TRISTAR Managed Care
PARTICIPATING GROUP APPLICATION

Name of Group/Organization:		Incorporated: Yes ☐ No ☐
dba (If different than GROUP)		Incorporated: Yes ☐ No ☐
Group Website:		

Please Note: All pertinent information for billing & referral purposes should be included on the attached individual provider application or the roster.

Does the GROUP 'subcontract' with other providers?	☐ YES; ☐ NO
▪ If YES, will the GROUP be billing for the services the provider to TMC beneficiaries?	☐ YES; ☐ NO

Is there a DECLINATION period for the members of the GROUP to decline participation:	☐ Yes: Specify time period:	☐ No
Please provide the total # of providers in your GROUP – Include mid level providers (i.e. PA's, NP's, etc):		
PCP's:_____; Specialists:_____; Other, specify:_____(Roster should accompany the Group Application)		

PLEASE NOTE

Note: All Federal Tax Identification Numbers listed in association with this application WILL BE PARTY TO THE CONTRACT. List only those Tax ID Numbers that are to be affiliated with the TRISTAR Managed Care PPO Contract.

** FEDERAL TAXID#: (*Please attach a copy of the W9 form submitted to the IRS for each TIN listed.)* **

Do ALL members of the GROUP bill using the GROUP's TaxID Number? Yes ☐ No ☐

Primary Tax ID #:		TIN Owner Name:	
Secondary Tax ID: #		TIN Owner Name:	
Tertiary Tax ID #:		TIN Owner Name:	

GROUP CLASSIFICATION

Which of the following best describes the GROUP:	☐ Provider Group	☐ Independent Physician Assoc. (IPA)
	☐ Industrial Medical Clinic	☐ Clinic
	☐ Physician Hospital Organization (PHO)	☐ Managed Services Organization (MSO)
	☐ Single Specialty	☐ Pain Management
	☐ Multi-Specialty	☐ Rural Health Clinic
	☐ Hospital Based	☐ Other:
	☐ Urgent Care Center	

PRIMARY SERVICE LOCATION

Information will be used in directories. *Check the box to exclude from directories* ☐

Address:		City:	
		State:	
		Zip:	
		County / Parish:	
Phone:		Fax:	

Do you provide 24 hour coverage? ☐Yes ☐No	Does this location accept new patients? ☐Yes ☐No

Hours of Operation	MONDAY From / To	TUESDAY From / To	WEDNESDAY From / To	THURSDAY From / To	FRIDAY From / To	SATURDAY From / To	SUNDAY From / To

TRISTAR MANAGED CARE

SECONDARY SERVICE LOCATION *Information will be used in directories.* *Check the box to exclude from directories* ☐					
Address:		City:			
		State:			
		Zip:			
		County / Parish:			
Phone:		Fax:			

Do you provide 24 hour coverage? ☐Yes ☐No	Does this location accept new patients? ☐Yes ☐No

Hours of Operation:	MONDAY From / To	TUESDAY From / To	WEDNESDAY From / To	THURSDAY From / To	FRIDAY From / To	SATURDAY From / To	SUNDAY From / To

ADDITIONAL SERVICE LOCATIONS ~ PLEASE LIST ON SEPARATE PAGE AND ATTACH TO BACK OF THE APPLICATION.

BILLING			
Is there a 'Universal Billing Address' for all the members of the group?	☐ YES; ☐ NO		
▪ If YES, please attach a copy of a HCFA 1500 form with the billing information (Please complete boxes 31, 32, and 33). ▪ If NO, each member of the GROUP must have a billing address identified on the attached individual provider application or the roster.			
Billing Address:		City:	
		State:	
		Zip:	
		County / Parish:	

GROUP CONTACT INFORMATION					
General Correspondence		Billing Contact		Contracting Contract	
Name:		Name:		Name:	
Phone:		Phone:		Phone:	
Fax:		Fax:		Fax:	
Email:		Email:		Email:	

HOSPITAL PRIVILEGES (Only complete if ALL PROVIDERS have privileges at the same facility. Otherwise, list each individual provider's admitting privileges on the attached individual provider application or the roster.)								
Facility:		Address:						
		City:		State:		Zip:		
Facility:		Address:						
		City:		State:		Zip:		
Facility:		Address:						
		City:		State:		Zip:		

MALPRACTICE INFORMATON ** If the GROUP provides members with professional liability insurance, please note that TMC requires professional liability insurance or an equivalent program of malpractice insurance. **						
Name of your malpractice insurance carrier: (please include a copy of your malpractice certificate or declaration page)						
Coverage Amount:	$	Coverage Period:	From:	To:	Policy Number:	

1. Please attach a listing of providers that ARE covered by this policy;
2. If the GROUP does not provide professional liability insurance; please select from the following options:
    a. Complete the malpractice section of each member's individual provider application; OR
    b. Provide the items identified in #1 of this section for each member of the GROUP, if attaching a roster.

Your application to participate will be considered incomplete and will be returned unless you submit the following with your completed, signed application and signed TMC Provider Agreement.

PARTICIPATION STATEMENT / ACKNOWLEDGMENTS
I hereby submit this application with TRISTAR Managed Care (TMC). I understand that this application will be reviewed based on the information provided herein. To assist TMC in evaluating the application, I authorize any appropriate entity to release, furnish copies, or give details of professional credentials, qualifications, or hospital records related to privileges, qualifications and type of medical practice; or other information contained in any file maintained by such entity. GROUP releases from liability all TMC employees and all TMC representatives for their acts performed in good faith and without malice in connection with evaluating the application, credentials and qualifications. Further, I release all individuals and organizations which provide information to TMC regarding the professional competence, ethics, character, and other qualifications or affiliations from any liability provided they act in good faith and without malice. A photocopy of this authorization will grant said privilege. I hereby declare that I am empowered on behalf of the GROUP as identified on page 1 to enter into this Agreement on behalf of its members who have elected to participate in this agreement. I also hereby certify that each member of the GROUP has signed an Agreement or Statement for the GROUP to contract on his/her behalf with TMC. I fully understand that any misstatements in or omissions from this application could constitute cause for termination or denial from participation in the TMC provider network. I hereby affirm that the information furnished by me to TMC is true and complete to the best of my knowledge. Any and all information provided to, or accessed or reviewed by, TMC related to services provided, whether written, verbal, electronic or otherwise shall be considered confidential information (Confidential Information), except for information that is a matter of public record or that was made available by another party without restriction as to use or disclosure. TMC may use Confidential Information only for the purposes contemplated under this Application and may not disclose Confidential Information to any other party without the prior written consent of GROUP, except as required by law.

SIGNATURES ***STAMPED SIGNATURES WILL NOT BE ACCEPTED*** I attest to the fact all of the information submitted by me in this document are true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from the application may constitute cause for denial of participation or cause for summary dismissal.						
Provider's Name (Please Print):						
Provider's Signature:				Date:		
Person Submitting the Form:				Title:		
Phone:		Fax:		Email:		