



**Quartz Provider Participation Request Form**

<b>SECTION II: GENERAL INFORMATION</b>	
1.	Have you ever applied for or had a contract with? If yes, under what name or group? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
2.	Covered Service Area (Cities and Counties):
3.	Please list any Quartz network providers that currently refer to your office:
4.	Please provide a brief description regarding your facility and the services you currently provide:
5.	Is public transportation accessible to and from your facility? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
6.	Does your facility accommodate for people with physical disabilities (including exam rooms, equipment, restrooms, handicap entrance and parking)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
7.	Describe how you meet the needs for members with physical disabilities and limited mobility: Comments:
8.	Describe how you meet the needs of non-English speaking patients: Comments:
9.	Please list the number of hours per week facility is open for appointments:
10.	Please list the hours staff are available (include evening/weekend hours):
11.	Please describe your process for handling calls after hours for urgent and emergent patient situations:
12.	Does your organization allow mid-level practitioners (e.g. nurse practitioners and/or physician assistants) to be selected by patients as a Primary Care Providers? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
13.	Does your facility provide e-Visits, Virtual Visits or Telehealth services? Comments: <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
14.	a. Does your facility use restraint measures such as restraints or seclusion? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> b. Do you have a policy* to support the use of restrictive measures? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> c. If you do not use restrictive measures, do you have a policy* to support your patient's right to be free from any form of restraint or seclusion? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>*Policy must be available upon request.</i>

<b>Providers Employed by Facility:</b>				<b># Hours practice per week</b>
<b>Practitioner Name</b>	<b>Degree</b>	<b>License State/Number</b>	<b>Date license issued</b>	

**Quartz Provider Participation Request Form**

<b>SECTION III: CONTACT INFORMATION</b>				
<b>Contact Type</b>	<b>Contact Name/Title (First and Last Name)</b>	<b>Phone Number</b>	<b>E-mail Address</b>	<b>Preferred Contact Method</b>
Primary Contact:				<input type="checkbox"/> Phone <input type="checkbox"/> E-mail
Contract Signature:				<input type="checkbox"/> Phone <input type="checkbox"/> E-mail
Agreement Notification:				<input type="checkbox"/> Phone <input type="checkbox"/> E-mail
Billing:				<input type="checkbox"/> Phone <input type="checkbox"/> E-mail
Provider Manual:				<input type="checkbox"/> Phone <input type="checkbox"/> E-mail
Provider Updates/CMS Verifications:				<input type="checkbox"/> Phone <input type="checkbox"/> E-mail
Compliance Representative:				<input type="checkbox"/> Phone <input type="checkbox"/> E-mail

**SECTION IV: BEHAVIORAL HEALTH PROVIDER INFORMATION**

**A. Practice Type**

<input type="checkbox"/> Group	<input type="checkbox"/> Individual
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**B. Treatment Information**

1.	Area(s) of specialization/interest (include special populations):	
2.	Conditions treated:	
3.	Methods/approaches used in treatment:	
4.	Does the practice have a Psychiatrist consulting on staff or referral arrangements with a Psychiatrist at another location? Describe these arrangements and if there aren't any, what are the means for getting patients psychiatric care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	What are these arrangements and if there aren't any, what are the means for getting patients psychiatric care?	
6.	Will your facility be providing Medication Assisted Treatment (MAT)? Buprenorphine: <input type="checkbox"/> Yes <input type="checkbox"/> No Vivitrol: <input type="checkbox"/> Yes <input type="checkbox"/> No Methadone: <input type="checkbox"/> Yes <input type="checkbox"/> No  <ul style="list-style-type: none"> <li>• If yes, please describe your process for providing or arranging counseling with a therapist for primary substance use disorder:</li> <li>• If services are not provided by you, list the providers that you have agreements with to provide therapy and describe how patients are referred:</li> <li>• List the medical specialty of providers prescribing MAT:</li> </ul> Comments:	

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**SECTION V: FACILITY CREDENTIALING FORM**

