MSO-CRE-PPT-107-120921-S

MSO | HOLDINGS

Working Instructions: Ancillary Application

CREDENTIALING TEAM

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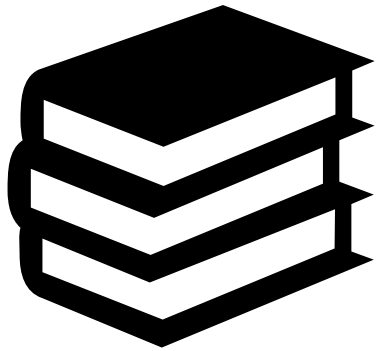
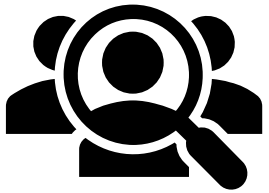


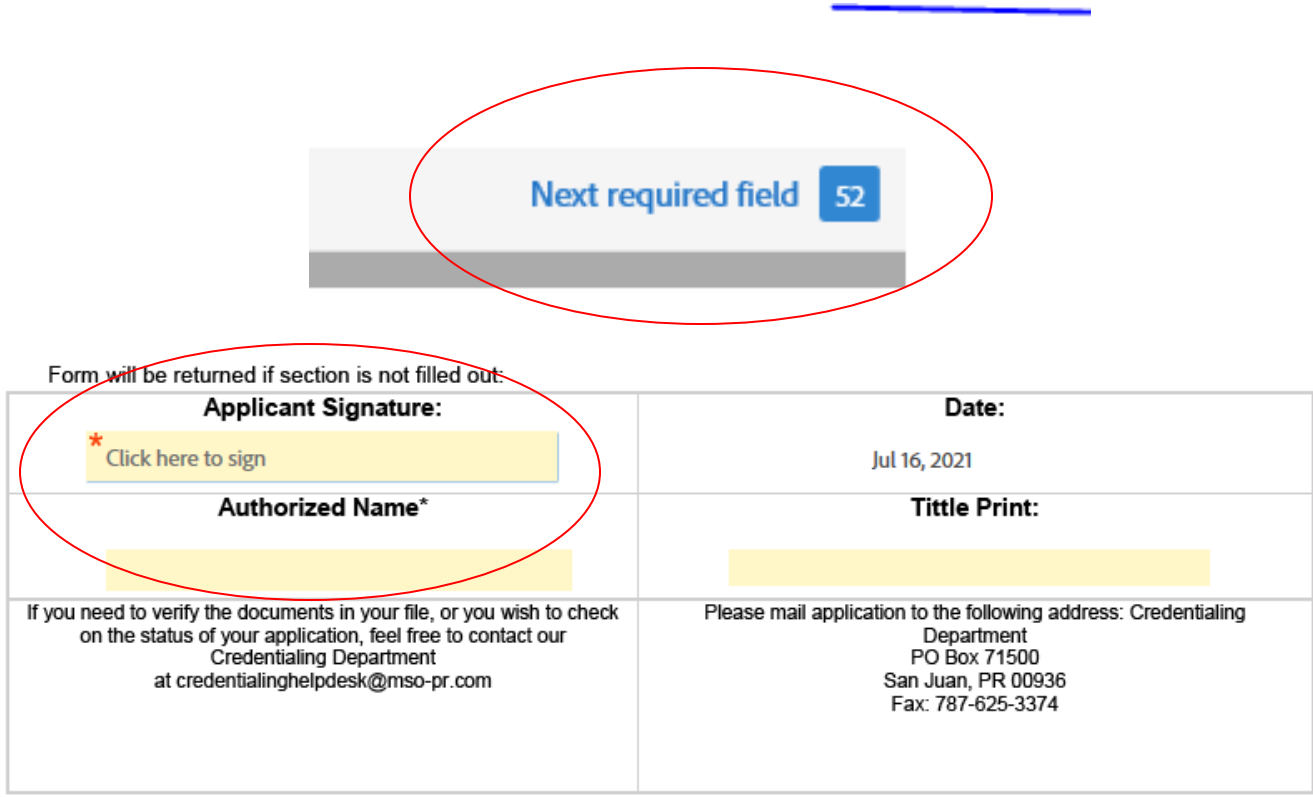


Important points

- 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 application option) to find out what documents you need before you begin the process.
- Have all credentials available prior to the start of the event.
- Before you begin, confirm that you filled out the facility application and not the vendor application.
- The application will appear in the fields as you complete the document.

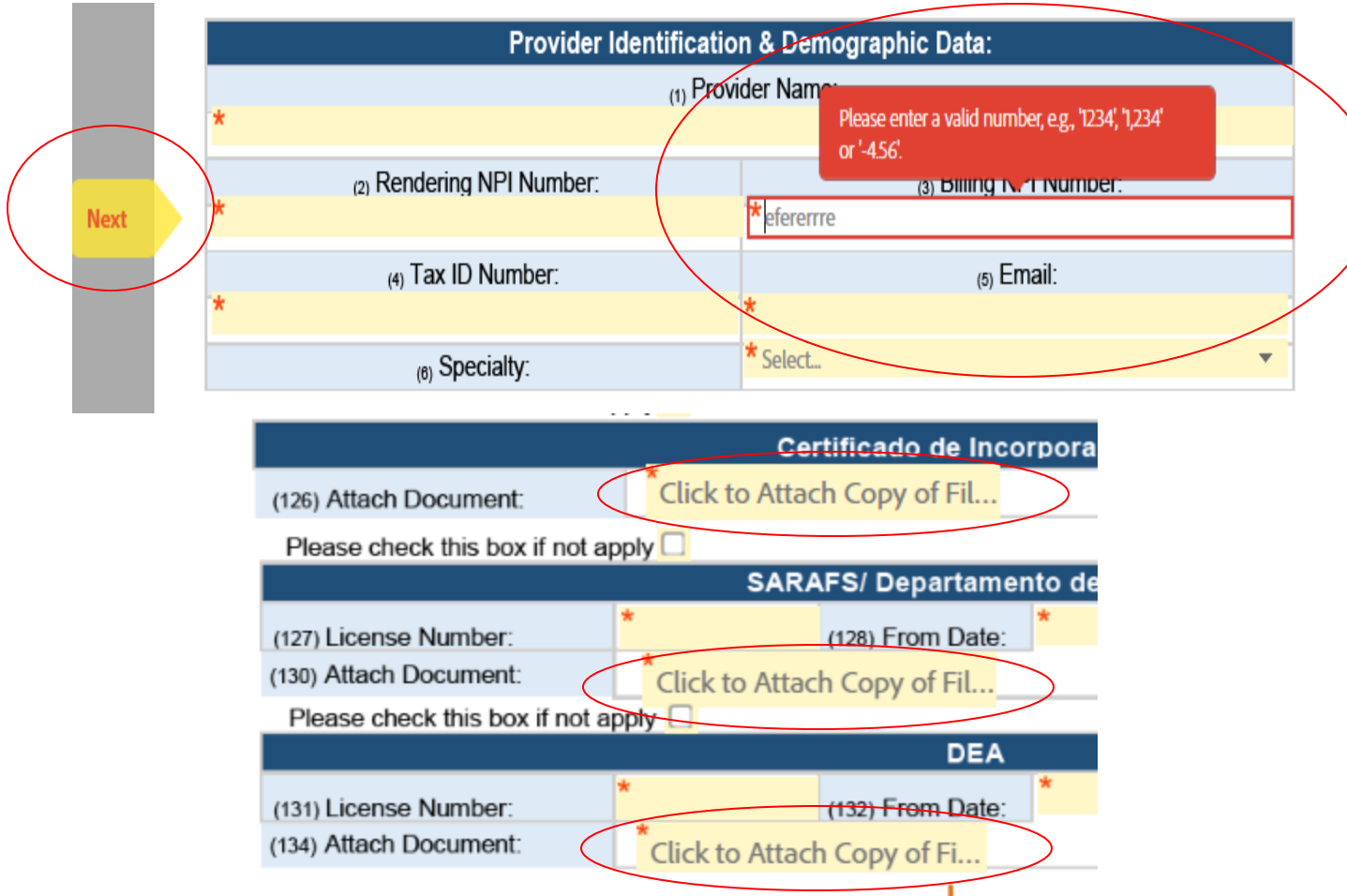
Important points

- If the Click to sign option does not appear at the end of the application, it means that it has not been filled out completely.
- In the upper right part of the screen, there is a button that will show you the errors in the application to solve them quickly.
- 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 name of the owner or administrator (page 8).
- 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, press Click to Attach and select the required document. It will be attached to the application.

