Print Form

Soteria Healthcare Network
3440 Preston Ridge Road, Suite 130
Alpharetta, Georgia 30005

www.SOTERIAHEALTHCARE.com

SOTERIA HEALTHCARE - NEW MEMBER - APPLICATION PART 3

Instructions:

These questions pertain to chiropractic doctors only.

It is important that all pages of this Part 3 be completed and submitted with your other application materials.

If you have any questions, please contact our Credentialing Department At (770) 455-8190 x 127 or (800) 816-2671 x 127.

Thank you!

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Curriculum Vitae
(CV)

DOCTOR'S NAME: _____ **PHONE:** _____

UNDERGRADUATE COLLEGE/UNIVERSITY GRADUATED FROM

_____

YEAR & MONTH OF GRADUATION

(XX/XXXX) - _____

CHIROPRACTIC SCHOOL/COLLEGE/UNIVERSITY GRADUATED FROM

_____

YEAR & MONTH OF GRADUATION

(XX/XXXX) - _____

OTHER POST-GRADUATE COLLEGE/UNIVERSITY (Please List Degrees Obtained; School Attended &; Year)

_____

CERTIFICATION(S) (Specialty; Board; Year)

_____

PROFESSIONAL PRACTICE (Mo/Year) -

from DATE _____/_____ **to DATE** _____/_____

PROFESSIONAL ASSOCIATIONS/APPOINTMENTS/MEMBERSHIP(S)

_____

_____

WORK HISTORY

place _____ **Month/Year (XX/XXXX) -** _____

place _____ **Month/Year (XX/XXXX) -** _____

place _____ **Month/Year (XX/XXXX) -** _____

additional information we should know...

_____

_____

_____

SIGNATURE

date _____ **signature** _____

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PART 3 - NEW MEMBER ACTIVATION APPLICATION

Primary Office Location Data

☐ Free-Standing ☐ Medical Bldg. ☐ Office Bldg. ☐ Storefront Other _____
Office Size (in Sq. Ft.) _____ Do you have ownership in these facilities? ☐ Yes ☐ No

# of Treatment Tables _____ # of Examination Rooms _____
Provider's Individual/Personal NPI # _____
Provider's Group/Practice NPI # _____
Average # of Patient Visits Per Day _____ Per Week _____
# of Continuing Chiropractic Education Credits for past 12 months: _____

Do you have any massage therapists, nutritionists, dieticians, etc., practicing out of your office? ☐ Yes ☐ No
If Yes, Please list their names: _____

On-Site X-Ray?
☐ Yes ☐ No
IF YES...please provide the following:
Make _____ Model _____
Size Unit:_____ KV:_____ MA:_____
Year Manufactured: _____ Table Bucky:_____ Wall Bucky: _____
State X-Ray Certification Obtained ☐ Yes ☐ No
Last Date Certified: _____

# of CAs Employed
Front Office: _____ # of Back Office: _____
Other Employees/Positions: _____
What office software system do you currently use? _____
Do you currently file your claims electronically? ☐ Yes ☐ No
IF YES, name of claims clearinghouse, or name of vendor you use. _____
IF NO, do you plan to implement electronic filing & within what timeframe? ☐ Yes ☐ No
Timeframe: _____ #Months _____ #Weeks
Would you be interested in a quote from an Electronic Claims Processing Vendor for which Soteria Healthcare "MEMBERS ONLY" rates apply? ☐ Yes ☐ No

For Urgent Care, Patients are seen within (Please Check One Below)

☐ 1 Hour ☐ 2 Hours ☐ 3 Hours ☐ 3-5 Hours ☐ Same Day

For Routine/Maintenance Care, Patients are seen (Please Check One Below)

☐ Same Day ☐ Within 2 Days ☐ Within 3 Days

Do you provide physiotherapy on-site? ☐ Yes ☐ No
If No, Do you have a referral affiliation with a physiotherapy or rehabilitation facility? _____

Does This Practice Support Chiropractic Emergency/Urgent Care Services? ☐ Yes ☐ No
If Yes, By Whom? _____

Do you have ownership in any facility/place/practice to which you **REFER** patients? ☐ Yes ☐ No
If yes, please describe. _____

Do you practice in an MD's office or does an MD provide services in your office? ☐ Yes ☐ No
If yes, explain in detail the referral and financial relationship. _____

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Practice Technique/Methods

Do you take history, physical and x-rays at the initial visit for all patients? ☐ Yes ☐ No

Do you routinely prepare a written plan of treatment during your initial history and physical? ☐ Yes ☐ No

Techniques: Exclusive: (Used more than 95%) _____

Preferred: (Used less than 95%) _____

Others Used: _____

Do you utilize: (Yes or No) If Yes, Protocols for Use & List Equipment Used (Type, Make, etc.)

