GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

Please contact the Hospital, Health Plan or other Healthcare Organization, hereinafter "Healthcare Entity(ies)", to which you are applying for instructions on how to proceed. The Healthcare Entity may not have adopted this form for use and/or may require a pre-application prior to submitting this form.

This Application has been designed and organized into two main parts: Part One and Part Two.

Part One is standardized for Healthcare Entity(ies), and contains identical questions that Healthcare Entities need to ask as a part of their credentialing processes. Part One is available on the Georgia Uniform Healthcare Practitioner Credentialing Application Form (UHPCAF) web site at www.georgiacredentialing.org.

Part Two for health plans is standardized and contains additional identical questions that health plans need to ask as part of their credentialing processes and, is also available at www.georgiacredentialing.org.

Part Two for hospitals contains additional, customized or more specific questions as part of their credentialing and privileging processes.

PREPARED AND ENDORSED BY MEMBERS OF:

GHA/AN ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS
GEORGIA IN-HOUSE COUNSEL ASSOCIATION
GEORGIA ASSOCIATION MEDICAL STAFF SERVICES
GEORGIA ASSOCIATION OF HEALTH PLANS

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

Prior to completing this Application, please read and observe the following:

GENERAL INSTRUCTIONS

- Please type or print legibly your responses.
- Please note that modification to the wording or format of this Application will invalidate it.
- All information requested must be FULLY and TRUTHFULLY provided.
- Any changes to your responses must be lined through and initialed. Use of any form of correctional fluid or tape is not acceptable.
- If an entire section does not apply to you, then please check the box provided at the top of the section. If a particular question does not apply to you, then write "N/A" in the answer blank. If there are multiple, repetitive answer blanks in a particular section (as, for example, in the section entitled "Residencies and Fellowships"), it is not necessary to mark "N/A" in each unneeded answer blank.
- Unless *specifically permitted* by a particular question, please understand that a reference to "See CV" for an answer is not appropriate.
- **If more space than is provided on this Application is needed in order to answer a question completely, use the attached Explanation Form as necessary. Make as many copies of the Explanation Form as needed to fully answer each question. Include the section and page number of the question being answered as well as your name and Social Security Number on each Explanation Form. Attach all Explanation Forms to this Application.**
- After **Part One** of the Application has been completed in its entirety but *before* you sign and date it or fill in the information on page **ii**, make a copy of the Application to retain in your files and/or computer for future use.
  In so doing, at the time of a submission to another Healthcare Entity, all you will need to do is to check to ensure that all the information remains complete, current and accurate before completing page **ii** and signing and forwarding the Application as needed.
- Any gaps of time greater than thirty (30) days from completion of medical school to the present date must be accounted for before your Application will be considered complete.
- Please sign and date the Application.
- Please sign and date Schedule A, Schedule B and Schedule C (as appropriate).
- Identify the Healthcare Entity to which you are submitting this Application and for what practice area(s) you are applying in the spaces provided on page **ii**.
- Mail the Application, Schedules, any Explanation Form(s) prepared in order to answer any question(s) completely, as well as a copy of all applicable enclosures listed on page **ii** to the Healthcare Entity.

GENERAL INSTRUCTIONS - continued

A current copy of the following documents must be submitted with your Application:

- One recent passport size photograph of yourself
- State Professional License(s)
- Federal Narcotics License (DEA Registration)
- Curriculum Vitae with complete professional history in chronological order (month & year)
- Diplomas and/or certificates of completion (e.g. medical school, internship, residency, fellowship, etc.)
- Diplomate of National Board of Medical Examiners or Educational Commission for Foreign Medical Graduates (ECFMG) Certificate (if applicable)
- Specialty/Subspecialty Board Certification or letter from Board(s) stating your status (if applicable)
- Declaration Page (Face Sheet) of Professional Liability Policy or Certificate of Insurance
- Permanent Resident Card or Visa Status (if applicable)
- Military Discharge Record (Form DD-214) (if applicable)

Name of Healthcare Entity to which you are submitting this Application:
For what type of relationship (i.e., staff membership, network participation, etc.):

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

**********PART ONE**********

If more space than is provided on this Application is needed in order to answer a question completely, please use the attached Explanation Form as necessary.