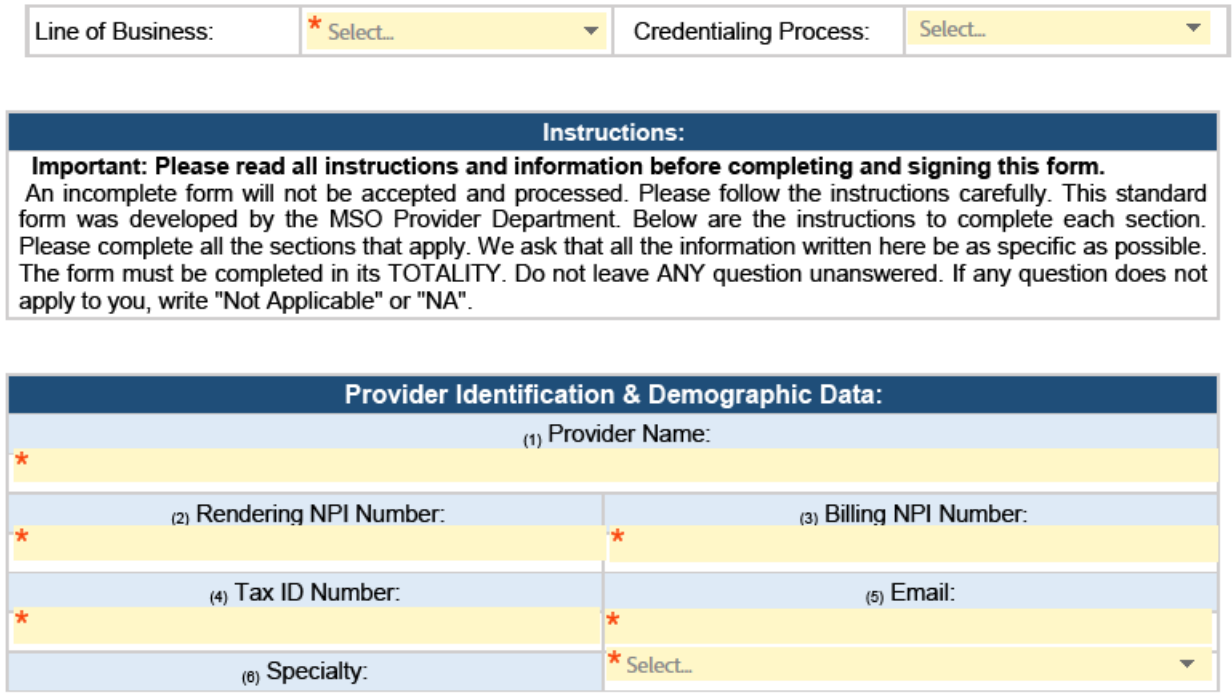


How is the process carried out?

- ✓ Visit this link: https://www.mso-pr.com/solicitudes/#
- ✓ At the bottom, look for the View Requirements option 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 begin, you will need to return to the previous window and scroll up until you reach the Request as Facility option.

How is the process carried out? (Continued)

- ✓ Start the application by choosing:
- ✓ *Line of Business*
  - ✓ Medicare Advantage (MMM)
  - ✓ MMM Multi health (Vital)
  - ✓ Medicare Advantage and Vital
- ✓ *Credentialing Process*
  - ✓ Initial
  - ✓ Recredentialing
  - ✓ Change
- ✓ Then, read instructions carefully and follow them
- ✓ Under Supplier Identification and Demographics, include:
- ✓ *Provider Name*
  - ✓ *Rendering NPI number and Billing NPI Number*
  - ✓ *Tax ID Number and Email*
  - ✓ *Select your Speciality*



Line of Business:	* Select...	Credentialing Process:	Select...

Instructions:

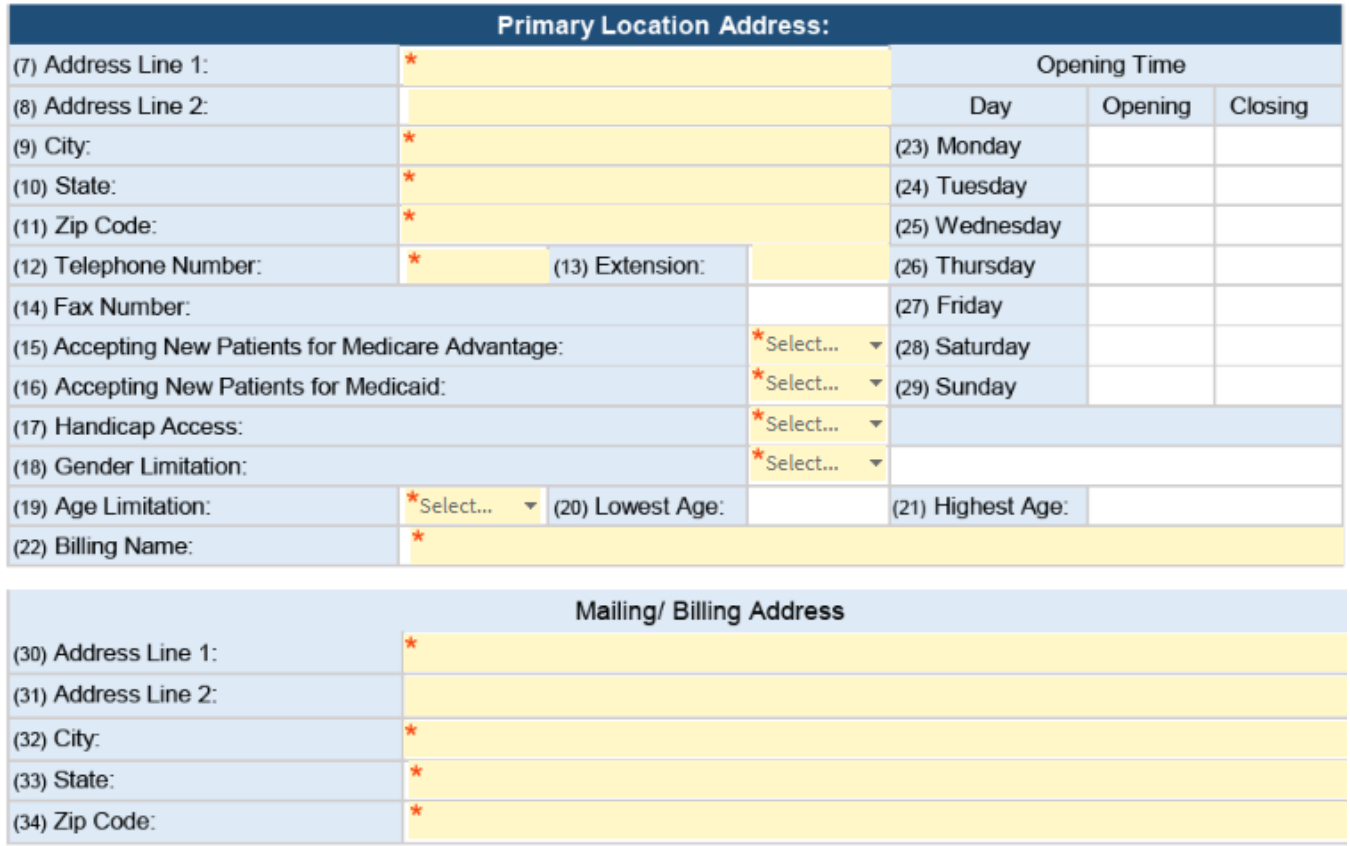
Important: Please read all instructions and information before completing and signing this form.
An incomplete form will not be accepted and processed. Please follow the instructions carefully. This standard form was developed by the MSO Provider Department. Below are the instructions to complete each section. Please complete all the sections that apply. We ask that all the information written here be as specific as possible. The form must be completed in its TOTALITY. Do not leave ANY question unanswered. If any question does not apply to you, write "Not Applicable" or "NA".

Provider Identification & Demographic Data:

(1) Provider Name: *	
(2) Rendering NPI Number: *	(3) Billing NPI Number: *
(4) Tax ID Number: *	(5) Email: *
(6) Specialty:	* Select...