<b>License/Accrediting Body</b>	<b>Indicate Yes, No or N/A</b>	<b>Number</b>	<b>Effective Date</b>	<b>Expiration Date</b>
<b>Facility Type:</b> <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> Nursing Home <input type="checkbox"/> Surgery Center <input type="checkbox"/> Behavioral Health Inpt/Residential				
<b>Facility State License</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
<b>Medicare Certification</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
<b>Medicaid Certification</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
<b>The Joint Commission</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
<b>AAAH</b> - Accreditation Association for Ambulatory Health Care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
<b>AAAASF</b> - American Association for Accreditation of Ambulatory Surgical Facilities	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
<b>ACHC</b> - Accreditation Commission for Health Care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
<b>CARF</b> - Commission on Accreditation of Rehabilitation Facilities	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
<b>CHAP</b> - Community Health Accreditation Program	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
<b>COA</b> - Council on Accreditation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
<b>DNV Healthcare</b> - Det Norske Veritas Healthcare, Inc.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
<b>HFAP</b> - Healthcare Facilities Accreditation Program	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
<b>CLIA</b> – Clinical Laboratory Improvement Amendments	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			

**Please attach copies of the following documents:**

- Copy of the facility’s state license
- Most recent State/CMS survey results and the cover letter stating acceptance of the plan of correction, if applicable
- Explanation regarding any loss or change of certification or accreditation status within the past three years.

*For facilities without accreditation, Quartz Health Solutions, Inc. reserves the right to conduct an on-site visit of your facility.*

**Quartz Provider Participation Request Form**

**SECTION VI: SERVICES**

*Please review each service listed and indicate the services provided by your facility.*

BEHAVIORAL HEALTH SERVICES		BILLING NPI
<input type="checkbox"/>	Mental Illness Adult– Inpatient Treatment	
<input type="checkbox"/>	Mental Illness Child/Adolescent–Inpatient Treatment	
<input type="checkbox"/>	Mental Illness Adult – Outpatient Treatment	
<input type="checkbox"/>	Mental Illness Child/Adolescent – Outpatient Treatment	
<input type="checkbox"/>	AODA Adult – Inpatient Treatment	
<input type="checkbox"/>	AODA Adolescent – Inpatient Treatment	
<input type="checkbox"/>	AODA Adult – Outpatient Treatment	
<input type="checkbox"/>	AODA Adolescent – Outpatient Treatment	
<input type="checkbox"/>	Other:	
EYE CLINICS SERVICES		BILLING NPI
<input type="checkbox"/>	Ophthalmology Services	
<input type="checkbox"/>	Optometry Services	
<input type="checkbox"/>	Vision Care/Screening	
<input type="checkbox"/>	Vision Supplies (Eye Glasses & Contacts)	
<input type="checkbox"/>	Other:	
DIALYSIS		BILLING NPI
<input type="checkbox"/>	Inpatient	
<input type="checkbox"/>	Outpatient	
<input type="checkbox"/>	Other:	
DURABLE MEDICAL EQUIPMENT SERVICES		BILLING NPI
<input type="checkbox"/>	Apnea Monitors	
<input type="checkbox"/>	BI-Pap	
<input type="checkbox"/>	Bone Growth Stimulator	
<input type="checkbox"/>	CPAP	
<input type="checkbox"/>	DME/HME (standard wheelchair, hospital bed, etc.)	
<input type="checkbox"/>	Oxygen Concentrator	
<input type="checkbox"/>	Oxygen-Liquid	
<input type="checkbox"/>	Photo Therapy	
<input type="checkbox"/>	Respiratory DME	
<input type="checkbox"/>	TENS Unit	
<input type="checkbox"/>	Ventilators	
<input type="checkbox"/>	Wound Vac	
<input type="checkbox"/>	Other Specialty DME Items:	
HOME HEALTH SERVICES		BILLING NPI
<input type="checkbox"/>	Durable Medical Equipment	
<input type="checkbox"/>	Home Infusion	
<input type="checkbox"/>	Home Health Services - Skilled	
<input type="checkbox"/>	Home Health Services - Aid	
<input type="checkbox"/>	Occupational Therapy	
<input type="checkbox"/>	Physical Therapy	
<input type="checkbox"/>	Speech Therapy	
<input type="checkbox"/>	Other:	

