UNIVERSITY PHYSICIANS
BROOKLYN, INC.

PROVIDER ENROLLMENT DATABASE FORM

UNIVERSITY PHYSICIANS
BROOKLYN, INC.

GUIDELINES

The document you are about to complete will be the source of data that will be used to process the enrollment delegation and print your credentialing applications. It is very important for UPB Enrollment to provide the payors with data that is complete and accurate.

When completing your Provider Database Form (PDF), please remember to:

1. Print Legibly.
2. Fill in all fields. No fields should be left blank.
3. Enter the dates in the following format: MM/DD/YYYY.
4. Place "N/A" in any field not applicable to you.
5. Send copies of any documents listed on the "Required Credentials for Enrollment" page.
6. Submit all applications with original signatures (copies will not be accepted).
7. Sign the Authorization and Signature Pages.

No Application will be accepted for processing if application is incomplete and/or there is missing information from the attached check list.

Personal Information

Demographic Data

Last Name | First | Middle | Suffix (e.g. Jr., Sr., III)

Maiden Name, Alias or Other Surname | Title (e.g. MD, PhD, ARNP) | Gender

Date of Birth | Place of Birth | Are you a US Citizen? ☐ Yes ☐ No

If not a US citizen, please complete the following: Are you eligible to work in the US? ☐ Yes ☐ No

Visa Number | Visa Status | Country of Citizenship

Home Address

Address | Suite / Apartment #

City | County | State | Zip

Home Telephone | Mobile Telephone | E-Mail Address

Identifying Numbers

Social Security Number | Individual Medicare Number

Federal UPIN (e.g. Z12345) | Individual Medicaid Number | Medicaid State

CAQH ID | National Provider Identifier

Miscellaneous Data

Foreign Languages Spoken By You

Specialty and Board Certification

Primary Specialty

**** List Specialties in the order they should appear on applications.****

1. Specialty Name _____ Name of Certifying Specialty Board _____

Board Certification Status: ☐ Certified ☐ Qualified ☐ Eligible ☐ Not Eligible ☐ Not Pursuing

If Certified: Initial Cert _____ Last Recert _____ Expiration _____ Cert # _____ If Pursuing: Exam Date _____

Additional Specialty(ies)

2. Specialty Name _____ Name of Certifying Specialty Board _____

Board Certification Status: ☐ Certified ☐ Qualified ☐ Eligible ☐ Not Eligible ☐ Not Pursuing

If Certified: Initial Cert _____ Last Recert _____ Expiration _____ Cert # _____ If Pursuing: Exam Date _____

3. Specialty Name _____ Name of Certifying Specialty Board _____

Board Certification Status: ☐ Certified ☐ Qualified ☐ Eligible ☐ Not Eligible ☐ Not Pursuing

If Certified: Initial Cert _____ Last Recert _____ Expiration _____ Cert # _____ If Pursuing: Exam Date _____

4. Specialty Name _____ Name of Certifying Specialty Board _____

Board Certification Status: ☐ Certified ☐ Qualified ☐ Eligible ☐ Not Eligible ☐ Not Pursuing

If Certified: Initial Cert _____ Last Recert _____ Expiration _____ Cert # _____ If Pursuing: Exam Date _____

Educational Background

Medical or Professional Education

Medical or Professional School Name

City | State/Foreign Equivalent | Country

Date Enrolled | Date Graduated | Degree Awarded

Foreign Medical School Graduates Please Complete

ECFMG Number | ECFMG Date

OR ☐ 5th Pathway (Please provide 5th Pathway internship on page 4 with Post Graduate Training)

Other Graduate Education

University or College Name

City | State/Foreign Equivalent | Country

Date Enrolled | Date Graduated | Degree Awarded

Undergraduate Education

University or College Name

City | State/Foreign Equivalent | Country

Date Enrolled | Date Graduated | Degree Awarded

Post Graduate Training

**** List training in chronological order.****

**** Make additional copies of this page as necessary.****

Internship, Residency and Fellowship

Type: ☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship

Institution or Facility Name

City | State | Start Date | Complete Date

Specialty | Program Director | Affiliated University

Type: ☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship

Institution or Facility Name

City | State | Start Date | Complete Date

Specialty | Program Director | Affiliated University

Type: ☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship

Institution or Facility Name

City | State | Start Date | Complete Date

Specialty | Program Director | Affiliated University

Other Training

Type

Institution or Facility Name

City | State | Start Date | Complete Date

Specialty | Program Director | Affiliated University

Patient Care Locations

**** List Locations where YOU provide patient care for in the order they should appear on applications.****

Primary Location

1. _____

Address _____

Department, Suite, Office or Floor Number _____

City _____ County _____ State _____ Zip _____

Provider Type: ☐ PCP ☐ Specialist ☐ PCP/Specialist ☐ Allied Health

Are you currently accepting new patients? ☐ Yes ☐ No

Do you wish to receive mail at this location? ☐ Yes ☐ No

Are there any restrictions on your practice? ☐ Yes ☐ No If yes, list restrictions: _____

