RHODE ISLAND PRIMARY CARE PHYSICIANS CORPORATION

BEHAVIORAL HEALTH AFFILIATE MEMBERSHIP APPLICATION

Please return along with your CV and application fee to:

Behavioral Health Affiliate Membership Committee
Rhode Island Primary Care Physicians Corporation
1150 New London Avenue, Suite 20
Cranston, RI 02920
(401) 654-4000

I. APLLICANT INFORMATION

Name: _____ Social Security Number: _____

Mailing Address: _____ Tax ID Number: _____

_____ Date of Birth: _____

Email Address: _____

Secure Direct Mail Email Address: _____

This will be the primary means of communication between RIPCPC and Behavioral Health Affiliate Members. If you do not have Direct Mail, have you contacted Joyce Coutu at RIQI to initiate the process (jcoutu@riqi.org) Yes ☐ No ☐

Would you like your email listed with your address on the RIPCPC public/external website: Yes ☐ No ☐

Website: _____

II PRACTICE INFORMATION

Practice Name: _____Number of Partners/Owners: _____

Please list your practice owners/management: _____

_____

Will partners also be joining RIPCPC? _____

Please list other clinicians associated with your practice: _____

_____

Practice Location(s): Address (street, city, zip) Main Line/Back Line/Fax Number Handicapped Access

1. _____ _____ Yes ☐ No ☐

2. _____ _____ Yes ☐ No ☐

3. _____ _____ Yes ☐ No ☐

Professional Liability Carrier: _____

Policy Limits: _____ Expiration Date: _____

Hours:

Location	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1.							
2.							
3.							
Note:							

Type of practice: (check one) Solo ☐ (annual fee: $60) Group Practice ☐ (annual fee: $300)

Administrative/Office Manager: _____

Please list providers who routinely provide coverage for you (other than members of your group practice):

_____

Please note your areas of specialization on the enclosed Affiliate Collaboration Questionnaire:
(Note this information will be available to RIPCPC Physicians and providers for reference in making referrals.)

Are there any other limitations to your practice? (patients served, etc.) _____

_____

List the insurance companies and managed care organization for whom you are a contracted provider?
Please note this information will be available to referring RIPCPC Physicians and providers.

Name _____ Inclusive Dates _____

Name _____ Inclusive Dates _____

Name _____ Inclusive Dates _____

Name _____ Inclusive Dates _____

III. LICENSES, CERTIFICATES and REGISTRATIONS

Please list the following:

State Licenses:

License as	State	License #	Expiration Date
1			
2			
3			
4			

Board Certifications:

Certificate and Certifying Organization	State	Certificate #	Expiration Date
1			
2			
3			

Registrations:

NPI#	
Federal DEA:	
RI CMD#	
MA DEA#	

IV. DISCIPLINARY HISTORY

If you answer YES to any of the following questions, please provide a detailed explanation on a separate sheet.

a. Have you ever had your state license refused, restricted, suspended or revoked in MA, RI or any other state?	Yes ☐ No ☐
b. Has the Licensing Board of any state ever taken action against you?	Yes ☐ No ☐
c. Has your license to prescribe narcotics ever been suspended, refused or revoked, if relevant?	Yes ☐ No ☐
d. Have your hospital privileges ever been suspended, restricted or revoked, if relevant?	Yes ☐ No ☐
e. Are you now or have you ever been involved in any malpractice suit, including arbitration?	Yes ☐ No ☐
f. Have any malpractice judgments been entered against you?	Yes ☐ No ☐
g. Has any malpractice claim settlement, not involving litigation or arbitration, ever been paid by you or on your behalf?	Yes ☐ No ☐
h. Have you ever been the subject of investigation by a peer review committee?	Yes ☐ No ☐
i. Have you ever been convicted of a crime?	Yes ☐ No ☐
j. Have you ever been treated for alcoholism or drug addiction?	Yes ☐ No ☐
k. Do you have any physical or mental disorders that may interfere with your obligation and duties as a provider	Yes ☐ No ☐
l. Have you ever been suspended from receiving payment under the Medicare or Medicaid program?	Yes ☐ No ☐
m. Has your malpractice insurance ever been terminated or revoked except with your consent or at your request?	Yes ☐ No ☐
n. Have you ever been denied membership or renewal in any professional organization?	Yes ☐ No ☐
o. Have you ever been subject to disciplinary action in any professional organization?	Yes ☐ No ☐
p. Have you ever voluntarily relinquished or not renewed privileges in a professional organization?	Yes ☐ No ☐

Have you satisfied the continuing education requirement for your current license? Yes ☐ No ☐
Have you satisfied the continuing education requirement for your upcoming licensing renewal? Yes ☐ No ☐

V. DOCUMENTATION

Please attach copies of documentation of each of the following (legible photocopy or photograph accepted):

Rhode Island professional license	Yes ☐ No ☐ Not applicable☐
Other state professional license(s)	Yes ☐ No ☐ Not applicable☐
Professional degree (diploma or transcript)	Yes ☐ No ☐ Not applicable☐
Pre or Post Graduate training	Yes ☐ No ☐ Not applicable☐
Professional liability insurance cover sheet	Yes ☐ No ☐ Not applicable☐
State Controlled Substance Registration	Yes ☐ No ☐ Not applicable☐
DEA Registration	Yes ☐ No ☐ Not applicable☐
Hospital Privileges*	Yes ☐ No ☐ Not applicable☐
W-9 Form	Yes ☐ No ☐ Not applicable☐

* Letter from Hospital confirming privileges dated within 60 days of receipt of this application by RIPCPC is acceptable.

VI. REFERENCES

List two professional references at least one of whom is a current RIPCPC member, not including relatives:

Name _____ Telephone_____

Address _____

Email: _____

Name _____ Telephone_____

Address _____

Email: _____

VII. ENDORSEMENT

RHODE ISLAND PRIMARY CARE PHYSICIANS CORPORATION ***reserves the right to request additional information for purposes of determining membership eligibility.***

I certify that the information provided is true and accurate to the best of my knowledge and understand that if Rhode Island Primary Care Physicians Corporation determines that this information is in any way incomplete, false or misleading, acceptance of this application will be considered void.

Signature: _____ Date: _____

Print Name: _____

VIII. APPLICATION CONSENT

In order to more completely evaluate my application for inclusion in Rhode Island Primary Care Physicians Corporation (RIPCPC) and my continuing participation status with RIPCPC, I hereby give permission to RIPCPC to solicit information regarding my professional credentials and qualifications.

Specifically included in the consent, but not by way of limitation, is specific data on my quality of care and utilization statistics from chief(s) of Clinical Departments of hospitals or other health care facilities in which I have privileges, the National Data Bank, State Boards of Professional Regulation, the Department of Welfare, Medicaid and Medicare regulating agencies, drug enforcement agencies and colleagues.

I understand that RIPCPC will use this information solely in confidence.

I hereby release from liability RIPCPC and its employee(s), Members, Directors or agents and any person(s) listed above who is approached for information concerning my professional qualifications.

Signature: _____ Date: _____

Print Name: _____

If you need extra space to respond to any item, please indicate that on the form and attach your response.