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NURSING HOME SERVICES		BILLING NPI
<input type="checkbox"/>	Skilled Nursing Services	
<input type="checkbox"/>	Other:	
PATHOLOGY SERVICES		BILLING NPI
<input type="checkbox"/>	Pathology Services (Professional)	
<input type="checkbox"/>	Pathology Services (Technical)	
<input type="checkbox"/>	Other:	
PODIATRIC SERVICES		BILLING NPI
<input type="checkbox"/>	Radiology – Diagnostic & Therapeutic	
<input type="checkbox"/>	Podiatric Services	
<input type="checkbox"/>	Other:	
PROSTHETICS/ORTHOTICS SERVICES		BILLING NPI
<input type="checkbox"/>	Mastectomy Supplies	
<input type="checkbox"/>	Orthotic Supplies	
<input type="checkbox"/>	Prosthetic Supplies	
<input type="checkbox"/>	Other:	
RADIOLOGY SERVICES		BILLING NPI
<input type="checkbox"/>	Bone Density Measurement	
<input type="checkbox"/>	CT (Professional)	
<input type="checkbox"/>	MRI (Professional)	
<input type="checkbox"/>	MRI (Technical)	
<input type="checkbox"/>	Nuclear Medicine	
<input type="checkbox"/>	Nuclear Medicine (Professional)	
<input type="checkbox"/>	Open MRI	
<input type="checkbox"/>	Radiation Oncology	
<input type="checkbox"/>	Radiation Therapy	
<input type="checkbox"/>	Radiology – General Services (Technical)	
<input type="checkbox"/>	Radiology Services – Diagnostic & Therapeutic	
<input type="checkbox"/>	Radiology Services – Mammography	
<input type="checkbox"/>	Ultrasound	
<input type="checkbox"/>	Vascular and Interventional Radiology	
<input type="checkbox"/>	Other:	
SPORTS MEDICINE SERVICES		BILLING NPI
<input type="checkbox"/>	Durable Medical Equipment (Dispensed In-house)	
<input type="checkbox"/>	Occupational Therapy (Outpatient)	
<input type="checkbox"/>	Physical Therapy (Outpatient)	
<input type="checkbox"/>	Orthotic Supplies	
<input type="checkbox"/>	Prosthetic Supplies	
<input type="checkbox"/>	Radiology – Diagnostic & Therapeutic (In-house)	
<input type="checkbox"/>	Orthopedic Surgery (Adult)	
<input type="checkbox"/>	Orthopedic Surgery (Pediatric)	
<input type="checkbox"/>	Other:	
OTHER SERVICES		BILLING NPI
<input type="checkbox"/>	Anti-Hemophilic Factor	
<input type="checkbox"/>	Anesthetists	