How is the process carried out? (Continued)

- ✓ Under Primary Location Address, include:
  - ✓ *Primary Location Address – Address Line #1 (Address Line #2 is optional), City, State, Zip Code*
  - ✓ *Telephone, Extension, Fax, Office Hours, Accessibility Questions* y *Billing Name*.
- ✓ Then, continue to Mailing Billing Address, including:
  - ✓ *Location Address- Address line #1 (Address Line #2 is optional), City, State, Zip Code.*

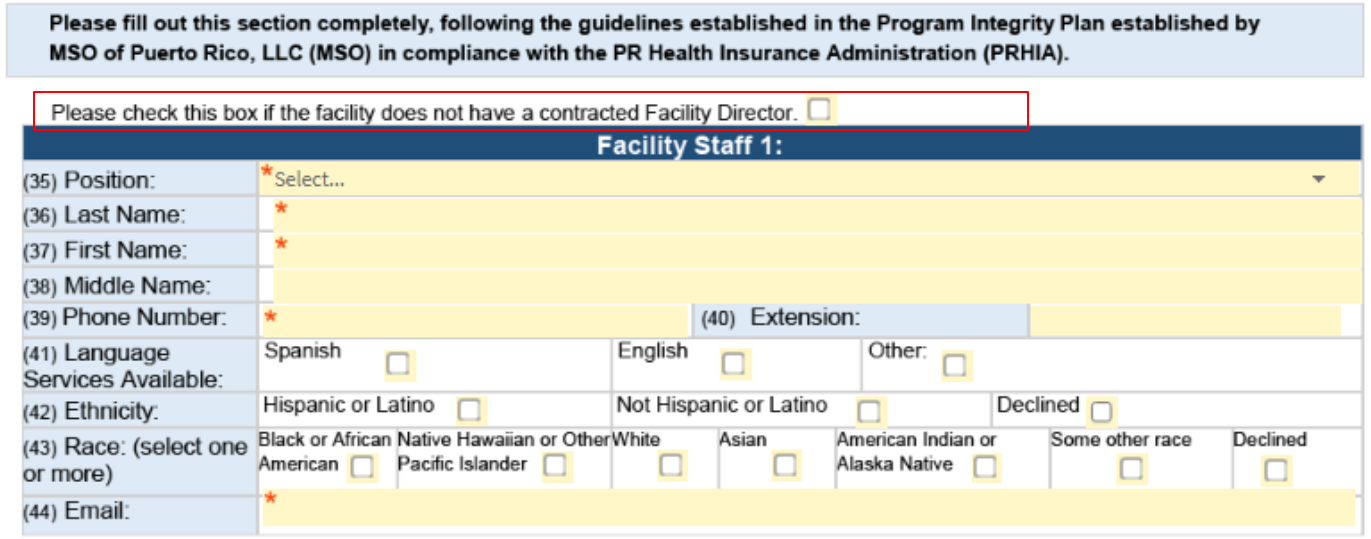


Primary Location Address:						
(7) Address Line 1:	*			Opening Time		
(8) Address Line 2:				Day	Opening	Closing
(9) City:	*			(23) Monday		
(10) State:	*			(24) Tuesday		
(11) Zip Code:	*			(25) Wednesday		
(12) Telephone Number:	*	(13) Extension:		(26) Thursday		
(14) Fax Number:				(27) Friday		
(15) Accepting New Patients for Medicare Advantage:			*Select...	(28) Saturday		
(16) Accepting New Patients for Medicaid:			*Select...	(29) Sunday		
(17) Handicap Access:			*Select...			
(18) Gender Limitation:			*Select...			
(19) Age Limitation:	*Select...	(20) Lowest Age:		(21) Highest Age:		
(22) Billing Name:	*					

Mailing/ Billing Address	
(30) Address Line 1:	*
(31) Address Line 2:	
(32) City:	*
(33) State:	*
(34) Zip Code:	*

How is the process carried out? (Continued)

- ✓ Complete the following section using the guidelines established by the Program Integrity Plan established by MSO de Puerto Rico, LLC (MSO).
- ✓ Please check this box if the facility does not have a contracted Facility Director if it does not apply to you.
- ✓ In Facility Staff #1, #2, #3, #4, include :
  - ✓ Position
    - ✓ *Administrator*
    - ✓ *Biller*
    - ✓ *Secretary*
    - ✓ *Other Office Staff*
  - ✓ Last name
  - ✓ First name
  - ✓ Middle Name
  - ✓ Phone and extension
  - ✓ Languages
  - ✓ Ethnicity
  - ✓ Race
  - ✓ Email



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).

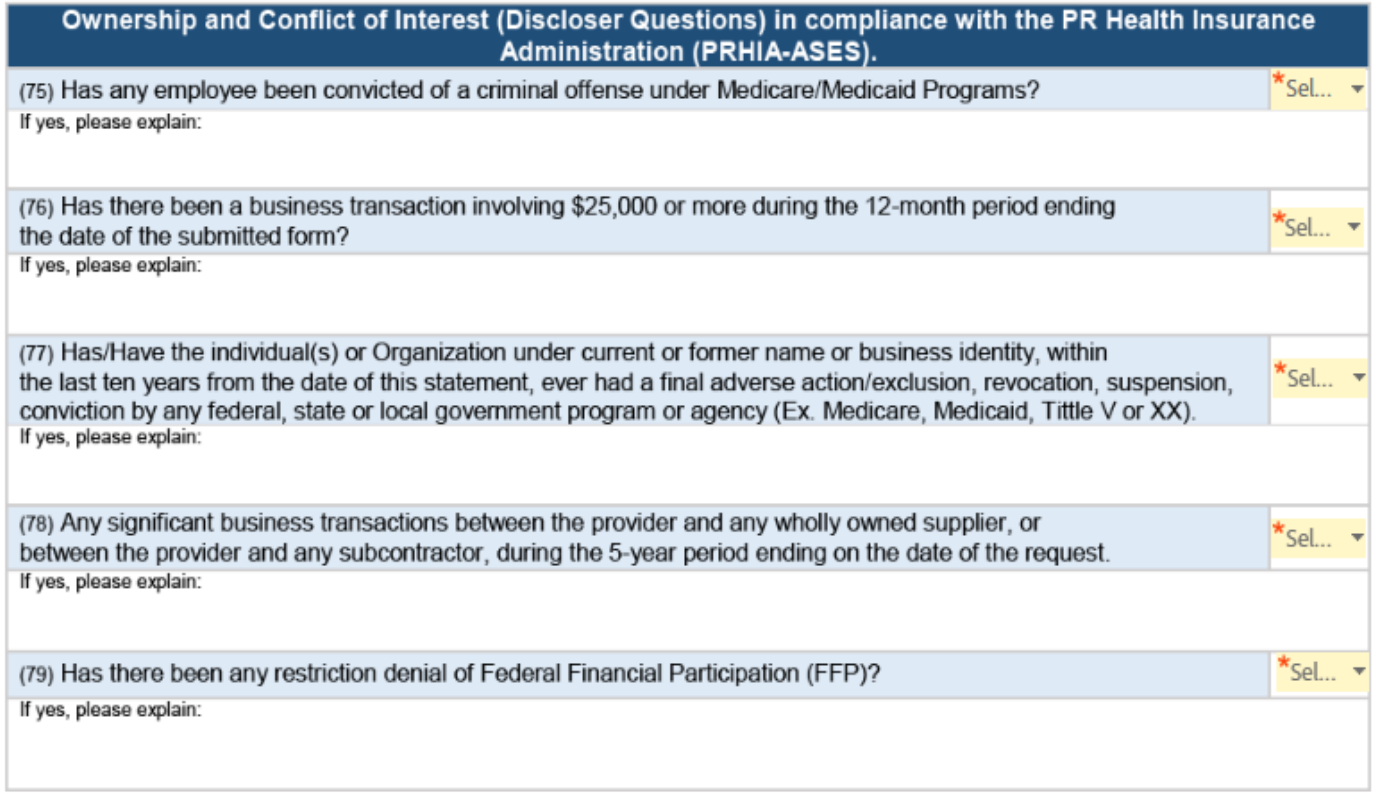
Please check this box if the facility does not have a contracted Facility Director. ☐

Facility Staff 1:

(35) Position:	*Select...						
(36) Last Name:	*						
(37) First Name:	*						
(38) Middle Name:							
(39) Phone Number:	*	(40) Extension:					
(41) Language Services Available:	Spanish ☐	English ☐	Other: ☐				
(42) Ethnicity:	Hispanic or Latino ☐	Not Hispanic or Latino ☐	Declined ☐				
(43) Race: (select one or more)	Black or African American ☐	Native Hawaiian or Other Pacific Islander ☐	White ☐	Asian ☐	American Indian or Alaska Native ☐	Some other race ☐	Declined ☐
(44) Email:	*						

How is the process carried out? (Continued)