2. _____

Address _____

Department, Suite, Office or Floor Number _____

City _____ County _____ State _____ Zip _____

Provider Type: ☐ PCP ☐ Specialist ☐ PCP/Specialist ☐ Allied Health

Are you currently accepting new patients? ☐ Yes ☐ No

Do you wish to receive mail at this location? ☐ Yes ☐ No

Are there any restrictions on your practice? ☐ Yes ☐ No If yes, list restrictions: _____

3. _____

Address _____

Department, Suite, Office or Floor Number _____

City _____ County _____ State _____ Zip _____

Provider Type: ☐ PCP ☐ Specialist ☐ PCP/Specialist ☐ Allied Health

Are you currently accepting new patients? ☐ Yes ☐ No

Do you wish to receive mail at this location? ☐ Yes ☐ No

Are there any restrictions on your practice? ☐ Yes ☐ No If yes, list restrictions: _____

Covering Providers

Covering Provider List **

Covering Provider's Full Name	Specialty	Phone Number

Hospital/Other Facility Affiliations

Primary Hospital/Other Facility Affiliation

** **List Hospital Affiliations in the order they should appear on applications.****

1. Hospital/Facility Name

City State Zip

Do you have admitting privileges? ☐ Yes ☐ No

Staff Category/Privilege Type Department or Service Start Date

Additional Hospital/Facility Affiliation(s)

2. Hospital/Facility Name

City State Zip

Do you have admitting privileges? ☐ Yes ☐ No

Staff Category/Privilege Type Department or Service Start Date

Affiliation Status: ☐ Current ☐ Previous

If previous: End Date Reason for Leaving

3. Hospital/Facility Name

City State Zip

Do you have admitting privileges? ☐ Yes ☐ No

Staff Category/Privilege Type Department or Service Start Date

Affiliation Status: ☐ Current ☐ Previous

If previous: End Date Reason for Leaving

4. Hospital/Facility Name

City State Zip

Do you have admitting privileges? ☐ Yes ☐ No

Staff Category/Privilege Type Department or Service Start Date

Affiliation Status: ☐ Current ☐ Previous

If previous: End Date Reason for Leaving

Professional Affiliations

Academic/Teaching Appointments

**** List Appointments in the order they should appear on applications.****

1. Organization Name

Affiliation Status: ☐ Current ☐ Previous

City | State | Zip

Start Date | End Date | Appointment Type/Academic Rank

2. Organization Name

Affiliation Status: ☐ Current ☐ Previous

City | State | Zip

Start Date | End Date | Appointment Type/Academic Rank

3. Organization Name

Affiliation Status: ☐ Current ☐ Previous

City | State | Zip

Start Date | End Date | Appointment Type/Academic Rank

Professional Societies/Associations

1. Society/Association Name
2. Society/Association Name
3. Society/Association Name
4. Society/Association Name
5. Society/Association Name

Liability Insurance

Current Liability Carrier

Insurance Carrier (not broker/producer) | Policy Number

Policy Effective Dates: From | To | Limits: Per Claim/Occurrence | Annual Aggregate

Policy Type: ☐ Occurrence ☐ Claims Made Retroactive Date (Claims Made only):

Excess Liability Insurance

Insurance Carrier (not broker/producer) | Policy Number

Policy Effective Dates: From | To | Limits: Per Claim/Occurrence | Annual Aggregate

Previous Insurance Carriers (10 yrs)

Insurance Carrier (not broker/producer) | Policy Number

Policy Effective Dates: From | To | Limits: Per Claim/Occurrence | Annual Aggregate

Policy Type: ☐ Occurrence ☐ Claims Made Retroactive Date (Claims Made only):

Insurance Carrier (not broker/producer) | Policy Number

Policy Effective Dates: From | To | Limits: Per Claim/Occurrence | Annual Aggregate

Policy Type: ☐ Occurrence ☐ Claims Made Retroactive Date (Claims Made only):

Insurance Carrier (not broker/producer) | Policy Number

Policy Effective Dates: From | To | Limits: Per Claim/Occurrence | Annual Aggregate

Policy Type: ☐ Occurrence ☐ Claims Made Retroactive Date (Claims Made only):

Work History

Work History

** **List work history for last 10 years in reverse chronological order (current first).****

1. **Current** Organization Name

Address | Suite, Office, Floor Number, etc.