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<input type="checkbox"/>	ECG Interpretation	
<input type="checkbox"/>	Insulin Pump Therapy	
<input type="checkbox"/>	Cardiac Outpatient Telemetry	
<input type="checkbox"/>	Specialty Clinic	
<input type="checkbox"/>	Urgent Care Services	
<input type="checkbox"/>	Other:	
<b>CLINIC SERVICES</b>		<b>BILLING NPI</b>
<input type="checkbox"/>	Allergy Services	
<input type="checkbox"/>	Audiology – Hearing Screening	
<input type="checkbox"/>	Audiology – Hearing Aids	
	<b>Behavioral Health:</b>	
<input type="checkbox"/>	• Mental Illness Adult – Outpatient Treatment	
<input type="checkbox"/>	• Mental Illness Child/Adolescent – Outpatient Treatment	
<input type="checkbox"/>	• Alcoholism/Chemical Dependency Adult – Outpatient Treatment	
<input type="checkbox"/>	• Alcoholism/Chemical Dependency Adolescent – Outpatient Treatment	
<input type="checkbox"/>	Cardiology Services	
<input type="checkbox"/>	Dental Services	
<input type="checkbox"/>	Dermatology Services	
<input type="checkbox"/>	Durable Medical Equipment	
<input type="checkbox"/>	Endocrinology Services	
<input type="checkbox"/>	Eye Glasses & Contacts	
<input type="checkbox"/>	Family Practice	
<input type="checkbox"/>	Gastroenterology Services	
<input type="checkbox"/>	Hematology/Oncology Services	
<input type="checkbox"/>	Infectious Disease Services	
<input type="checkbox"/>	Internal Medicine Services	
<input type="checkbox"/>	Laboratory Services	
<input type="checkbox"/>	Nephrology Services	
<input type="checkbox"/>	Neurology Services	
<input type="checkbox"/>	Neurosurgery	
<input type="checkbox"/>	Obstetrics & Gynecology	
<input type="checkbox"/>	Occupational Health Services	
<input type="checkbox"/>	Occupational Therapy (Outpatient)	
<input type="checkbox"/>	Ophthalmology Services	
<input type="checkbox"/>	Optometry Services	
<input type="checkbox"/>	Oral/Maxillofacial Surgery	
<input type="checkbox"/>	Orthopedics Services	
<input type="checkbox"/>	Otolaryngology (ENT)	
<input type="checkbox"/>	Pediatric Services	
<input type="checkbox"/>	Physical Medicine & Rehabilitation	
<input type="checkbox"/>	Physical Therapy (Outpatient)	
<input type="checkbox"/>	Plastic & Reconstructive Surgery - General	
<input type="checkbox"/>	Podiatric Services	
<input type="checkbox"/>	Orthotic Supplies	

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<input type="checkbox"/>	Prosthetic Supplies	
<input type="checkbox"/>	Pulmonary Medicine Services	
<input type="checkbox"/>	Radiation Therapy	
<input type="checkbox"/>	Radiology Services – Diagnostic & Therapeutic	
<input type="checkbox"/>	Radiology Services – Mammography	
<input type="checkbox"/>	Renal Dialysis	
<input type="checkbox"/>	Rheumatology Services	
<input type="checkbox"/>	Speech Therapy	
<input type="checkbox"/>	Sports Medicine Services	
<input type="checkbox"/>	Surgery - Outpatient or Ambulatory	
<input type="checkbox"/>	Urgent Care Services	
<input type="checkbox"/>	Urology Services	
<input type="checkbox"/>	Other:	
<b>HOSPITAL SERVICES</b>		<b>BILLING NPI</b>
<input type="checkbox"/>	Acute Inpatient Hospital Care	
	<b>Behavioral Health:</b>	
<input type="checkbox"/>	• Mental Illness Adult– Inpatient Treatment	
<input type="checkbox"/>	• Mental Illness Child/Adolescent–Inpatient Treatment	
<input type="checkbox"/>	• Mental Illness Adult – Outpatient Treatment	
<input type="checkbox"/>	• Mental Illness Child/Adolescent – Outpatient Treatment	
<input type="checkbox"/>	• Alcoholism/Chemical Dependency Adult – Inpatient Treatment	
<input type="checkbox"/>	• Alcoholism/Chemical Dependency Adolescent – Inpatient Treatment	
<input type="checkbox"/>	• Alcoholism/Chemical Dependency Adult – Outpatient Treatment	
<input type="checkbox"/>	• Alcoholism/Chemical Dependency Adolescent – Outpatient Treatment	
<input type="checkbox"/>	Cardiology Services	
<input type="checkbox"/>	Cardiac Surgery Program	
<input type="checkbox"/>	Cardiac Catheterization Services	
<input type="checkbox"/>	Critical Care Services – Intensive Care Units (ICU)	
<input type="checkbox"/>	Durable Medical Equipment	
<input type="checkbox"/>	Emergency & Trauma Center	
<input type="checkbox"/>	Endocrinology Services	
<input type="checkbox"/>	Gastroenterology Services	
<input type="checkbox"/>	Hematology/Oncology Services	
<input type="checkbox"/>	Home Health	
<input type="checkbox"/>	Infectious Disease Services	
<input type="checkbox"/>	Laboratory Services	
<input type="checkbox"/>	Neonatal Intensive Care Unit	
<input type="checkbox"/>	Neurology Services	
<input type="checkbox"/>	Neurosurgery	
<input type="checkbox"/>	Occupational Health Services	
<input type="checkbox"/>	Occupational Therapy (Inpatient)	
<input type="checkbox"/>	Occupational Therapy (Outpatient)	
<input type="checkbox"/>	Orthopedic Surgery (Adult)	
<input type="checkbox"/>	Orthopedic Surgery (Pediatric)	
<input type="checkbox"/>	Otolaryngology (ENT)	
<input type="checkbox"/>	Outpatient Infusion/Chemotherapy	
<input type="checkbox"/>	Pediatric Services	