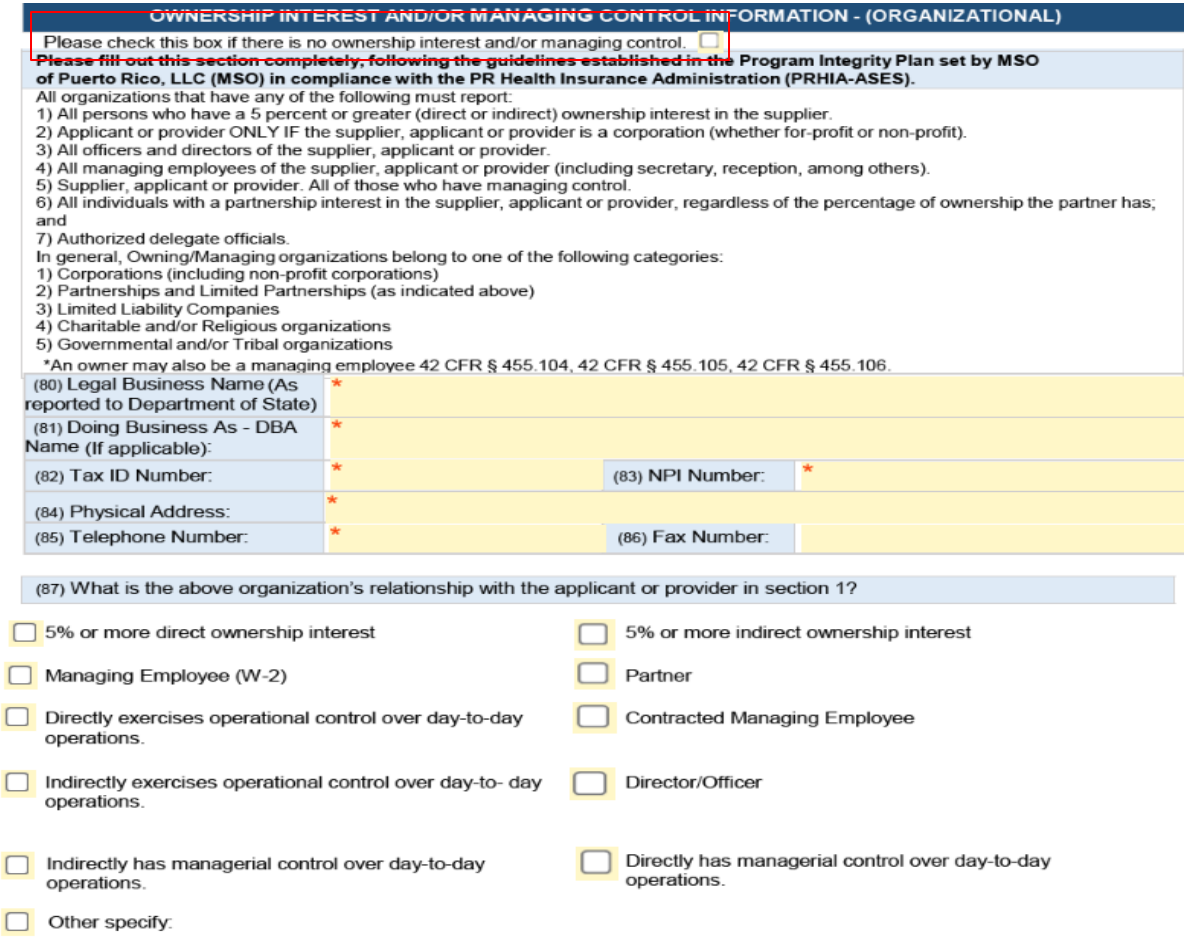
- ✓ Under Ownership and Conflict of Interest Disclosure Questions in compliance with the PR Health Insurance Administration, do the following:
  - ✓ Answer questions with the Yes or No options to the right of the question.
    - ✓ If the answer is Yes, please provide an explanation in the box below the question.



Ownership and Conflict of Interest (Discloser Questions) in compliance with the PR Health Insurance Administration (PRHIA-ASES).	
(75) Has any employee been convicted of a criminal offense under Medicare/Medicaid Programs?	*Sel...
If yes, please explain:	
(76) Has there been a business transaction involving $25,000 or more during the 12-month period ending the date of the submitted form?	*Sel...
If yes, please explain:	
(77) Has/Have the individual(s) or Organization under current or former name or business 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 government program or agency (Ex. Medicare, Medicaid, Tittle V or XX).	*Sel...
If yes, please explain:	
(78) 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.	*Sel...
If yes, please explain:	
(79) Has there been any restriction denial of Federal Financial Participation (FFP)?	*Sel...
If yes, please explain:	

How is the process carried out? (Continued)

- ✓ In Ownership Interest and/or Managing Control Information - (Organizational):
  - ✓ Check *Please check this box* if there is no ownership interest and/or managing control if not applicable to you.
  - ✓ Read the guidelines before starting to fill out the section.
  - ✓ Include :
    - ✓ *Legal Business Name, Doing Business As – DBA Name, Tax ID Number, NPI Number, Physical Address, Telephone Number and Fax Number.*
  - ✓ Answer the question What is the above organizations' relationship with the applicant or Provider in section 1 by checking all that apply. There is also an option to add an other.



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
7) 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
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.

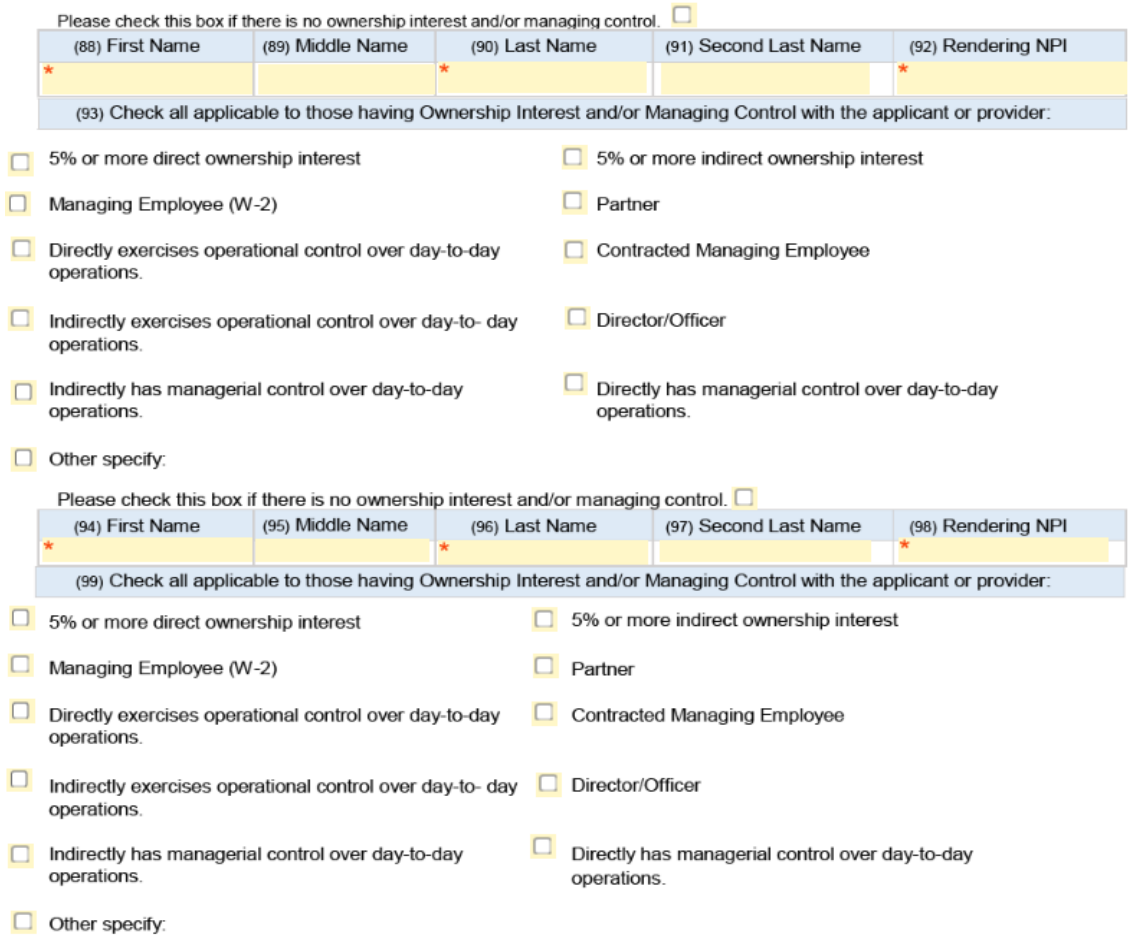
(80) Legal Business Name (As reported to Department of State)	*		
(81) Doing Business As - DBA Name (If applicable):	*		
(82) Tax ID Number:	*	(83) NPI Number:	*
(84) Physical Address:	*		
(85) Telephone Number:	*	(86) Fax Number:	

