DeanHealthPlan
A member of SSM Health

1277 Deming Way
Madison, WI 53717
phone: 800-279-1301
Medicare: 888-422-3326
TTY: 711
deancare.com

DEAN HEALTH PLAN PROVIDER APPLICATION

Personal Identifiers:

Full Name: (Last) _____ (First) _____ (MI) _____

DOB: _____ Gender: _____ Male _____ Female

Professional Title: _____

Social Security Number: _____-_____-_____

Professional Information:

Wisconsin License Number: _____ Expiration Date: _____

Active Inactive Restricted Suspended *(circle one)*

NPI # _____ Facility NPI# _____

DEA Number: _____ Expiration Date: _____

Federal Tax Identification Number: _____

Medicare Provider Number: _____

Supervising Physician Name (if applicable): _____

Supervising Physician Medicare Provider Number: _____

Medicaid Provider Number: _____

Practice Specialty: _____

Practice Effective Date: _____

Non-English Languages spoken by provider:

Language spoken: _____ Language spoken: _____

Medical Specialty:

Primary Specialty: _____ Are you Board Certified: Yes _____ No ____

If yes, name of Board: _____Year _____ Exp Date_____

Secondary Medical Specialty: _____Are you Board Certified: Yes _____ No ____

If yes, name of Board: _____ Year _____ Exp Date_____

Hospital Privileges:

List all hospital and professional practice affiliations, where you currently have STAFF PRIVILEDGES.

Hospital name: _____

Street Address: _____ City, State, Zip _____

Staff Category: _____ Department: _____

From: _____To: _____(Indicate Month and Year)

Type of Privileges: _____ (Active/Other) Explain: _____

Hospital name: _____

Street Address: _____ City, State, Zip: _____

Staff Category: _____ Department _____

From: _____To: _____ (Indicate Month and Year)

Type of Privileges: _____ (Active/Other) Explain _____

Practice Information:

Primary Office: _____

_____

_____

Telephone Number: ( ) _____

Fax Number: ( ) _____

Contact Person: ( ) _____

Other Office: _____

_____

_____

Telephone Number: ( ) _____

Fax Number: ( ) _____

Contact Person: ( ) _____

Billing Office: _____

(If different) _____

_____

Telephone Number: ( ) _____

Fax Number: ( ) _____

Contact Person: _____

Practitioner Attestation

In submitting my application to Dean Health Plan, Inc. (DHP) I am agreeing to the following:

I certify that all information in my application is accurate and complete. I also agree to provide additional information and execute additional forms as may be requested by DHP in order to evaluate my professional qualifications, competence and conduct.

As an applicant with DHP, I have the right to review the information submitted in support of my application. I acknowledge that DHP will notify me of any information obtained during the process that varies substantially from the information provided to DHP by me. I have the right to correct any and all erroneous information in my application. I have the right upon request, to be informed of the status of my application, by contacting the DHP Provider Service Representative. DHP will reply within two working days as to what materials may be missing from the application and/or when the application may be expected to be completed. Review of applicants will be conducted in a manner that is non-discriminatory.

All information provided by me in this application is warranted to be true, correct and complete.

_____ _____

Dated **Signature**

_____

Name (printed)

(Dean Health Plan, Internal use only)
Provider Services Rep _____
Date send to QI _____
QI Rep Name _____
Date Verification Completed _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I have applied to be a participating practitioner with Dean Health Systems, Inc. (DHS). In order for DHS to completely evaluate my qualifications, I hereby authorize DHS and its authorized representatives and agents to consult with any third party who may have information (including information that otherwise may be privileged or confidential) relating to my professional qualifications, competence and conduct. I also authorize any such third party to release information, related reports and documents to DHS and its authorized representatives and agents upon request and receipt of a copy of this **AUTHORIZED FOR RELEASE OF INFORMATION**.

I understand DHS will use this information solely in conjunction with my application for status as a participating practitioner with DHS and that the information is not subject to re-disclosure except as permitted by Federal or State law.

In consideration of accepting for review my application, I hereby release from liability Dean Health Systems, Inc. and its directors, officers, employees and authorized representatives and agents and third parties for any acts performed in good faith in providing or receiving information, reports or other documents relating to, or in evaluating my professional qualifications, competence or conduct.

This release from liability shall include, but not be limited to, actions relating to the following:

- My application to be a participating practitioner with DHS or other organizations or networks that have contracted with DHS and/or its authorized representatives or agents;
- Periodic appraisals undertaken for utilization review or otherwise for quality management; and
- Proceedings for restriction, suspension or termination of my status as a participating practitioner, or any other disciplinary action.

This authorization is valid for **180** days and, if I become a participating practitioner with DHS, for the time that I remain a participating practitioner with DHS.

_____ _____

Dated Signature

_____

Name (print)