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<input type="checkbox"/>	Physical Medicine & Rehabilitation	
<input type="checkbox"/>	Physical Therapy (Inpatient)	
<input type="checkbox"/>	Physical Therapy (Outpatient)	
<input type="checkbox"/>	Plastic & Reconstructive Surgery - General	
<input type="checkbox"/>	Pulmonary Medicine Services	
<input type="checkbox"/>	Radiation Oncology Services	
<input type="checkbox"/>	Radiology Services – Diagnostic & Therapeutic	
<input type="checkbox"/>	Radiology Services - Mammography	
<input type="checkbox"/>	Rheumatology Services	
<input type="checkbox"/>	Speech Therapy (Outpatient)	
<input type="checkbox"/>	Surgery – Outpatient or Ambulatory	
<input type="checkbox"/>	Surgery (General)	
<input type="checkbox"/>	<b>Transplant Program:</b>	
<input type="checkbox"/>	• Heart Transplant	
<input type="checkbox"/>	• Heart/Lung Transplant	
<input type="checkbox"/>	• Kidney Transplant	
<input type="checkbox"/>	• Liver Transplant	
<input type="checkbox"/>	• Lung Transplant	
<input type="checkbox"/>	• Pancreas Transplant	
<input type="checkbox"/>	Swing Bed – (Skilled Nursing Services)	
<input type="checkbox"/>	Urgent Care Services	
<input type="checkbox"/>	Urology	
<input type="checkbox"/>	Vascular Surgery	
<input type="checkbox"/>	Other:	

#### SECTION VII: LANGUAGES

*Please list below all languages spoken by the practitioners and employees of your facility.*

#### SECTION VIII: ATTESTATION

I hereby verify that the information provided herein is current, correct and complete as of the date of my signature below and that, at a minimum, the staff are legally and professionally qualified for the positions they hold and that there are no state or federal sanctions against this facility. As an administrative representative of this facility, I have the authority to sign on behalf of the organization.

Signature

Title

Date

# QUARTZ CONTRACT IMPLEMENTATION FORM

## Billing and Facility Information

**Contact Information (for information regarding claims, address changes, and/or practitioner changes):**

Contact Name:			
Contact Address:			
Contact Telephone Number:		Contact Fax Number:	
Contact Email Address:			

**Credentialing Recipient:**

Contact Name:			
Contact Address:			
Contact Telephone Number:		Contact Fax Number:	
Contact Email Address:			

**Service Site Locations:**

<b>1.</b>	Location/Clinic:							
	Street Address:		City:		State:		Zip + 4:	
	Billing Address:		City:		State:		Zip + 4:	
	County:		Phone Number:		Fax Number:			
	Billing National Provider Identification (NPI) Number:							
	Swing Bed Facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Essential Community Provider Type:				
	Total # of Beds:		<input type="checkbox"/>	Federally Qualified Health Center Provider		<input type="checkbox"/>	Ryan White Provider	
	# of Certified Medicare Beds:		<input type="checkbox"/>	Indian Health Provider		<input type="checkbox"/>	Other ECP Provider	
	# of ICU/CCU Beds:		<input type="checkbox"/>	Family Planning Provider		<input type="checkbox"/>	Hospital Provider	
	On Call/After Hours Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No				Regular Office Hours:			