(87) 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
- ☐ Managing Employee (W-2)
- ☐ Partner
- ☐ Directly exercises operational control over day-to-day operations.
- ☐ Contracted Managing Employee
- ☐ Indirectly exercises operational control over day-to- day operations.
- ☐ Director/Officer
- ☐ Indirectly has managerial control over day-to-day operations.
- ☐ Directly has managerial control over day-to-day operations.
- ☐ Other specify:

How is the process carried out? (Continued)

- ✓ In Ownership Interest and/or Managing Control Information - (Individuals*):*
  - ✓ If not applicable, check *Please check this box* if there is no ownership interest and/or managing control*.*
  - ✓ Read the instructions before proceeding.
  - ✓ This step will appear three (3) times. Include:
    - ✓ *First name, middle name, first name, last name, middle name and rendering NPI.*
    - ✓ *Then check all applicable options in the Check all applicable to those having Ownership interest and/or Managing Control with the applicant or provider question.*


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

(88) First Name	(89) Middle Name	(90) Last Name	(91) Second Last Name	(92) Rendering NPI
*		*		*

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

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

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

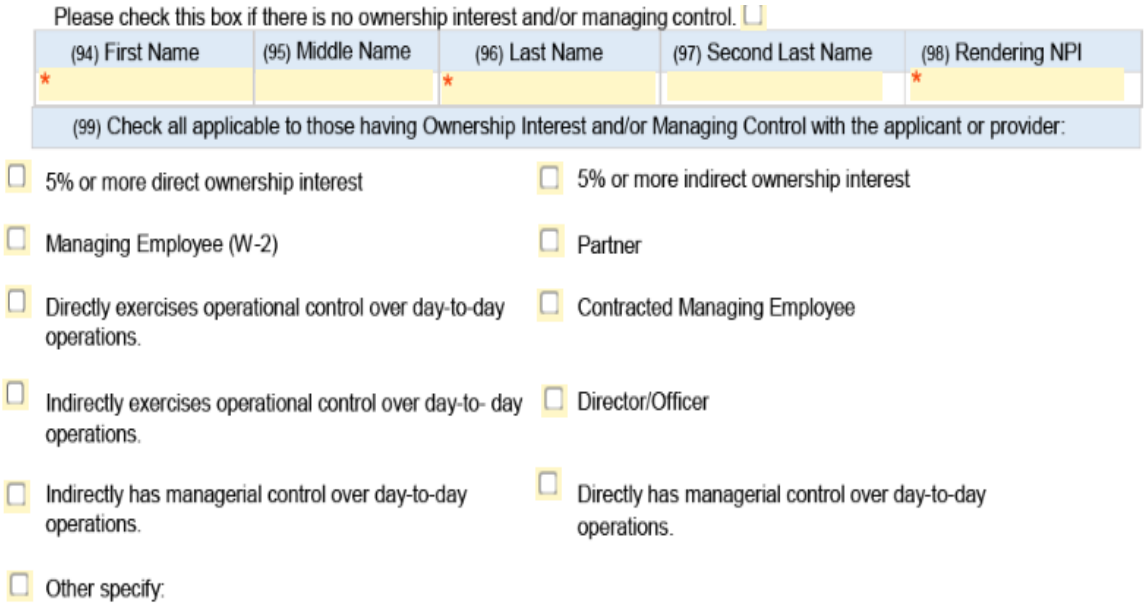
(94) First Name	(95) Middle Name	(96) Last Name	(97) Second Last Name	(98) Rendering NPI
*		*		*

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

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

How is the process carried out? (Continued)

- ✓ In Ownership Interest and/or Managing Control Information- (Individuals)
  - ✓ If not applicable, check *Please check this box* if there is no ownership interest and/or managing control.
  - ✓ Then check all applicable options in Check all applicable to those having Ownership interest and/or Managing Control with the applicant or provider.
  - ✓ If not applicable, check *Please check this box* if there is no ownership interest and/or managing control.
  - ✓ Then check all applicable options in Check all applicable to those having Ownership interest and/or Managing Control with the applicant or provider.
  - ✓ If not applicable, check *Please check this box* if there is no ownership interest and/or managing control.
  - ✓ Then check all applicable options in Check all applicable to those having 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.

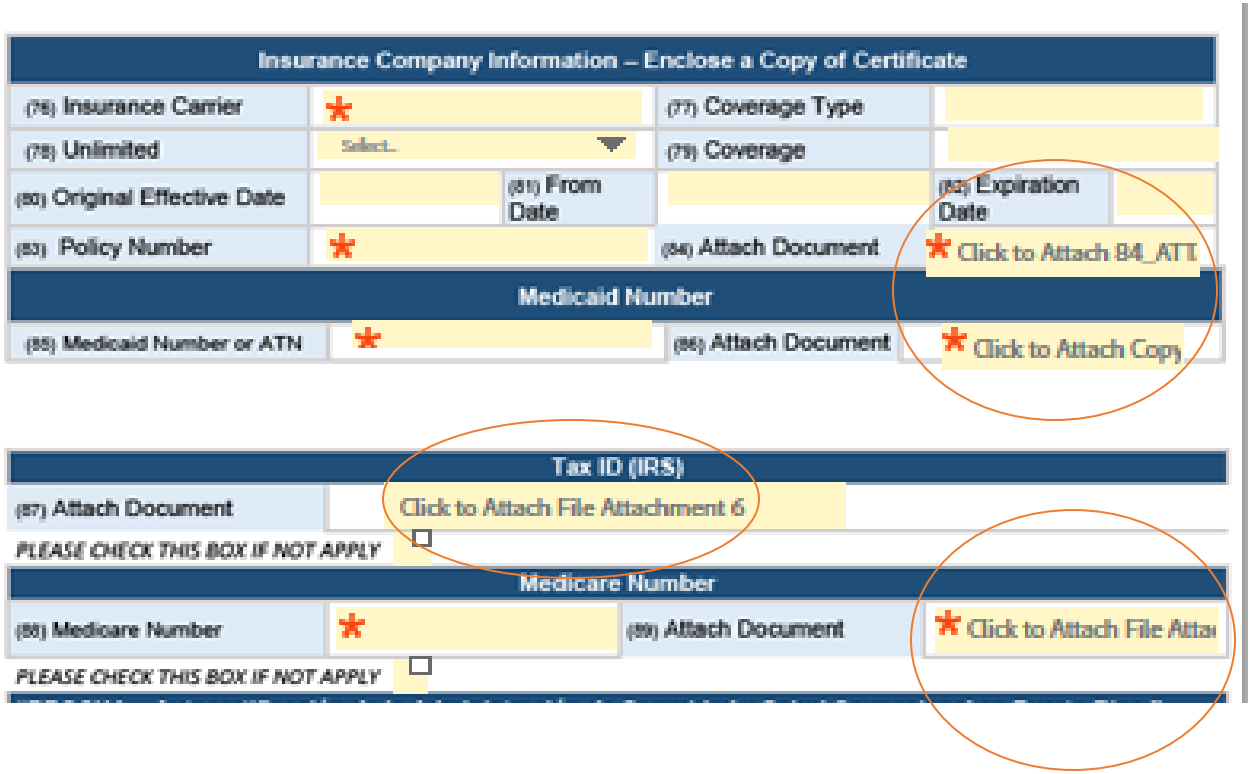
(94) First Name	(95) Middle Name	(96) Last Name	(97) Second Last Name	(98) Rendering NPI
*		*		*

