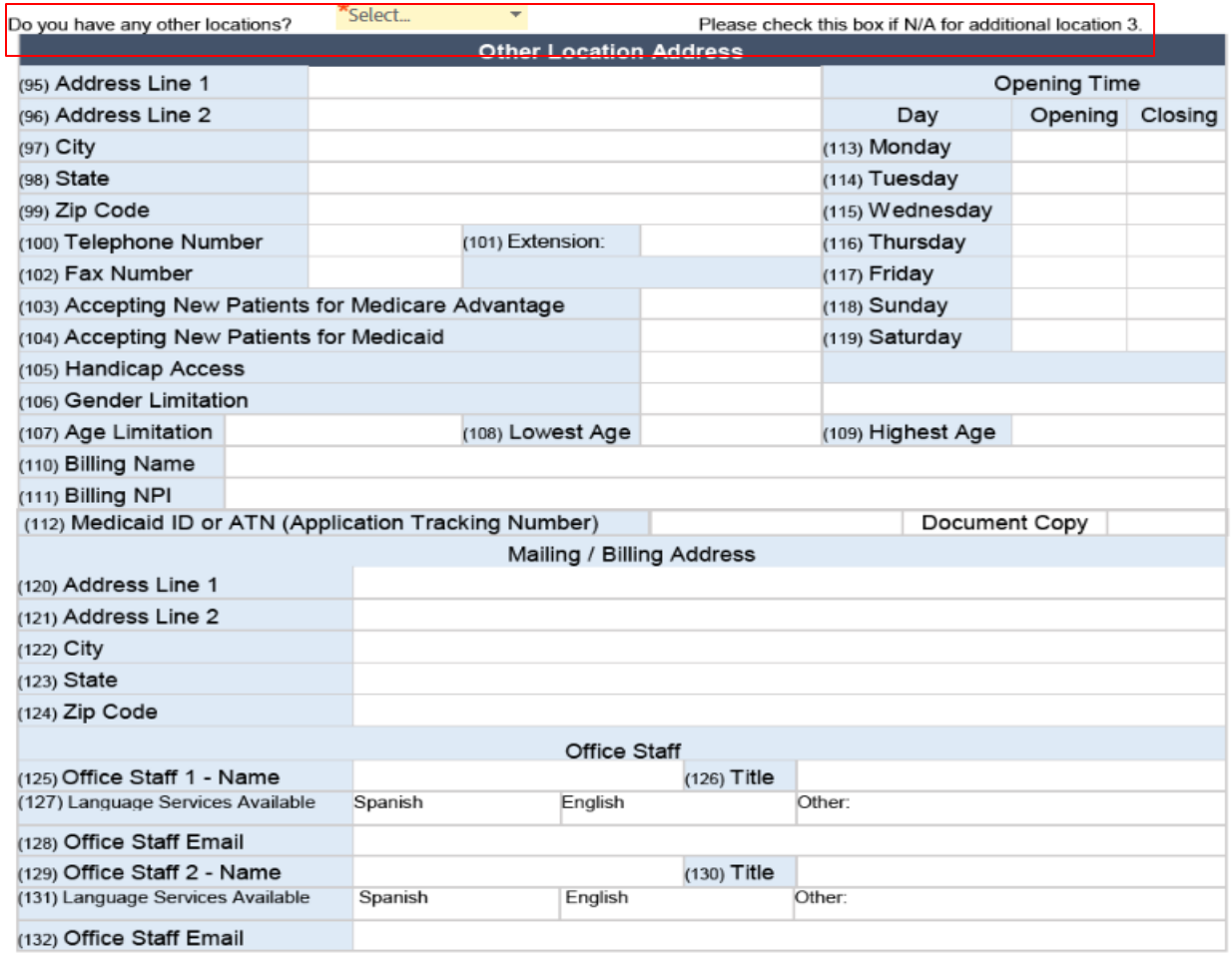
Secondary Location Address						
(57) Address Line 1				Opening Time		
(58) Address Line 2				Day	Opening	Closing
(59) City				(75) Monday		
(60) State				(76) Tuesday		
(61) Zip Code				(77) Wednesday		
(62) Telephone Number		(63) Extension:		(78) Thursday		
(64) Fax Number				(79) Friday		
(65) Accepting 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			

¿Cómo se realiza el proceso? (Continuación)