<b>2.</b>	Location/Clinic:							
	Street Address:		City:		State:		Zip + 4:	
	Billing Address:		City:		State:		Zip + 4:	
	County:		Phone Number:		Fax Number:			
	Billing National Provider Identification (NPI) Number:							
	Swing Bed Facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Essential Community Provider Type:				
	Total # of Beds:		<input type="checkbox"/>	Federally Qualified Health Center Provider		<input type="checkbox"/>	Ryan White Provider	
	# of Certified Medicare Beds:		<input type="checkbox"/>	Indian Health Provider		<input type="checkbox"/>	Other ECP Provider	
	# of ICU/CCU Beds:		<input type="checkbox"/>	Family Planning Provider		<input type="checkbox"/>	Hospital Provider	
	On Call/After Hours Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No				Regular Office Hours:			

**Quartz Provider Participation Request Form**  
**QUARTZ CONTRACT IMPLEMENTATION FORM**  
 Billing and Facility Information

**Service Site Locations Cont'd:**

<b>3.</b>	Location/Clinic:										
	Street Address:					City:		State:		Zip + 4:	
	Billing Address:					City:		State:		Zip + 4:	
	County:				Phone Number:			Fax Number:			
	Billing National Provider Identification (NPI) Number:										
	Swing Bed Facility?				<input type="checkbox"/> Yes <input type="checkbox"/> No		Essential Community Provider Type:				
	Total # of Beds:				<input type="checkbox"/>		Federally Qualified Health Center Provider		<input type="checkbox"/>		Ryan White Provider
	# of Certified Medicare Beds:				<input type="checkbox"/>		Indian Health Provider		<input type="checkbox"/>		Other ECP Provider
	# of ICU/CCU Beds:				<input type="checkbox"/>		Family Planning Provider		<input type="checkbox"/>		Hospital Provider
	On Call/After Hours Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					Regular Office Hours:					

<b>4.</b>	Location/Clinic:										
	Street Address:					City:		State:		Zip + 4:	
	Billing Address:					City:		State:		Zip + 4:	
	County:				Phone Number:			Fax Number:			
	Billing National Provider Identification (NPI) Number:										
	Swing Bed Facility?				<input type="checkbox"/> Yes <input type="checkbox"/> No		Essential Community Provider Type:				
	Total # of Beds:				<input type="checkbox"/>		Federally Qualified Health Center Provider		<input type="checkbox"/>		Ryan White Provider
	# of Certified Medicare Beds:				<input type="checkbox"/>		Indian Health Provider		<input type="checkbox"/>		Other ECP Provider
	# of ICU/CCU Beds:				<input type="checkbox"/>		Family Planning Provider		<input type="checkbox"/>		Hospital Provider
	On Call/After Hours Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					Regular Office Hours:					

<b>5.</b>	Location/Clinic:										
	Street Address:					City:		State:		Zip + 4:	
	Billing Address:					City:		State:		Zip + 4:	
	County:				Phone Number:			Fax Number:			
	Billing National Provider Identification (NPI) Number:										
	Swing Bed Facility?				<input type="checkbox"/> Yes <input type="checkbox"/> No		Essential Community Provider Type:				
	Total # of Beds:				<input type="checkbox"/>		Federally Qualified Health Center Provider		<input type="checkbox"/>		Ryan White Provider
	# of Certified Medicare Beds:				<input type="checkbox"/>		Indian Health Provider		<input type="checkbox"/>		Other ECP Provider
	# of ICU/CCU Beds:				<input type="checkbox"/>		Family Planning Provider		<input type="checkbox"/>		Hospital Provider
	On Call/After Hours Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					Regular Office Hours:					