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

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

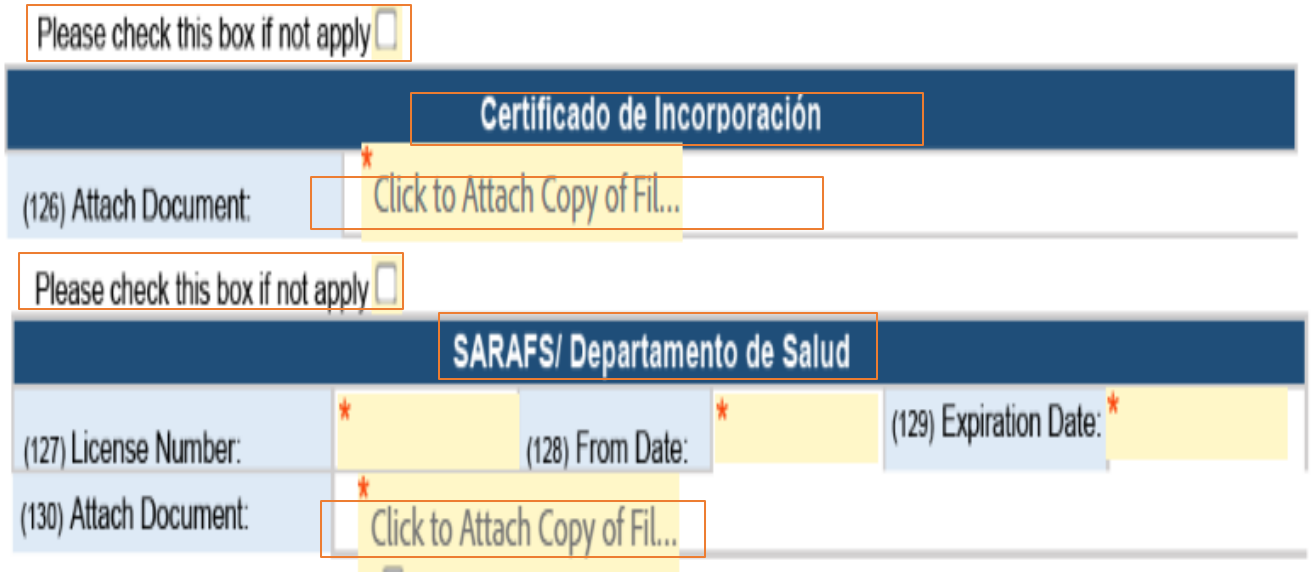
How is the process carried out? (Continued)

- ✓ Under Insurance Company Information - Enclose a Copy of Certificate, include:
  - ✓ *Insurance carrier, coverage type, unlimited (yes or no), coverage, original effective date, from date, expiration date, policy number, and attach document*.
- ✓ Under Medicaid Number, include:
  - ✓ *Medicaid Number or ATN and attach a copy*.
- ✓ In Tax ID (IRS), include:
  - ✓ *Attach Document*
- ✓ In *Medicare Number*:
  - ✓ If it does not apply, check *Please check this box if not apply.*
  - ✓ Include:
    - ✓ *Medicare number and attached document.*



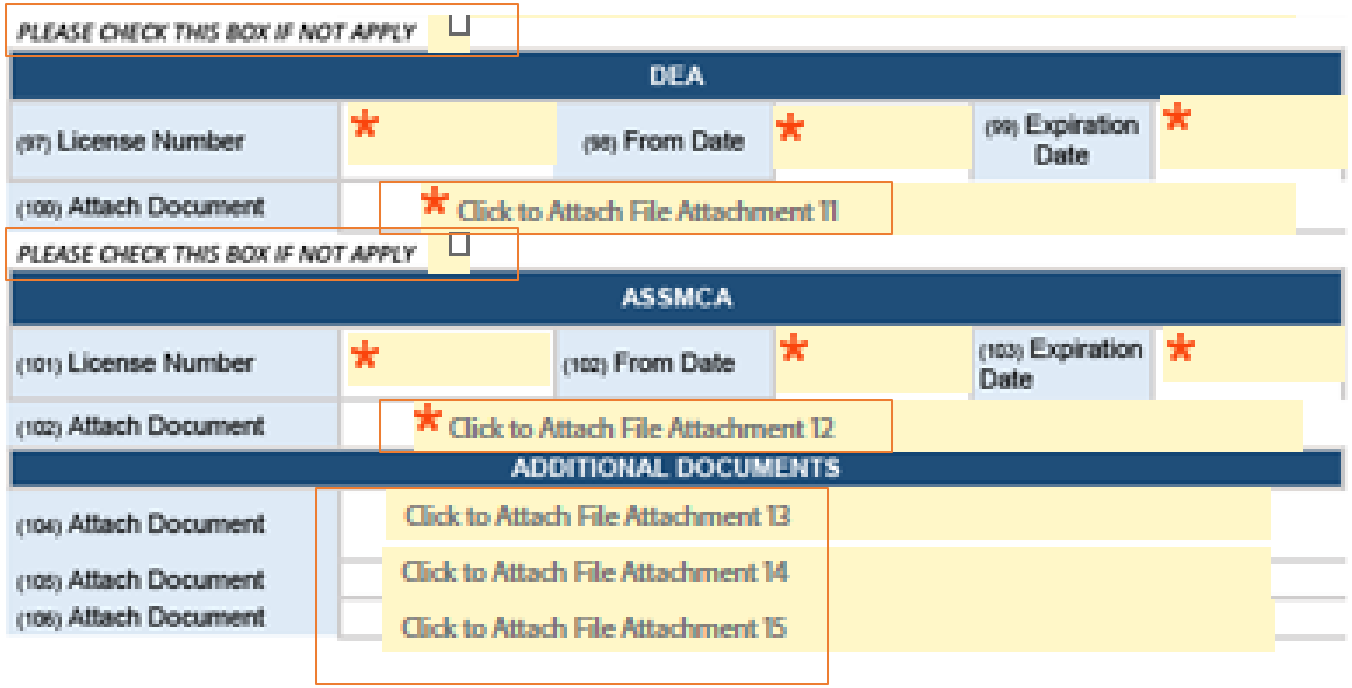
How is the process carried out? (Continued)

- ✓ In *Certificate of Incorporation*:
  - ✓ If this does not apply to you, check *Please check this box if not apply.*
  - ✓ Include:
    - ✓ *Attach Document*
- ✓ At *SARAFS/Department of Health* :
  - ✓ If this does not apply to you, check *Please check this box if not apply.*
  - ✓ Include:
    - ✓ *License Number, from date and Expiration date.*
    - ✓ *Attach Document*



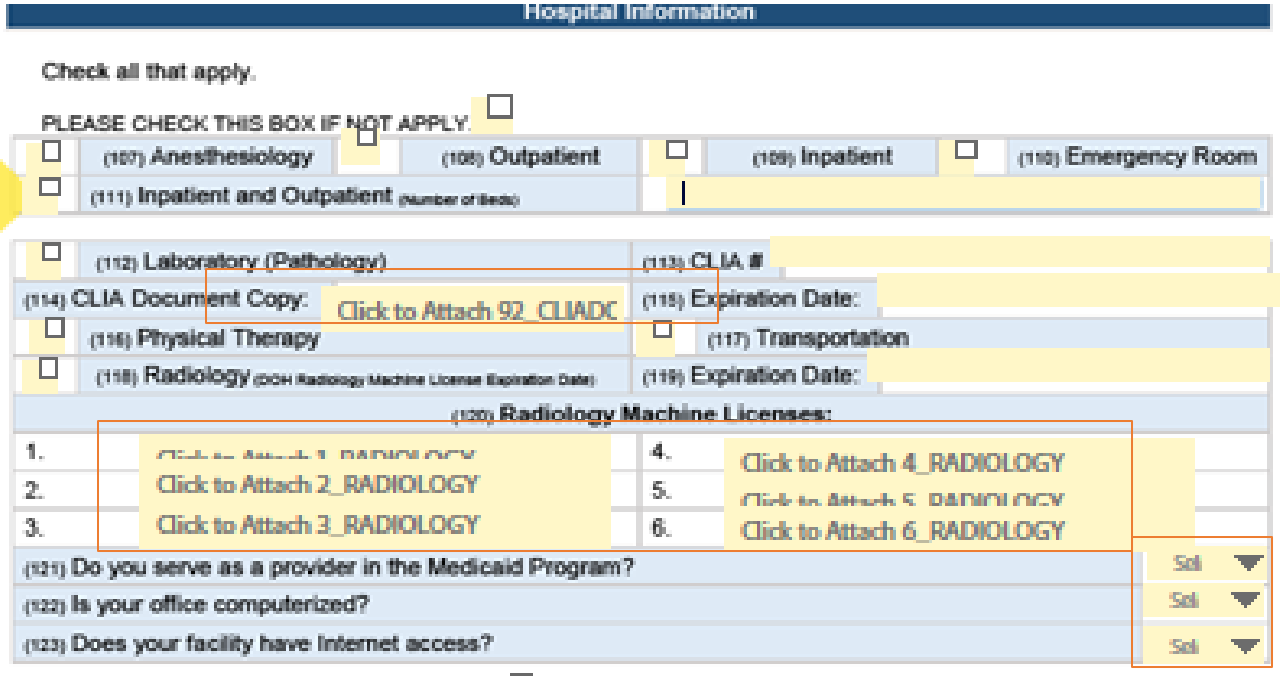
How is the process carried out? (Continued)

- ✓ At *DEA*:
  - ✓ If this does not apply to you, check *Please check this box if not apply.*
  - ✓ Include:
    - ✓ *License Number, from date and Expiration date.*
    - ✓ *Attach Document*
- ✓ In *ASSMCA*
  - ✓ If this does not apply to you, check *Please check this box if not apply.*
  - ✓ Include:
    - ✓ *License Number, from date and Expiration date.*
    - ✓ *Attach Document*
- ✓ There is an additional box to add more documents, if necessary.