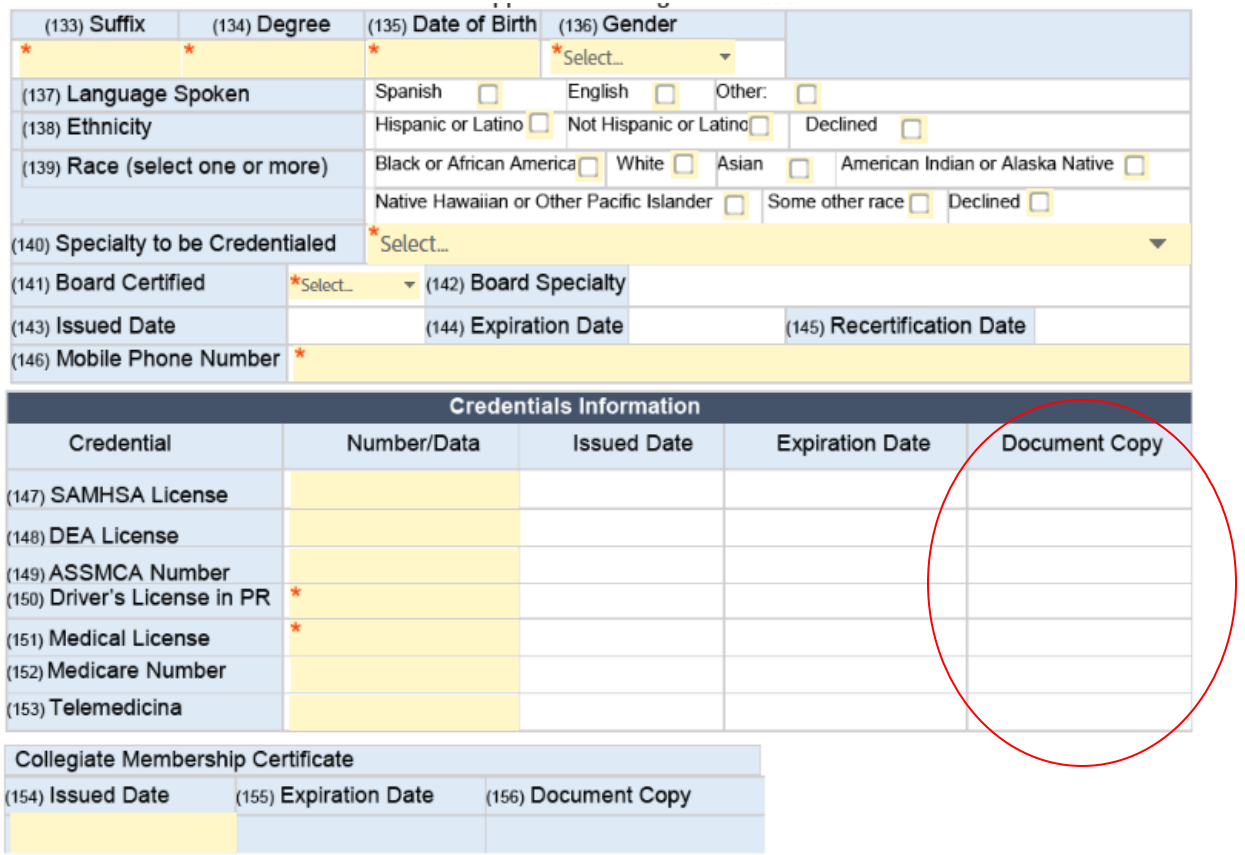
- ✓ Además, podrá añadir otra localidad, si así lo necesitara. De ser así, en la opción *Do you have any other locations?,* marque *Yes* o *No*. Si no tiene otra, marque *Please check this box if N/A for additional location 3*.
- ✓ En *Other Location Address*, incluya: *Other Location Address (Address Line #2 is optional), Telephone, Extension, Fax, Office Hours, Accessibility Questions, Billing Name* y *Billing NPI*.
- ✓ En *Mailing Billing Address,* incluya: *Primary Location Address (Address Line #2 is optional), City, State* y *Zip Code*.
- ✓ En la sección de *Office Staff*, incluya *Office Staff 1 Name,* su título, idiomas y email; luego el *Office Staff 2 Name,* su título, idiomas y 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					

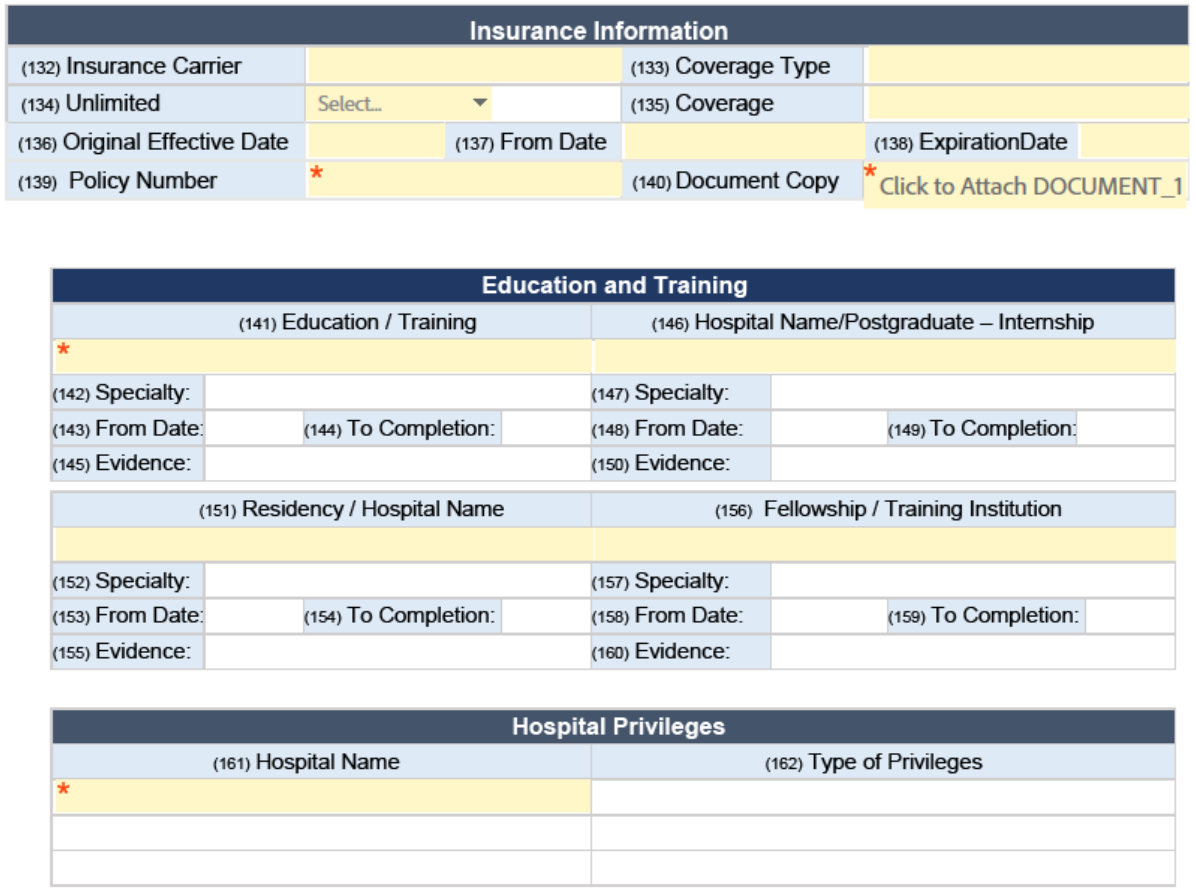
¿Cómo se realiza el proceso? (Continuación)