I. IDENTIFYING INFORMATION *Please provide the practitioner's full legal name.*

Last Name (include suffix; Jr., Sr., III): Adams	First: Lin	Middle: Marlisha
Degree(s): OT		
Is there any other name under which you have been known or have used (e.g. maiden name)? [X] Yes [ ] No Name(s) and Date(s) Used: Lin Marlisha Thomas -		
Home Street Address: 1936 Brookdale Road		
City: Naperville	State: IL	Zip: 60563-2015
Home Telephone Number: (706) 308-9890	E-Mail Address: lin.adams84@gmail.com	Citizenship (if not USA, provide type and status of visa and enclose a copy) United States
Date of Birth: 12/26/1984	Place of Birth:	Gender: [ ] Male [X] Female
Social Security Number: 100-92-5852	UPIN:	National Provider Identifier (NPI) (Type 1 Only): 1518421171
Medicare Provider Number:	Georgia Medicaid Provider Number(s):	Other State Medicaid Provider Number:

Georgia License Number: 007734	Expiration Date mm/yy: 03/22	Drug Enforcement Administration Registration #:	Expiration Date mm/yy:	Controlled Substance Registration Number	Date Issued (if applicable):

Marital Status (optional): [ ] Single [ ] Married [ ] Divorced [ ] Widow	Name of Spouse (if applicable) (optional):	Medical Specialty for Which Applying Primary: Occupational Therapist Secondary:

II. PRACTICE INFORMATION

A. NAME OF PRIMARY CLINICAL PRACTICE: HealthPRO Heritage Rehab & Fitness LLC	Type of Practice Setting: [ ] Solo [ ] Group/Single	Specialty: [ ] Group/Multi-Specialty [ ] Hospital Based [ ] Other
Primary Clinical Practice Street Address: 12200 CRABAPPLE RD	Start Date at Location (mm/yy): 07/20	

City: ALPHARETTA	County:	State: GA	Zip: 30004-4020

Primary Office Telephone Number: (770) 753-9177	Primary Office Fax Number:	Patient Appointment Telephone Number: (770) 753-9177
Mailing Address (if different from above): PO BOX 69211 Baltimore, MD 21264-9211		
Name of Office Manager /Administrative Contact: Tom Guild	Office Manager's Telephone Number:	Office Manager's Fax Number:
Answering Service Number:	Pager/Beeper Number :	Office E-Mail Address:
Credentialing Contact and Address (if different from above):		

Credentialing Contact's Telephone Number:	Credentialing Contact's Fax Number:
Federal Tax ID Number for this Practice Address: 30-0015400	Name Affiliated with Tax ID Number:

II. PRACTICE INFORMATION - continued

Does Not Apply ☐

NAME OF SECONDARY CLINICAL PRACTICE:	Type of Practice Setting:	Specialty:
Genesis Eldercare Rehabilitation Services	☐ Solo ☐ Group/Single	☐ Group/Multi-Specialty ☐ Hospital Based ☐ Other

Secondary Clinical Practice Street Address: 22320 Classic Court	Start Date at Location (mm/yy): 05/19

City: Lake Barrington	County: Lake County	State: IL	Zip: 60010-5903

Answering Service Number:	Pager/Beeper Number:	Office E-Mail Address:

Federal Tax ID Number for this Practice Address: 23-2446104	Name Affiliated with Tax ID Number:

B. OTHER OFFICES: ***Please list any other current office locations with the above information on Explanation Form(s).***

C. BILLING ADDRESS: If different than primary clinical site address, please provide complete billing address:

Name of Office Manager/Administrative Contact:	Office Phone Number:	Office Fax Number:
Kim Schwartz	(804) 269-0350	(610) 335-4355

D. INTENTION: If you are not currently in practice, please describe your intentions regarding beginning and/or reinstating your practice.

E. CORRESPONDENCE: To what address would you like all correspondence forwarded?
☐ Primary Office ☐ Secondary Office ☐ Billing Office ☐ Home ☐ Other (Please specify)

F. LANGUAGES:
1. Please list any language other than English (including sign language) in which you are fluent:
2. Please list any language other than English (including sign language) in which a member of your staff is fluent and identify staff member:

III. BOARD CERTIFICATION/RECERTIFICATION

Are you board certified? ☐ YES ☒ NO ***List all current and past board certifications.***

Name of Issuing Board	Specialty	Date Certified (mm/yy):	Date Recertified (mm/yy):	Date Recertified (mm/yy):	Expiration Date (if any) (mm/yy):
	Occupational Therapist				

Please answer the following questions. Attach Explanation Form(s), if necessary.

