Cameron and Associates, Inc. – Affiliate Application

Providers must submit updated copies of licenses and Malpractice Insurance Face Sheets at time of renewal. *Please Note: *All areas must contain a response. If not applicable, 'N/A' should appear.*

SECTION I – PERSONAL DATA

A. Name: ______________________________ Title: ______________________

License Discipline: Psychiatrist (M.D.)___Psychologist (Ph.D., Psy.D.)___LCSW___LPC___

B. Affiliate Type: *(Please select all the apply)*
EAP______ PPO_____

C. Contact Information
Phone: _________________________ Fax: ______________________

E-mail Address: ____

D. Social Security #: Date of Birth / / Gender: Female/Male

Ethnicity: ___African American___Asian___Caucasian___Hispanic___Native American___Other

SECTION II – PRACTICE DATA

A. Primary Location: TAX ID #: __________________

Practice/Billing Name: ____

Site Address: ____

City: ___________________ State: __________________ Zip: ___________

Mailing Address: ____

City: ___________________ State: __________________ Zip: ___________

B. Secondary Location: TAX ID #: __________________

Practice/Billing Name: ____

Site Address: ____

City: ___________________ State: __________________ Zip: ___________

Hours of Operation *(Please indicate actual practice hours held each day)*
MON. _________________ TUE. ___________________ WED. _______________

THURS. _______________ FRI. ____________________ SAT. ________________

Is your office handicap accessible? Y/N

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SECTION II – CONTINUED

C. Federal DEA # (M.D.s and RNs) ____________ Expiration Date (mm/dd/yy): _________

D. State DEA # (M.D.s and RNs) ______________ Expiration Date (mm/dd/yy): _________

E. List the states in which you are, or have been, licensed. (Please indicate initial licensure date through current expiration date for each state in which you are license)

State	Dates (mm/dd/yy)	Licensure & #	Please circle on status below
____	From: / / To: / /	______________	Active Inactive Restricted Suspended
____	From: / / To: / /	______________	Active Inactive Restricted Suspended
____	From: / / To: / /	______________	Active Inactive Restricted Suspended

F. *Board Eligible M.D. only): Yes ___ No ___ Specialty: ______________

G. *Board Certification # (M.D. only): Yes ___ No ___ Specialty: ______________

Date Certified: / /

H. National Registry # (Psychologists Only): _______________________ Date Issued: / /

I. ACSW Certification # (Social Workers Only): ___________________ Date Issued: / /

J. Other Certification(s) _______________________________________ Date Issued / /

K. Areas of Practice: (Please indicated the percentage of patients from the following categories within your practice and the percentage of you time dedicated to these treatment modalities.)

Population	% of Practice	Modality	% of Practice
Child	___________	Inpatient	_____________
Adolescent	___________	Day Tx	_____________
Adult	___________	Outpatient	_____________
Geriatric	___________	Intensive Outpatient Programs	_______

L. Languages Spoken: (Please list only languages in which you are fluent)

____

____

____

***Board certification and eligibility is a requirement for all M.D.s applying to CAIs network panel.**

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M. Call Coverage:

All Practitioners providing care for CAI clients must arrange for twenty-four (24) hour call coverage. Services performed in your absence for patients are subject to the terms of the participating practitioner's agreement.

I. Call – Coverage Practitioner:

Name: ________________________ Licensure: _________________ Phone #: ________________

II. After – Hours Answering Phone Service:

Name: ____________________________________ Phone #: _________________________

Pager #: ___________________________________ Voicemail #: ______________________

SECTION III – EDUCATION HISTORY

A. Education

____/_____________/__
Undergraduate Address Degree From (mm/yy) To (mm/yy)

____/_____________/__
Graduate/Med. School Address Degree From (mm/yy) To (mm/yy)

____/_____________/__
Internship Address Degree From (mm/yy) To (mm/yy)

____/_____________/__
Residency Address Degree From (mm/yy) To (mm/yy)

____/_____________/__
Residency Address Degree From (mm/yy) To (mm/yy)

____/_____________/__
Fellowship Address Degree From (mm/yy) To (mm/yy)

B. If you are a foreign medical school graduate, are you certified by the Education Council for Foreign Medical Graduates (ECFMG)? ____ Yes ____ No

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SECTION IV – PROFESSIONAL AFFILIATIONS

A. Medical/Professional Associations or Society memberships:

____

____

____

B. List hospitals where you have staff privileges and type of privilege:

Hospital/Address	Type of Privileges
________________________________	Full ____ Courtesy ____ Restricted ____
________________________________	Full ____ Courtesy ____ Restricted ____
________________________________	Full ____ Courtesy ____ Restricted ____

C. List all current contracts with HMO, IPA, or other managed care companies:

Name/Address of Company   Approximate % of Practice

____

____

____

D. Are you paid employee or consultant for any health care plan? _______ Yes _______ No
If yes, please list the name of company and contact person/telephone.