- ✓ En **Información para uso de credencialización**, incluya:
  - ✓ *Suffix, Degree, Date of Birth, Gender, Languages, Ethnicity, Race.*
  - ✓ *Specialty to be Credential*
  - ✓ *Board Certified* y *Specialty*
  - ✓ *Issued Date, Expiration Date* y el recertification date
  - ✓ Mobile Phone Number
- ✓ En la sección de *Credentials Information,* incluya:
  - ✓ *SAMHSA, DEA License, ASSMCA Number, Drivers License in PR, Medical License, Medicare Number* y Telemedicina (Incluir copia de estos documentos en sección circulada en la imagen).
  - ✓ Incluir *Issued Date, Expiration Date* y copia de documento en la sección de *Membership Certificate*.



¿Cómo se realiza el proceso? (Continuación)

- ✓ En *Insurance Information*, incluya:
  - ✓ *Insurance Carrier* y *Coverage Type*
  - ✓ *Unlimited* y *Coverage*
  - ✓ *Original Effective Date, From Date* y *Expiration Date*
  - ✓ *Policy Number* y *Document Copy* (adjunto)
- ✓ En *Education and Training*, incluya:
  - ✓ *Speciality*
  - ✓ *From Date* y *To Completion*
  - ✓ *Evidence*
    - ✓ *Aplican a *Education/Training, Hospital Name/Postgraduate-Internship, Residency/Hospital name* y *Fellowship/Training Institution**
- ✓ En *Hospital Privileges*, incluya:
  - ✓ Nombre de hospital y tipo de privilegio



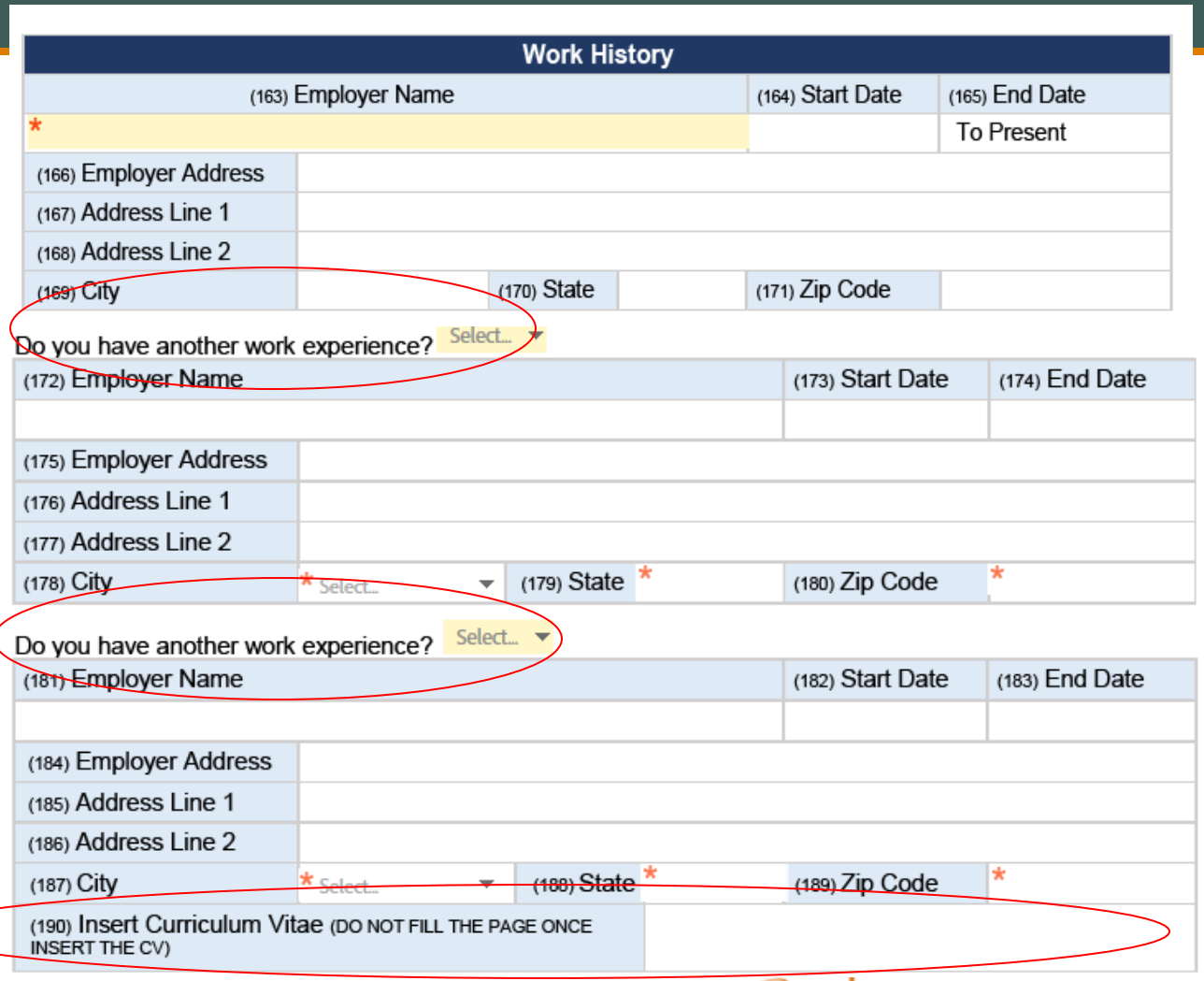
Insurance Information			
(132) Insurance Carrier		(133) Coverage Type	
(134) Unlimited	Select...	(135) Coverage	
(136) Original Effective Date	(137) From Date		(138) ExpirationDate
(139) Policy Number	*	(140) Document Copy	* Click to Attach DOCUMENT_1