A.	Have you ever been examined by any specialty board, but failed to pass? If yes, please provide name of board(s) and date(s):	☐ YES ☒ NO
B.	1. If you are not currently certified, have you applied for the certification examination?	☐ YES ☒ NO
	2. If you have not applied for the certification examination, do you intend to apply for the certification examination? If yes, when? Date:	☐ YES ☒ NO
	3. If you have applied for the certification examination, have you been accepted to take the certification examination?	☐ YES ☐ NO
	4. If you have been accepted, when do you intend to take the certification examination?	Date:
	5. If you do not intend to apply for the certification examination, please attach reason on Explanation Form(s)	

N/A

III. BOARD CERTIFICATION / RECERTIFICATION - continued

C.	If you are not currently board certified, please provide the expiration date of admissibility.	Date (mm/yy): 07/2020
D.	Have you ever had board certification revoked, limited, suspended, involuntarily relinquished, subject to stipulated or probationary conditions, received a letter of reprimand from a specialty board, or is any such action currently pending or under review? If yes, please attach Explanation Form(s).	☐ Yes ☒ No
E.	Have you ever voluntarily relinquished a board certification, including any voluntary non-renewal of a time limited board certification? If yes, please attach Explanation Form(s).	☐ Yes ☒ No

IV. EDUCATION, TRAINING AND PROFESSIONAL EXPERIENCE

A. UNDERGRADUATE

Complete School Name: University of Texas at San Antonio	Degree(s) Received: BS	Graduation Date (mm/yy): 05/15
City: San Antonio	State/Country: TX/United States	Course of Study or Major: Kinesiology with

B. GRADUATE OR OTHER PROFESSIONAL DEGREES

Does Not Apply ☐

Complete School Name:	Degree(s) Received:	Graduation Date (mm/yy):
City:	State/Country:	Course of Study or Major:

C. MEDICAL / PROFESSIONAL

Medical / Professional School Name and Street Address: Midwestern University 555 31st St

City: Downers Grove	State/Country: IL/United States	Zip: 60515

From (mm/yy): 08/16	To (mm/yy): 09/18	Date of Completion (mm/yy): 09/18	Degree(s) Received: MOT

Did you complete the program? ☒ Yes ☐ No (If you did not complete the program, please attach Explanation Form(s)

D. FOREIGN MEDICAL GRADUATE

Does Not Apply ☒

Educational Commission for Foreign Medical Graduates (ECFMG) Number: Please enclose a copy of your Certificate.	Date Issued (mm/yy):
Other: Fifth Pathway ☐ Yes ☐ No If Yes, please provide name and address of institution.	Dates of Attendance (mm/yy):

E. INTERNSHIP ☐ RESIDENCY ☐ Include all programs you attended, whether or not completed.

Does Not Apply ☒

Institution Name and Street Address:

City:	State/Country:	Zip:

From (mm/yy):	To (mm/yy):	Date of Completion (mm/yy):	Specialty:

Name of Program Director:

Did you complete the program? ☐ Yes ☐ No If you did not complete the program, please attach Explanation Form(s).

IV. EDUCATION, TRAINING AND PROFESSIONAL EXPERIENCE - continued

INTERNSHIP ☐ **RESIDENCY** ☐

Institution Name and Street Address:	Specialty:	
City:	State/Country:	Zip:
From (mm/yy):	To (mm/yy):	Date of Completion (mm/yy):
Name of Program Director:		
Did you complete the program? ☐ Yes ☐ No If you did not complete the program, please attach Explanation Form(s).		

F. FELLOWSHIPS If you completed more than one fellowship, please provide the information on an explanation form. Does Not Apply ☒

Institution Name and Street Address:	Specialty:	
City:	State/Country:	Zip:
From (mm/yy):	To (mm/yy):	Date of Completion (mm/yy):
Name of Program Director:		
Did you complete the program? ☐ Yes ☐ No If you did not complete the program, please attach Explanation Form(s).		

G. OTHER CLINICAL TRAINING PROGRAMS
(For example, preceptorship, procedural certificate course, etc.) Does Not Apply ☒

Institution Name and Street Address:	Specialty:	
City:	State/Country:	Zip:
From (mm/yy):	To (mm/yy):	Date of Completion (mm/yy):
Name of Program Director:	Certificate Awarded:	
Did you complete the program? ☐ Yes ☐ No If you did not complete the program, please attach Explanation Form(s).		
Institution Name and Street Address:	Specialty:	
City:	State/Country:	Zip:
From (mm/yy):	To (mm/yy):	Date of Completion (mm/yy):
Name of Program Director:	Certificate Awarded:	
Did you complete the program? ☐ Yes ☐ No If you did not complete the program, please attach Explanation Form(s).		