EMG: ☐ Yes ☐ No _____
Thermography: ☐ Yes ☐ No _____
Electro-Diagnostic: ☐ Yes ☐ No _____
Ultrasound: ☐ Yes ☐ No _____
Manual/Intersegmental
Traction: ☐ Yes ☐ No _____
Diathermy: ☐ Yes ☐ No _____
Faradic: ☐ Yes ☐ No _____
Galvanic: ☐ Yes ☐ No _____
High-Volt: ☐ Yes ☐ No _____
Interferential: ☐ Yes ☐ No _____
Other (Identify) _____

Explain your Protocols for Determining the Need for X-rays: _____

_____

Please list the most common and number of modalities utilized as part of a treatment plan:

_____

Please list the average frequency/duration of chiropractic treatment for a patient with a soft tissue injury and continued subjective complaints with minimal objective findings. _____ times per week for _____ weeks _____ .

Does your practice include manipulation under anesthesia? ☐ Yes ☐ No
If Yes, How often and at what location? _____

If yes, Is any emergency equipment available? ☐ Yes ☐ No
Please List: _____

_____

ADDITIONAL NOTES --- PLEASE ATTACH

Please attach any additional information requested above or that you feel would be helpful in our review of your application. Please indicate any special services or specific reasons why you should be selected for membership in Soteria Healthcare.

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Attestation & Signature Page

I certify that all of the information submitted by me in this document is true and complete to the best of my knowledge and belief.

I understand that any misstatement in or omissions from this document constitutes cause for denial or termination of participation in Soteria Healthcare network.

I understand that I have the right to correct information used in the initial credentialing or recredentialing process, including information submitted by myself or another party. This right does not extend to information prohibited from release by statute, such as the NPDB report or peer review documents. If Soteria Healthcare has received conflicting information from a third party, I will be notified via the Credentialing Supervisor at Soteria Healthcare.

I understand that this application does not entitle me to participation in the network of any health plan using the application. I agree that any health plan using this application, their representatives, and any individuals or entities providing information to such health plan in good faith shall not be liable for any act or omission related to the evaluation or verification contained in this application. I further agree to notify the health plan with which I participate and which use this application about any changes to the information provided in this application by the next business day. Information requested in this application that is not publicly available will be treated as confidential by the health plan using it.

I authorize Soteria Healthcare, or its designated representative, to contact and consult with administrators, administrative staff, licensing organizations and professional peers at institutions and health care or other organizations with which I am or have been associated, and with past and present insurance carriers, who may have information relating to my professional and ethical qualifications, competence, character and personality.

I consent to the inspection by Soteria Healthcare or its designated representative for Soteria Healthcare beneficiaries of all records regarding beneficiaries, including institutions and health care organizations with which I am or have been associated which may contain information related to my professional and ethical qualifications, competence, character and personality.

I release from liability all individuals, corporations and organizations which provide information to Soteria Healthcare in good faith, including medical and otherwise privileged or confidential information.

I release Soteria Healthcare, its chiropractic administrators, management agents, directors, and staff from liability for acts performed in good faith in connection with the evaluation and investigation of information and materials I have authorized them to request and inspect.

I release Soteria Healthcare, its administrators, staff, directors and management agents from liability for disclosing information obtained in the course of their efforts to evaluate and/or investigate my qualifications an from liability for responding in good faith to inquiries from persons or entities to whom I may submit applications for employment and privileges in the future. I agree that photocopies of this signed authorization will be acceptable as an original signature.

I understand that Soteria Healthcare will rely upon the information given on this document during the evaluation of my credentials to determine compliance with network credentialing standards.

NAME: _____ **DATE:** _____

SIGNATURE:_____ **STATE LIC. #:** _____