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
*	

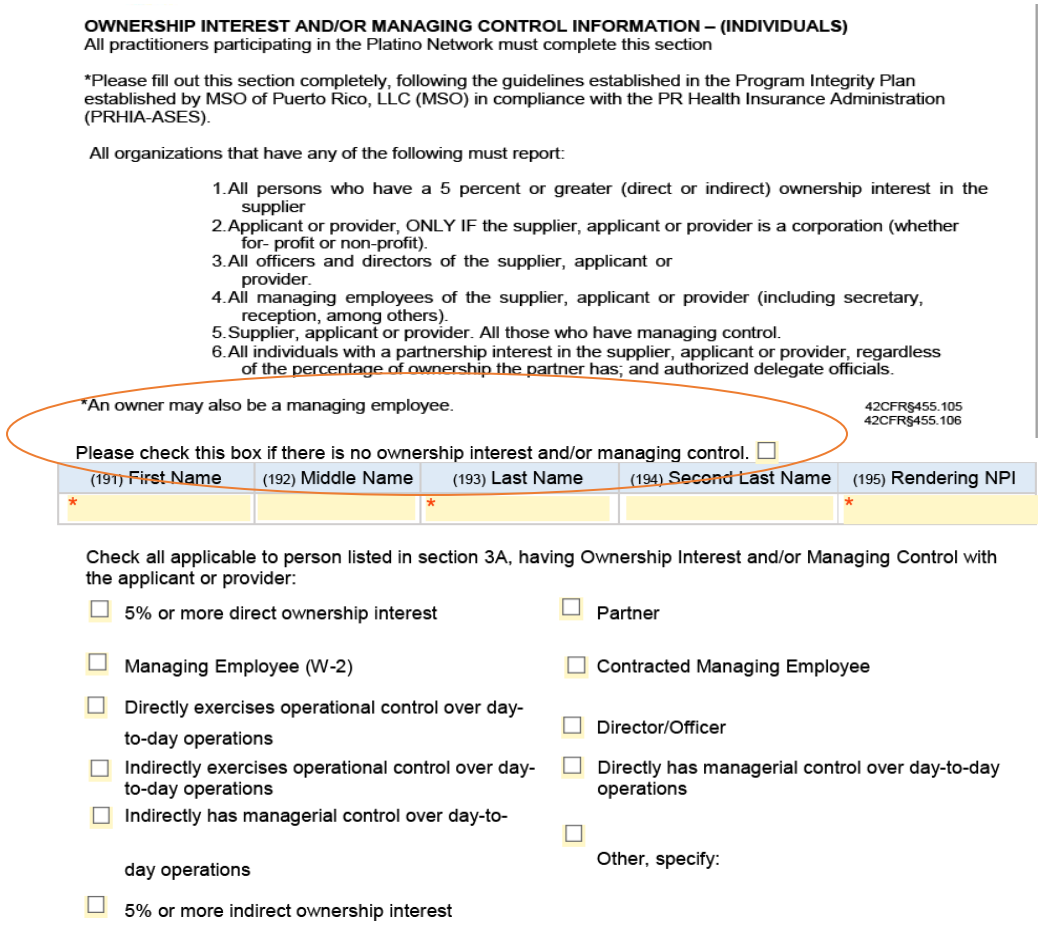
¿Cómo se realiza el proceso? (Continuación)

- ✓ En *Work History*, incluya:
  - ✓ *Employer Name, Start Date* y *End Date*
  - ✓ *Employer Address, Address line 1* y *2* (opcional)
  - ✓ *City, State* y *Zip Code*
- ✓ Si tiene más experiencia de trabajo, marque *Yes* o *No* en la pregunta *Do you have another work experience?,* añada:
  - ✓ *Employer Name, Start Date* y *el End Date*
  - ✓ *Employer Address, Address line 1* y *2* (opcional)
  - ✓ *City, State* y *Zip Code*
  - ✓ *Incluir un CV* o *Resume*