**Quartz Provider Participation Request Form**  
**QUARTZ CONTRACT IMPLEMENTATION FORM**

Practitioner Information

<b>Practitioner Name (First, MI, Last):</b>				DOB:	
Credentials/Degree:		License State/Number:			
Individual NPI:		Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		Taxonomy:	
Has Practitioner completed Cultural Competency Training?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Practitioner E-mail:	
Available for patients to choose as their PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is provider employed by your facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female		Area(s) of Specialty:		
Race:	<input type="checkbox"/> African American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other:				
In-Training/Non-Licensed?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Languages Spoken:	
Number of hours in practice each week:		Please List Hospital Affiliations:			
Medicare #:			Participating? <input type="checkbox"/> Yes <input type="checkbox"/> No		Accepting Assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medicaid #:			Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Comments:					
Please list the Service Site numbers for this practitioner (from the previous page(s)) and answer the following for each site:					
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Practitioner Name (First, MI, Last):</b>				DOB:	
Credentials/Degree:		License State/Number:			
Individual NPI:		Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		Taxonomy:	
Has Practitioner completed Cultural Competency Training?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Practitioner E-mail:	
Available for patients to choose as their PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is provider employed by your facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female		Area(s) of Specialty:		
Race:	<input type="checkbox"/> African American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other:				
In-Training/Non-Licensed?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Languages Spoken:	
Number of hours in practice each week:		Please List Hospital Affiliations:			
Medicare #:			Participating? <input type="checkbox"/> Yes <input type="checkbox"/> No		Accepting Assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medicaid #:			Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Comments:					
Please list the Service Site numbers for this practitioner (from the previous page(s)) and answer the following for each site:					
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	

## Quartz Provider Participation Request Form

<b>Practitioner Name (First, MI, Last):</b>				DOB:	
Credentials/Degree:		License State/Number:			
Individual NPI:		Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		Taxonomy:	
Has Practitioner completed Cultural Competency Training?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Practitioner E-mail:	
Available for patients to choose as their PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is provider employed by your facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female		Area(s) of Specialty:		
Race:	<input type="checkbox"/> African American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other:				
In-Training/Non-Licensed?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Languages Spoken:	
Number of hours in practice each week:		Please List Hospital Affiliations:			
Medicare #:			Participating? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accepting Assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicaid #:			Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Comments:					
Please list the Service Site numbers for this practitioner (from the previous page(s)) and answer the following for each site:					
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Practitioner Name (First, MI, Last):</b>				DOB:	
Credentials/Degree:		License State/Number:			
Individual NPI:		Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		Taxonomy:	
Has Practitioner completed Cultural Competency Training?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Practitioner E-mail:	
Available for patients to choose as their PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is provider employed by your facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female		Area(s) of Specialty:		
Race:	<input type="checkbox"/> African American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other:				
In-Training/Non-Licensed?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Languages Spoken:	
Number of hours in practice each week:		Please List Hospital Affiliations:			
Medicare #:			Participating? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accepting Assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicaid #:			Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Comments:					
Please list the Service Site numbers for this practitioner (from the previous page(s)) and answer the following for each site:					
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service Site #:		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can this Practitioner be selected as a PCP at this location: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can an appointment be scheduled at this location on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	

*\*This page may be copied if you have additional practitioner information to provide.*



**Medicare Advantage FDR Annual Compliance Attestation**

My organization is considered a First Tier Entity as we provide administrative or health service functions for Senior Preferred’s Medicare Parts C and D contracts. The Centers for Medicare and Medicaid Services (CMS) requires any individual or organization that contracts with a Medicare Advantage Plan Sponsor to provide administrative or health service functions to comply with various CMS compliance program requirements. These requirements are listed below and apply to all services your organization provides for Senior Preferred’s Medicare Advantage business. The requirements also apply to any Downstream Entities your organization uses for Senior Preferred’s Medicare Advantage business. By completing this attestation, you certify that your organization is committed to ensuring compliance with CMS and Senior Preferred requirements.