City | State | Zip

Position Held | Contact Name | Contact Telephone

Start Date

2. Organization Name

Address | Suite, Office, Floor Number, etc.

City | State | Zip

Position Held | Contact Name | Contact Telephone

Start Date | End Date

3. Organization Name

Address | Suite, Office, Floor Number, etc.

City | State | Zip

Position Held | Contact Name | Contact Telephone

Start Date | End Date

Professional References

Professional References

** Do not list current Associates in Practice.**

1. Reference Name _____ Title (e.g. MD) _____
   Specialty _____ Relationship: ☐ Peer ☐ Department Head
   Address _____
   City _____ State _____ Zip _____ Telephone _____

2. Reference Name _____ Title (e.g. MD) _____
   Specialty _____ Relationship: ☐ Peer ☐ Department Head
   Address _____
   City _____ State _____ Zip _____ Telephone _____

3. Reference Name _____ Title (e.g. MD) _____
   Specialty _____ Relationship: ☐ Peer ☐ Department Head
   Address _____
   City _____ State _____ Zip _____ Telephone _____

4. Reference Name _____ Title (e.g. MD) _____
   Specialty _____ Relationship: ☐ Peer ☐ Department Head
   Address _____
   City _____ State _____ Zip _____ Telephone _____

Licensure and Registration

State Professional License(s)

**** List up to 3 licenses in the order they should appear on applications.****

1. License Type | License Number | State | Original Issue Date | Expiration Date

Are you currently practicing in this state? ☐ Yes ☐ No

2. License Type | License Number | State | Original Issue Date | Expiration Date

Are you currently practicing in this state? ☐ Yes ☐ No

3. License Type | License Number | State | Original Issue Date | Expiration Date

Are you currently practicing in this state? ☐ Yes ☐ No

Federal DEA Registration(s)

1. DEA Number | State | Issue Date | Expiration Date

2. DEA Number | State | Issue Date | Expiration Date

State Controlled Substance License(s)

1. License Number | State | Issue Date | Expiration Date

2. License Number | State | Issue Date | Expiration Date

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REQUIRED CREDENTIALS FOR ENROLLMENT

*****You are REQUIRED to check off below, each item attached to the Provider Enrollment Database Form*****

- ☐ NYS License -Current Registration
- ☐ NYS License – Certificate
- ☐ DEA Certificate
- ☐ Internship Diploma
- ☐ Residency Diploma
- ☐ Fellowship Diploma
- ☐ Board Certificates
- ☐ Medical School Diploma
- ☐ CV-Curriculum Vitae (current – no gaps longer than 3 months)
- ☐ ECFMG –Certificate (if applicable)
- ☐ Malpractice Insurance Face Sheet
- ☐ Malpractice Explanation
- ☐ **Copy of Driver's License or Passport for signature verification at Medicare.**
- ☐ **Social Security Card for Name verification at Medicare.**
- ☐ **CAQH ID NUMBER, USERNAME & PASSWORD**
- ☐ **NPPES USERNAME & PASSWORD**

*****No Application will be accepted for processing if application is incomplete and/or there is missing documents and online access from the above check list.*****

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AUTHORIZATION AND SIGNATURE

I hereby acknowledge that I have reviewed the information presented herein and agree that, to the best of my knowledge and belief, it is true and accurate and free of any material misstatement or omission. I further authorize **University Physicians of Brooklyn, Inc.** to use said information in the completion of credentialing applications and to act on my behalf when necessary in matters relating to my credentialing and enrollment with health plans, third party payors, or for any other contracted purpose.

X _____ X _____

Signature/Title Date

*****No Application will be accepted for processing if application is incomplete and/or there is missing documents and online access from the attached check list.*****

Upon completion, please forward the Provider Database Form and all Attachments to:

University Physicians of Brooklyn, Inc.

450 Clarkson Avenue – MSC# 80

Brooklyn, New York 11203

ATTN: UPB ENROLLMENT