¿Cómo se realiza el proceso? (Continuación)

- ✓ En *Ownership Interest and/or Managing Control Information*:
  - ✓ Favor de leer y seguir las guías estipuladas.
  - ✓ Si no aplica, marque *Please check this box if there is no ownership interest and/or managing control.*
  - ✓ Si aplica, incluya:
    - ✓ Nombre, segundo nombre, primer apellido, segundo apellido y *Rendering NPI*
    - ✓ Marque lo que aplica a las personas listadas en la 3ª sección con *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. ☐

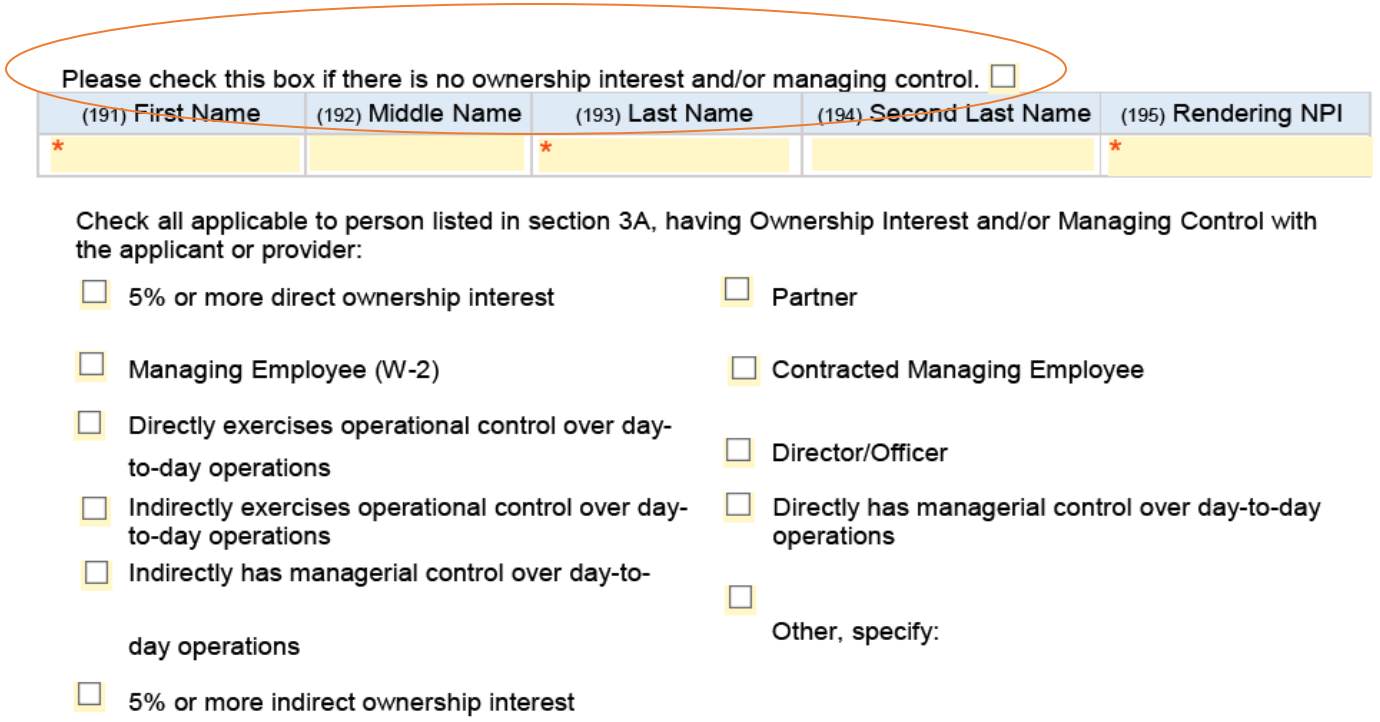
(191) First Name	(192) Middle Name	(193) Last Name	(194) Second Last Name	(195) Rendering NPI
*		*		*

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:

¿Cómo se realiza el proceso? (Continuación)

- ✓ Si le aplica, incluya:
  - ✓ Nombre, segundo nombre, primer apellido, segundo apellido y *Rendering NPI*
  - ✓ Marque lo que aplica a las personas listadas en la 3ª sección con *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. ☐