____

____

E. Other Insurance plans accepted (Please list those insurance plans which you accept as payment for services rendered.)

____

____

____

SECTION V – CLINICAL PSYCHOTHERAPEUTIC EXPERTISE

A. Treatment Modalities: Are there special treatment modalities that can facilitate appropriate referral and expedite treatment goals? ____ Yes ____ No Check at least 3 areas listed below for which you have had training and/or experience and how much training/experience you have had.

1. Training – A minimum of 6 months supervised training.

2. Experience – A minimum of one (1) year experience treating patients with this type of modality.

____ **Adolescent Therapy** ____ **Christian Therapy** ____ **Family Therapy**
____ **Behavior Therapy** ____ **Cognitive Therapy** ____ **Geriatric Therapy**
____ **Biofeedback** ____ **ECT** ____ **Group Therapy**
____ **Child Therapy** ____ **EAP** ____ **Psychopharmacology**

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SECTION V. CONTINUED

B. Clinical Specialties: Please select up to ten (10) area listed below in which you have training and experience and rate each for referral preferences **(1= Most Preferred / 10= Least Preferred)**

_____ ADHD	_____ Ethnic/Cultural Issues	_____ Chronic Mental Illness
_____ Domestic Violence	_____ School Related Problems	_____ Gay/Lesbian
_____ Alcohol/CD	_____ Forensics	_____ Sexual/Physical Abuse
_____ Adol. Behav. Disorders	_____ Personality Disorders	_____ Eating Disorders
_____ Grief/Bereavement	_____ Step/Blended Families	_____ Disabilities
_____ Chronic Pain	_____ Head Trauma	_____ Stress Management
_____ Chronic/Terminal Illness	_____ Hearing Impaired	_____ Women's Issues
_____ Crisis/Trauma	_____ Marital/Sep/Divorce	_____ Work Related Stress
_____ Men's Issues	_____ Children	_____ Dissociative Disorders
_____ Anger Management	_____ Anxiety Disorders	_____ Bipolar Disorder
_____ Dissociative Disorders	_____ OCD	_____ ODD
_____ PTSD	_____Schizophrenia	_____ Sleep Disorders
_____ Christian Counseling	_____ CISD	_____ SAP certified
_____ Other (please explain)		

____
____
____

Briefly state your theoretical and practice orientation in the treatment of Mental Health/Substance Abuse Problems.

____
____
____
____
____
____
____
____
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SECTION VI – CURRENT MEDICAL MALPRACTICE INFORMATION

A. Carrier: _________________________________ Policy #: _________________________

B. Coverage Amounts: _______________________ Policy Issue Date: / /
Renewal Date: / / (minimum coverage of $1,000,000)

C. Check the appropriate response. If you answer yes to any of the following questions, please complete a detailed description in Section VII on page 7:

1. Have you ever been treated for alcoholism, substance abuse, or mental illness? ___ Yes ___No

2. Do you have and chronic illness or mental impairments that will limit your ability to perform the essential functions of the position? If yes, please list those reasons here: ___ Yes ___ No

3. Has your professional liability insurance ever been denied or canceled? ___ Yes ___ No

4. Have you ever had you medical license revoked or suspended? ___ Yes ___ No

5. Have you had your permit to prescribe drugs revoked or suspended? ___ Yes ___ No

6. Has any hospital ever censured, restricted, suspended, or revoked your privileges? ___ Yes ___ No

7. Have you ever surrendered your clinical privileges upon threat of censure, restriction, suspension, or revocation of such privileges? ___ Yes ___ No

8. Have you ever been denied a medical license or certification by a specialty board? ___ Yes ___ No

9. Has your membership in any professional society or association ever been canceled, revoked, or censured? ___ Yes ___ No