**1. Compliance & Fraud, Waste and Abuse (FWA) Training:**

My organization provided General Compliance Training to all applicable employees (including temporary employees and volunteers), governing board members, and contractors within 90 days of hire or contracting and annually thereafter. (§50.3.1)

Yes  No

My organization provided FWA Training to all applicable employees (including temporary employees and volunteers), governing board members, and contractors within 90 days of hire or contracting and annually thereafter **or** has been deemed to have met the FWA certification requirements through enrollment in the Medicare program or accreditation as a supplier of Durable Medical Equipment, Prosthesis, Orthotics, and Supplies (DMEPOS). (§50.3.2)

Yes  No

**2. Code of Conduct and/or Compliance Program Policies**

My organization has a Code of Conduct and/or Compliance Program policies that explain its commitment to comply with federal and state laws, ethical behavior and compliance program operations, which are distributed to all employees, (including temporary employees and volunteers), governing board members, and contractors within 90 days of hire or contracting, upon revision, and annually thereafter. (§50.1.3)

Yes  No

**3. US Department of Health & Human Services Office of Inspector General (OIG) and General Services Administration’s System for Award Management (SAM) Exclusion Screenings**

My organization screens the OIG and SAM exclusion lists prior to hire or contracting and monthly thereafter, to ensure none of our employees (including temporary employees and volunteers), governing board members, contractors, and Downstream Entities are the exclusion lists, and immediately removes any person or entity from working on Senior Preferred Medicare Advantage business if found on either of the exclusion lists. (§50.6.8)

OIG  Yes  No

GSA  Yes  No

**4. Reporting Mechanisms**

My organization has communicated to employees how to report any suspected or detected non-compliance or potential fraud, waste, or abuse, and that it is their obligation to report without fear of retaliation or intimidation against anyone who reports in good faith. My organization either requests employees report concerns directly to Senior Preferred or maintains confidential and anonymous mechanisms for employees to report internally, and we will report these concerns to Senior Preferred as they occur. (§50.4.2)

Yes  No

## Quartz Provider Participation Request Form

### 5. Offshore Operations

My organization and/or our Downstream Entities engage in offshore operations that involves the receipt, processing, transferring, handling, storing or accessing of Protected Health Information (PHI).

Yes  No

If yes, you are required to complete Senior Preferred's "Offshore Subcontractor Attestation" for each entity, and submit along with your completed Medicare Advantage FDR Annual Compliance Attestation. This attestation can be found under "Resources" on Senior Preferred's webpage at [www.seniorpreferred.org](http://www.seniorpreferred.org).

### 6. Downstream Entity Oversight

My organization uses Downstream Entities for Senior Preferred Medicare Advantage business.

Yes  No

If yes, my organization conducts oversight (e.g., monitoring/auditing, obtains annual attestations) to ensure that they comply with all applicable Medicare laws, rules, and regulations that apply to me as a First Tier Entity, and communicates and requires compliance with Medicare compliance program requirements described in this attestation. (§50.6.6)

Yes  No

### 7. Record Retention

My organization agrees to maintain documentation supporting the statements made above (e.g. training materials/logs, exclusion screening checks, dissemination of COC and/or compliance program policies, reporting mechanisms, etc.) and will maintain this documentation in accordance with federal regulations and your contract with Senior Preferred, which is no less than ten (10) years. (§50.3.2)

Yes  No

### Attestation Authorization

I certify, as an authorized representative of my organization, that the statements made above are true and correct to the best of my knowledge. In addition, my organization will furnish evidence, upon request, and understands that the inability to provide this evidence may result in a request by Senior Preferred for a Corrective Action Plan (CAP) or other contractual remedies such as contract termination.

<b>Printed Name of Provider/Organization:</b>	<b>Date of Attestation:</b>
<b>Printed Name of First Tier Organization's Authorized Representative:</b>	<b>Signature of First Tier Organization's Authorized Representative:</b>
<b>First Tier Organization's Authorized Representative's Title:</b>	<b>First Tier Authorized Representative's Email Address:</b>