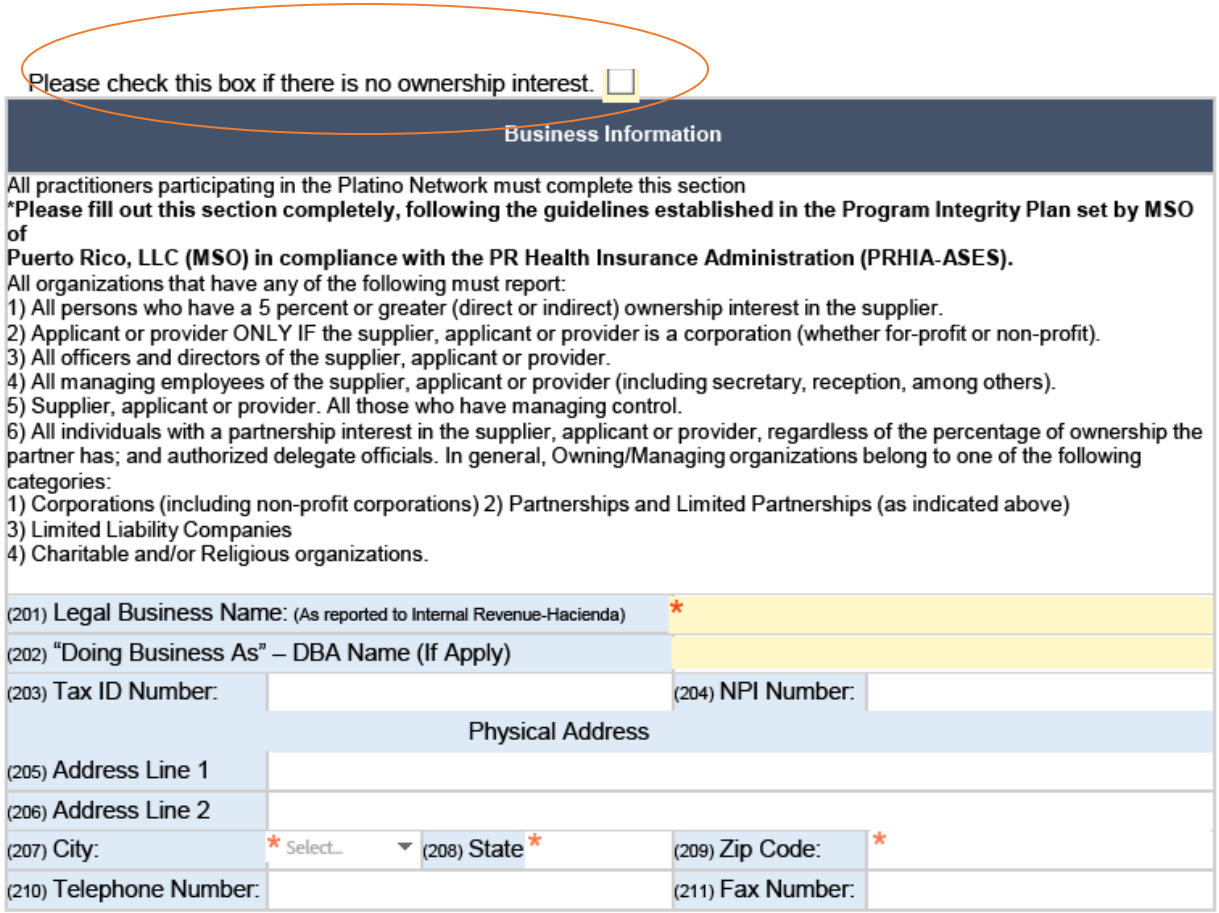
(191) First Name	(192) Middle Name	(193) Last Name	(194) Second Last Name	(195) Rendering NPI
*		*		*

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:

¿Cómo se realiza el proceso? (Continuación)

- ✓ Continúe en *Business Information*:
- ✓ De no aplicarle, marque *Please check this box if there is no ownership interest*
  - ✓ Leer y seguir las guías estipuladas.
  - ✓ Incluya:
    - ✓ *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* y *Fax Number*