10. To your knowledge, have any fee complaints been registered against you? ___ Yes ___ No

11. Have Medicare, Medicaid, PRO, or PSRO authorities brought documented charges against you for alleged inappropriate fees or quality of care issues? ___ Yes ___ No

12. Has any claim or suit for alleged malpractice ever been brought against you or Are you aware of any circumstances that might lead to such a claim or suit? ___ Yes ___ No

13. Have you ever been involved in business bankruptcy proceeding? ___ Yes ___ No

14. Have you ever been convicted of a felony or involved in charges relating to moral or ethical turpitude? ___ Yes ___ No

15. Have you ever been convicted or charged with fraud? ___ Yes ___ No

16. Are you currently using and illegal substances? ___ Yes ___ No

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SECTION VII – SPECIAL INFORMATION

Please describe below any question that you have responded "yes" to in Section VI. Please be as specific as possible with regard to dates of outcome on pending actions:

____
____
____
____
____
____

SECTION VIII – PROOF OF DOCUMENTATION

Copies of the following documents must be enclosed with this application:

Current Malpractice Face Sheet (photocopy)
Current License/Certification (photocopy)
Current DEA Certificate ***M.D.s only*** (photocopy)
Copy of current of Curriculum Vitae or Resume

Additionally, the applicant must provide primary source verification for the following items:

Ten-Year liability claims history (from your malpractice carrier)
MSN verification form (nurses only)
Board Certification for M.D.s

Attestation

I hereby attest that the information contained in the application is complete and accurate, I further understand that falsifying any of the information included in the application is grounds for termination of any contract entered into the Cameron and Associates, Inc.

I agree to maintain my professional liability insurance as describe in the application.

I agree to accept the fees listed in the fee schedule, and agree not to charge patients with additional charges beyond what is permitted under the fee schedule. I agree to abide by all policies and procedures of Cameron and Associates, Inc.

_______________________________________ _____________________________
Signature Date

Please submit completed forms to the following address:
Cameron and Associates, Inc.
Attn: Provider Relations Department
6100 Lake Forrest Drive
Suite 550
Atlanta, GA 30328
P.R. Direct: (404) 843-4861 CAI Main: (404) 843-3399 or (800) 334-6014

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Authorization to Verify Information

In order to attain appropriate quality standards, Cameron and Associates, Inc. must verify certain information through Primary Source Verification. This may include, but is not limited to written reports from applicant's graduate school, malpractice insurance carrier, and the National Practitioner Data Bank (NPDB). NPDB is a federally funded administrative body that gathers and distributes information regarding the professional credential of healthcare providers, as well as malpractice claims against healthcare providers and sanctions against, and the loss of license by healthcare providers.

Applicants are notified in writing of any adverse information arising from Primary Source Verification that may affect acceptance into Cameron and Associates, Inc.'s Managed Behavioral Healthcare Network. At the time of such notification, copies of policies and procedures related to this Component of the application process, including policies and procedures for the filing of a written appeal of or challenge to any decisions based upon this information will be forwarded to the applicant. An appeal process will include the provision of a fair hearing to the applicant to allow the applicant the opportunity to correct erroneous information in accordance with all applicable state and federal laws.

Applicants may also view any information in support of their application. In order to review any information, applicants must submit a written request specifying which information is requested. To protect the right to privacy of all practitioners, this request must be notarized, thus attesting to the identity of the person submitting the request.

Please review the following authorizing statement, then sign below to indicate your acceptance of the authorizing statement and your acknowledgement of having been advised of your rights to review credentialing information.

I hereby authorize Cameron and Associates, Inc. and/or its designee to obtain and verify information contained on my application. I further consent to the release of any information that may be utilized to support my application, or that reasonably may be relevant to an evaluation of the suitability for the tasks and functions involved in being a member of the network of practitioners managed by Cameron and Associates, Inc. In the event that information is released to Cameron and Associates, Inc. and/or its designee, I agree to hold harmless from any cause of action based on the release of such information any person, organization or other entity, responsible for the release.

_______________________________________ _______________________________

Signature Date

____

Print Name

Please submit completed forms to the following address:
Cameron and Associates, Inc.
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Suite 550
Atlanta, GA 30328
P.R. Direct: (404) 843-4861 CAI Main: (404) 843-3399 or (800) 334-6014

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