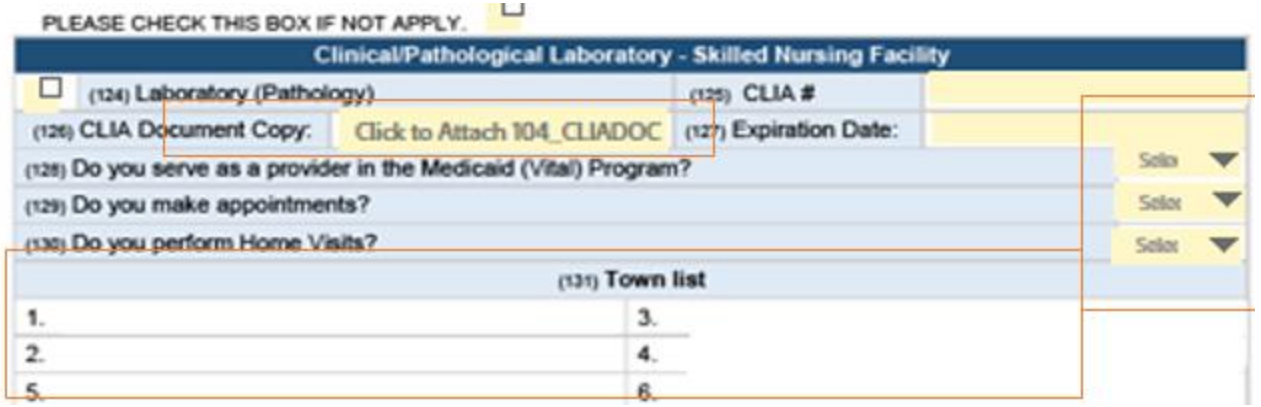
How is the process carried out? (Continued)

- ✓ In *Hospital Information*:
  - ✓ If this does not apply to you, check *Please check this box if not apply.*
  - ✓ Then, select all the options that apply to you, link necessary documents and licenses, and answer the questions with Yes or No, on the right.
- ✓ En *Clinical Pathological Laboratory- Skilled Nursing Facility*:
  - ✓ If this does not apply to you, check *Please check this box if not apply.*
  - ✓ Then, fill in the boxes and answer the questions with Yes or No, on the right side.
    - ✓ If the answer to the third question is yes, include the places in the pigeonholes under this one.



How is the process carried out? (Continued)

- ✓ In *Clinical Pathological Laboratory- Skilled Nursing Facility*:
  - ✓ If this does not apply to you, check *Please check this box if not apply.*
  - ✓ Fill in the fields and include copy of CLIA document.
  - ✓ Answer questions #128-#130 with Yes or No. These options are to the right of the question.
  - ✓ If the answer to question #130 is Yes, list the places in the boxes that say Town List.


PLEASE CHECK THIS BOX IF NOT APPLY.

Clinical/Pathological Laboratory - Skilled Nursing Facility

(124) Laboratory (Pathology) (125) CLIA #

(126) CLIA Document Copy: Click to Attach 104_CLIADOC (127) Expiration Date:

(128) Do you serve as a provider in the Medicaid (Vital) Program? Select

(129) Do you make appointments? Select

(130) Do you perform Home Visits? Select

(131) Town list

1.	3.
2.	4.
5.	6.

How is the process carried out? (Continued)

- ✓ In *Radiology Machine License*, include:
  - ✓ Fill in the DOH Radiology Machine License fields and expiration date.
  - ✓ Include licenses.

- In *Radiology Services*:

  - ✓ Please check the services and accreditations that the facility has issued by the American College of Radiology (ACR).
  - ✓ Include licenses.

Please check this box if not apply ☐

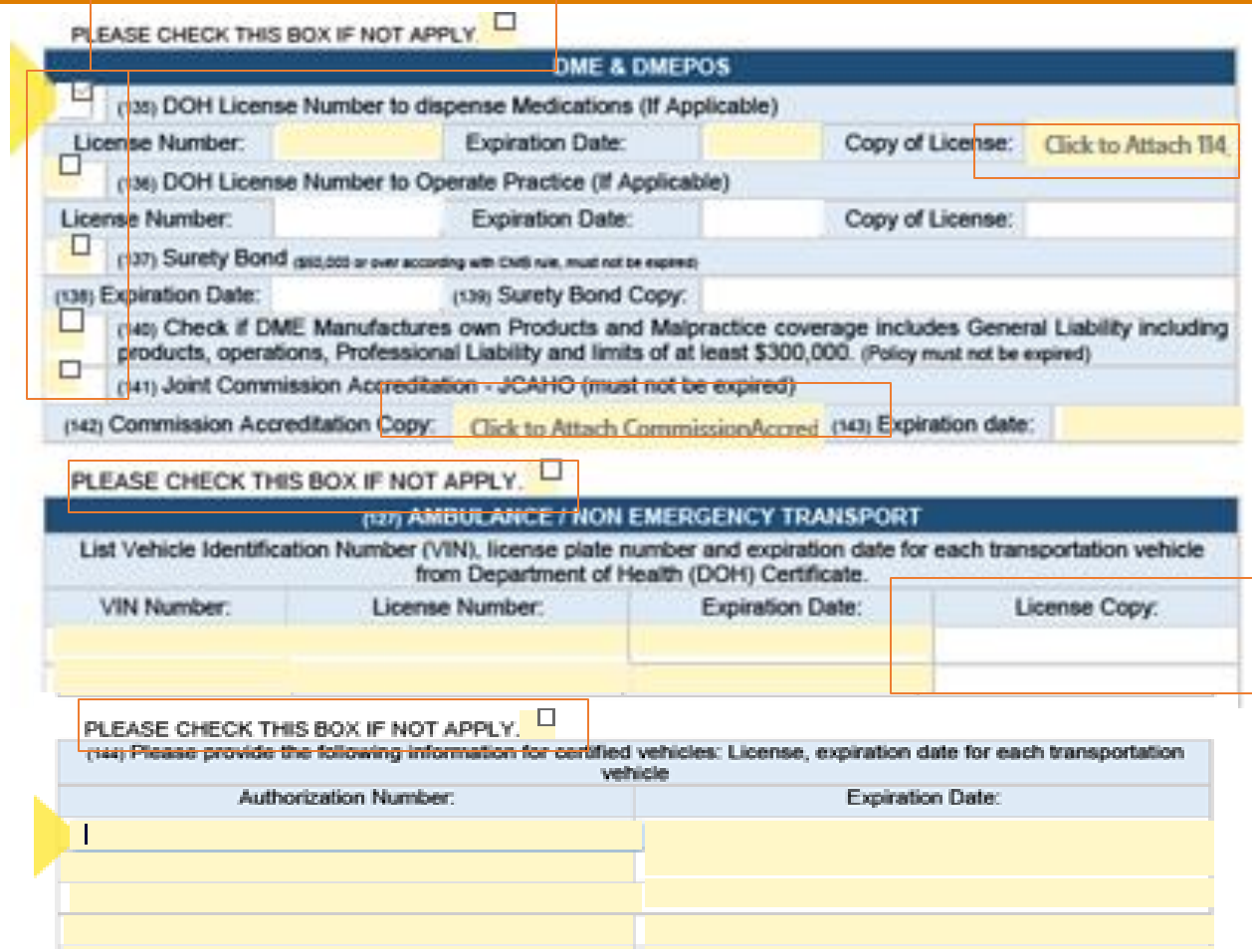
Radiology Facility with Mammogram			
☐	(167) DOH Radiology Machine License:	(168) Expiration Date:	
	(169) Radiology Machine License		
1.		4.	
2.		5.	
3.		6.	