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

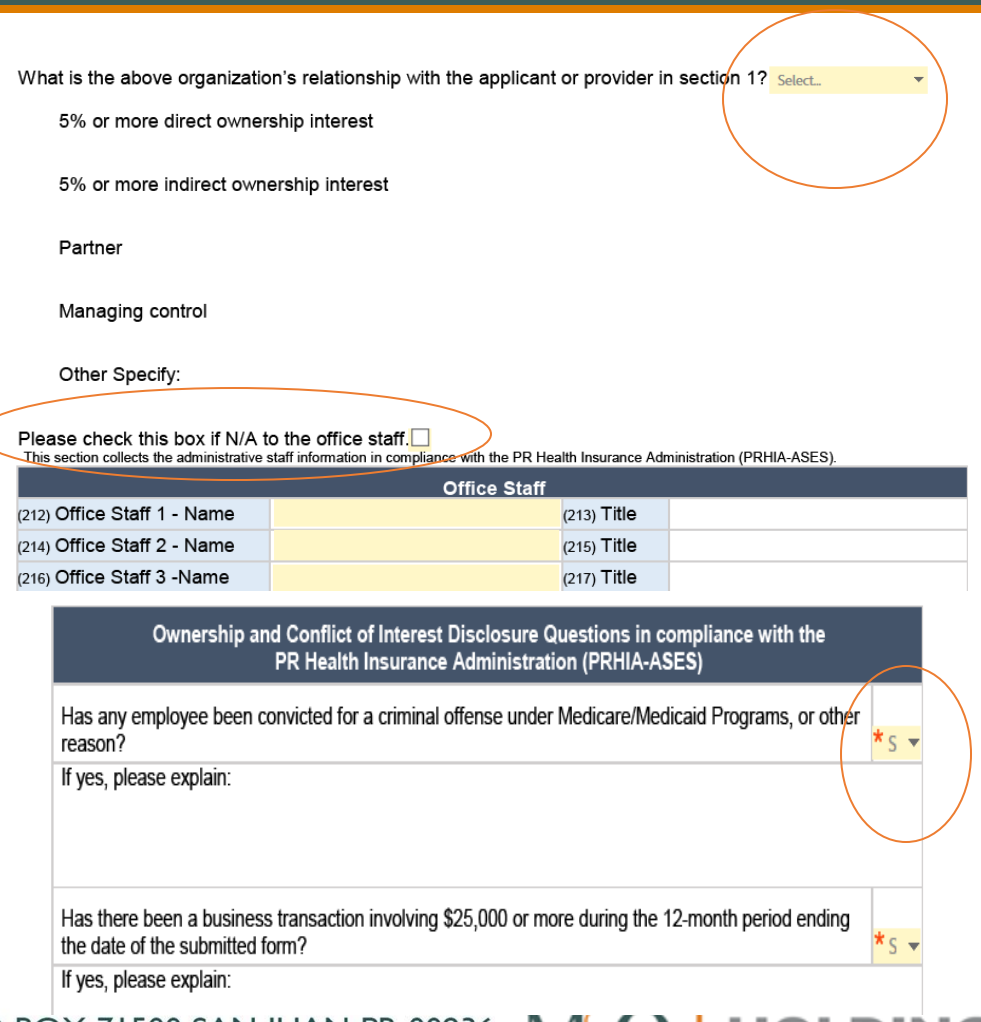
Business Information

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:	

¿Cómo se realiza el proceso? (Continuación)

- ✓ Marcar *Yes* o *No* en *What is the above organization's relationship with the applicant or provider in section 1?.* Si la respuesta es *Yes,* marque todas las que apliquen.
- ✓ En la siguiente sección, incluya información administrativa, de acuerdo con *PR Health Insurance Administration*.
- ✓ Si no le aplica, marque *Please check this box if N/A to the office staff*
  - ✓ Incluya:
    - ✓ Office Staff Name 1,2 y 3, y sus respectivos títulos.
- ✓ En *Ownership and Conflict of Interest Disclosure Questions in compliance with the PR Health Insurance Administration:*
  - ✓ Marque Sí o No a la derecha de las preguntas (17 en total)
  - ✓ Si la respuesta es **Sí**, ofrezca una explicación



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

5% or more direct ownership interest

5% or more indirect ownership interest

Partner

Managing control

Other Specify:

Please check this box if N/A to the office staff.

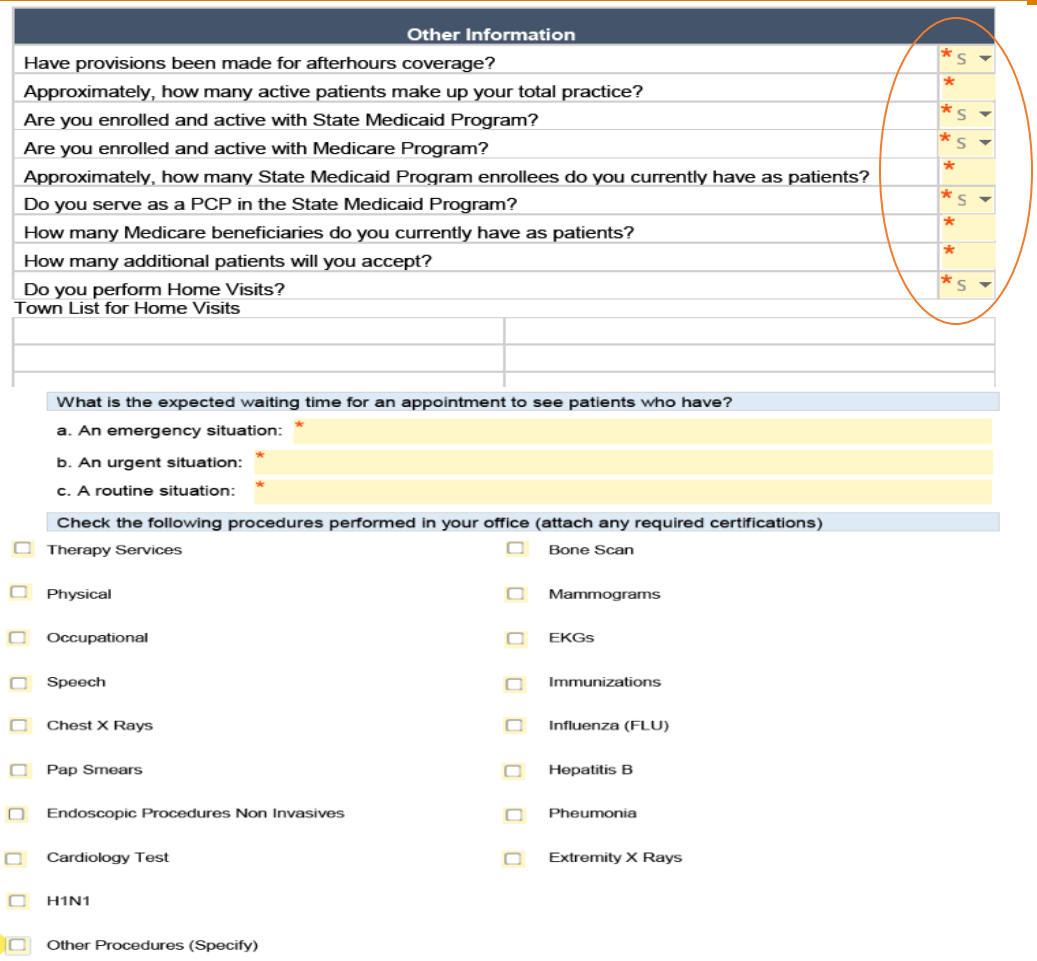
This section collects the administrative staff information in compliance with the PR Health Insurance Administration (PRHIA-ASES).