Please check this box if not apply ☐

Radiology Services		
Services		Certification (ACR) (Please Upload Document)
☐	Conventional Radiology	
☐	Breast Ultrasound	
☐	CT	
☐	Mammography	
☐	MRI	
☐	Nuclear Medicine & PET	
☐	Radiation Oncology Practice	
☐	Stereotactic Breast Biopsy	
☐	Ultrasound	

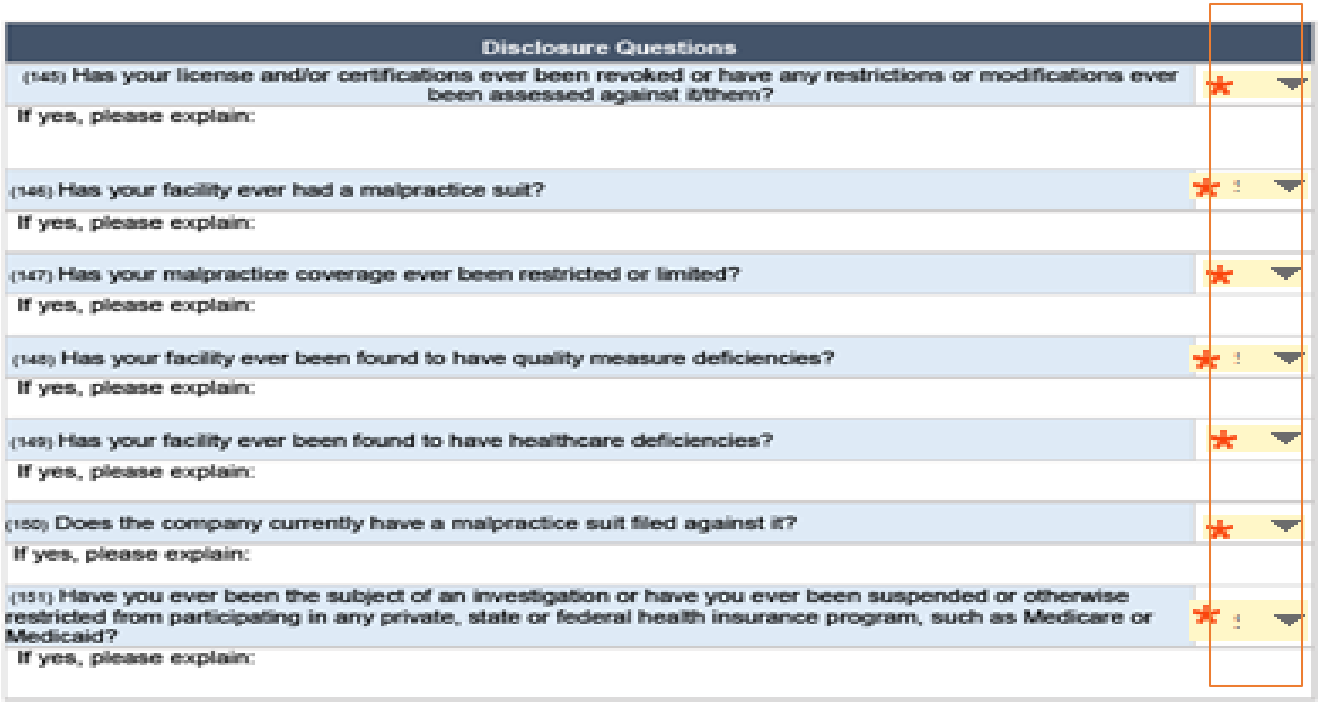
How is the process carried out? (Continued)

- ✓ In *DME & DMEPOS*:
  - ✓ If this does not apply to you, check *Please check this box if not apply.*
  - ✓ Then, fill in the fields and include copy of license and *commission accreditation copy*.
- ✓ In the section *Ambulance/Non Emergency Transport:*
  - ✓ If this does not apply to you, check *Please check this box if not apply.*
  - ✓ Include:
    - ✓ *VIN number, license number, expiration date and the license copy of each transportation vehicle*.
- ✓ In the following section:
  - ✓ If this does not apply to you, check *Please check this box if not apply.*
  - ✓ include:
    - ✓ Licenses and expiration dates for each transportation vehicle.

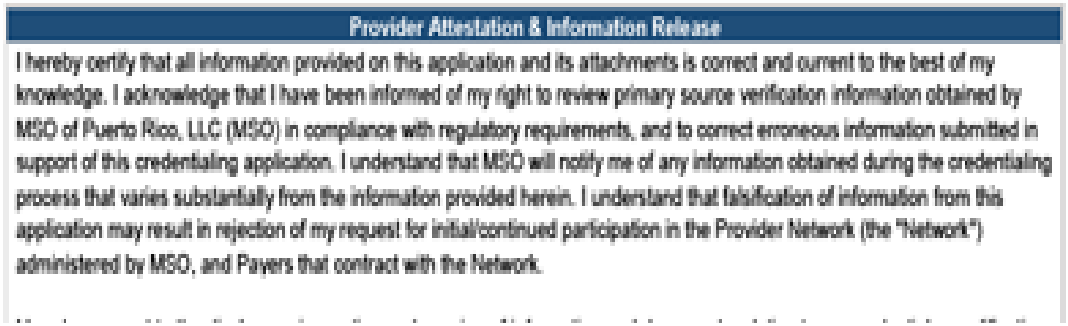


How is the process carried out? (Continued)

- ✓ Under Disclosure questions, answer the questions with Yes or No.
  - ✓ If the answer is Yes, explain in the box under the question.
- ✓ Read the entire Provider Attestation & Information Release before proceeding to the next section.



Disclosure Questions	
(145) Has your license and/or certifications ever been revoked or have any restrictions or modifications ever been assessed against it/them? *	
If yes, please explain:	
(146) Has your facility ever had a malpractice suit? *	
If yes, please explain:	
(147) Has your malpractice coverage ever been restricted or limited? *	
If yes, please explain:	
(148) Has your facility ever been found to have quality measure deficiencies? *	
If yes, please explain:	
(149) Has your facility ever been found to have healthcare deficiencies? *	
If yes, please explain:	
(150) Does the company currently have a malpractice suit filed against it? *	
If yes, please explain:	
(151) 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? *	
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.

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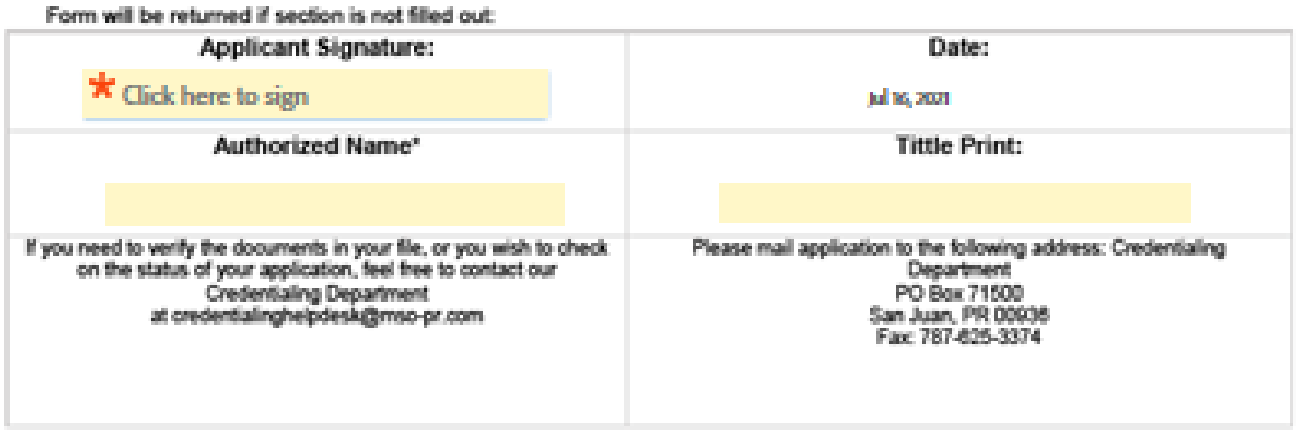
How is the process carried out? (Continued)

- ✓ Enter your name in Applicant Signature.
- ✓ Remember, when you click to sign, you will receive an email from Adobe to confirm and submit the completed application.



Form will be returned if section is not filled out:

Applicant Signature:	Date:
* Click here to sign	jul 16, 2021
Authorized Name*	**Tittle Print:**
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

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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:
  - **787-993-2317 (Metro Area)**
  - **1-866-676-6060 (Free of charge)**

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