Office Staff			
(212) Office Staff 1 - Name		(213) Title	
(214) Office Staff 2 - Name		(215) Title	
(216) Office Staff 3 -Name		(217) Title	

Ownership and Conflict of Interest Disclosure Questions in compliance with the PR Health Insurance Administration (PRHIA-ASES)	
Has any employee been convicted for a criminal offense under Medicare/Medicaid Programs, or other reason?	*S
If yes, please explain:	
Has there been a business transaction involving $25,000 or more during the 12-month period ending the date of the submitted form?	*S
If yes, please explain:	

¿Cómo se realiza el proceso? (Continuación)

- ✓ En *Other Information*:
  - ✓ Conteste con las opciones ofrecidas a la derecha de cada pregunta.
  - ✓ Al marcar **Sí** en *Do you perform home visits?*, debe enlistar en los encasillados los pueblos donde los realiza.
  - ✓ Conteste las preguntas sobre el tiempo de espera de los pacientes.
  - ✓ Marque todos los procedimientos que se llevan a cabo en su oficina.



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: *

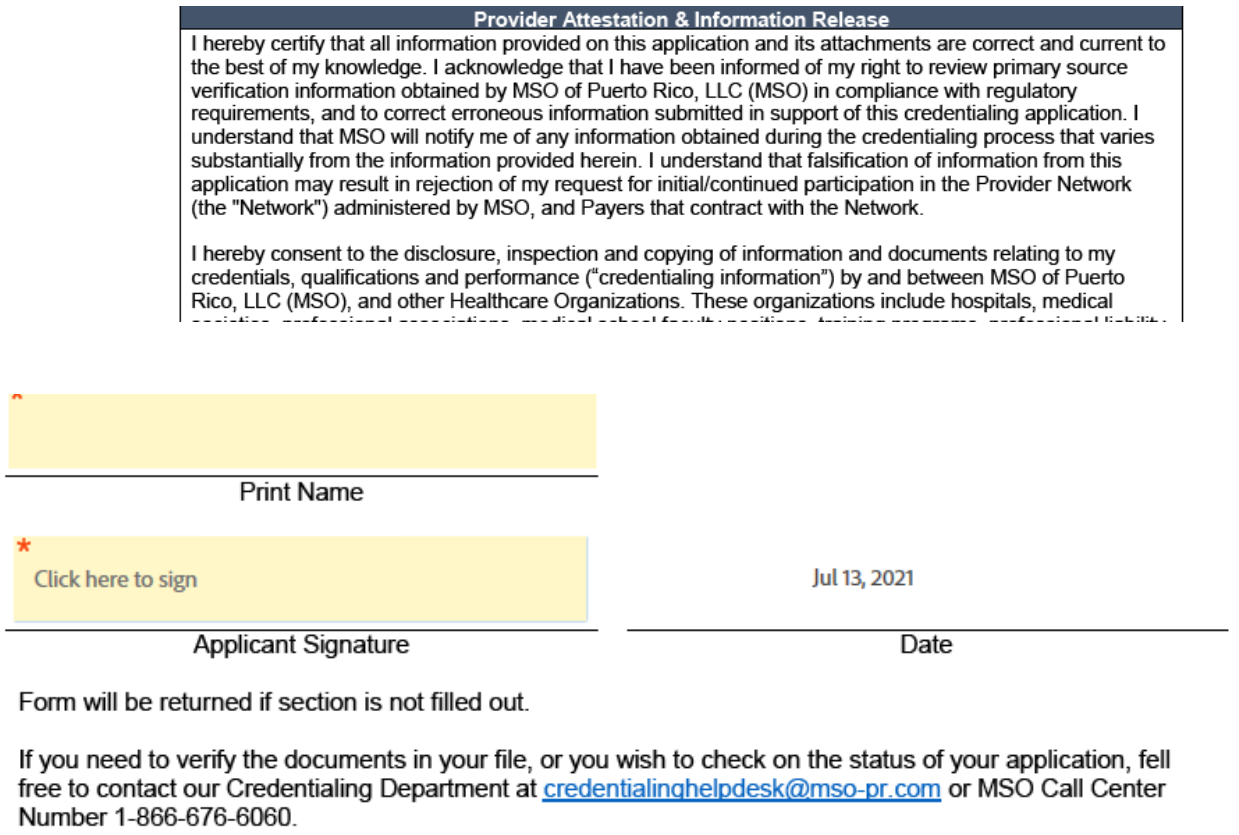
c. A routine situation: *

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

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

¿Cómo se realiza el proceso? (Continuación)

- ✓ En la última sección, encontrará el *Provider Attestation & Information Release*, que deberá leer completamente antes de culminar el proceso.
- ✓ Escribir el nombre del médico e incluir su firma, además de la fecha.
- ✓ Recuerde que, al pulsar *click to sign*, recibirá un correo electrónico de Adobe para confirmar y enviar la aplicación completada.



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

Applicant Signature

Jul 13, 2021

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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¿Aún tiene dudas sobre el proceso?

- Si necesita actualizar alguna credencial vencida para mantener su expediente al día, envíe la información a: **CredentialingUpdates@mso-pr.com**.
- Puede comunicarse a través del app InnovaMD Chat al seleccionar la opción **Credenciales**.
- De necesitar información adicional, llame a Servicios al Proveedor al:
  - **787-993-2317 (Área Metro)**
  - **1-866-676-6060 (Libre de cargos)**

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