H. FACULTY POSITIONS *List all academic, faculty, research, assistantships or teaching positions you have held and the dates of those appointments.* Does Not Apply ☒

Program Specialty & Institution:	Academic Rank or Title:		
Institution Name & Address:	City:	State/Country:	Zip:
From (mm/yy):	To (mm/yy):		
Program Specialty & Institution:	Academic Rank or Title:		
Institution Name & Address:	City:	State/Country:	Zip:
From (mm/yy):	To (mm/yy):		

IV. EDUCATION, TRAINING AND PROFESSIONAL EXPERIENCE - continued

I. MILITARY/PUBLIC HEALTH SERVICE

Does Not Apply ☒

Location of Last Duty Station:			
Rank at Discharge:	Branch:	Active Duty Dates: From (mm/yy)	Active Duty Dates: To (mm/yy)
Honorable Discharge: ☐ Yes ☐ No If no, attach Explanation Form(s).		Are you currently in the Reserves or National Guard? ☐ Yes ☐ No	
Have you ever been court-martialed? ☐ Yes ☐ No If yes, attach Explanation Form(s).			
Attach a copy of DD-214 Form.			

J. CONTINUING MEDICAL EDUCATION

If not listed on your Curriculum Vitae, please list on Explanation Form(s) all post graduate activities and scientific meetings that you have attended or for which you have received Category 1 credit in the past twenty-four months, or provide copies of certificates.

K. PROFESSIONAL MEDICAL ASSOCIATIONS

Please list, on the Explanation Form, all professional organizations and societies (local, state and national) in which you have membership.

V. OTHER STATE HEALTH CARE LICENSES, REGISTRATIONS & CERTIFICATES

Does Not Apply ☒

Please include all ever held. If more room is needed please list on an attached Explanation Form.

Type and Status:	Number:	State/Country:	Expiration Date (mm/yy):
Year Obtained:	Year Relinquished:	Reason:	
Type and Status:	Number:	State/Country:	Expiration Date (mm/yy):
Year Obtained:	Year Relinquished:	Reason:	

VI. CURRENT HOSPITAL AND OTHER FACILITY AFFILIATIONS

Please list in reverse chronological order with the current affiliation(s) first: *(A) current hospital affiliations, (B) hospital applications in process, (C) previous hospital affiliations and (D) other current facility affiliations (which includes surgery centers, dialysis centers, nursing homes and other health care related facilities).* ***Do not list residencies, internships or fellowships. Please list all employment in Section VII.***

A. CURRENT HOSPITAL AFFILIATIONS

Does Not Apply ☒

Primary Facility Name:		Complete Address:
Department/Status (e.g. active, courtesy, provisional, etc.):	Appointment Date (mm/yy):	
Facility Name:		Complete Address:
Department/Status (e.g. active, courtesy, provisional, etc.):	Appointment Date (mm/yy):	
Facility Name:		Complete Address:
Department/Status (e.g. active, courtesy, provisional, etc.):	Appointment Date (mm/yy):	
Facility Name:		Complete Address:
Department/Status (e.g. active, courtesy, provisional, etc.):	Appointment Date (mm/yy):	

B. HOSPITAL APPLICATIONS IN PROCESS *Please list all applications currently in process.*

Does Not Apply ☒

Facility Name:		Complete Address:
Department/Status (e.g. active, courtesy, provisional, etc.):	Submission Date (mm/yy):	
Facility Name:		Complete Address:
Department/Status (e.g. active, courtesy, provisional, etc.):	Submission Date (mm/yy):	

VI. CURRENT HOSPITAL AND OTHER FACILITYAFFILIATIONS - continued

Facility Name:		Complete Address:
Department/Status (e.g. active, courtesy, provisional, etc.):	Submission Date (mm/yy):	

C. PREVIOUS HOSPITAL AFFILIATIONS *Please list all previous affiliations.*

Does Not Apply ☒

Facility Name:		Complete Address:
From (mm/yy):	To (mm/yy):	
Reason for Leaving:		
Facility Name:		Complete Address:
From (mm/yy):	To (mm/yy):	
Reason for Leaving:		

D. OTHER FACILITY AFFILIATIONS *Please list all current affiliations with other facilities.*

Does Not Apply ☐

Facility Name:		Complete Address:
From (mm/yy):	To (mm/yy):	
Reason for Leaving:		
Facility Name:		Complete Address:
From (mm/yy):	To (mm/yy):	
Reason for Leaving:		

VII. PROFESSIONAL PRACTICE / WORK HISTORY

A curriculum vitae is not sufficient for a complete answer to these questions.

Does Not Apply ☐

***Please list in reverse chronological order all work and professional and practice history activities not detailed under Section II, IV or VI. Include any previous office addresses and any military experience*. Explain below any gaps greater than thirty (30) days.**

Name of Current Practice / Employer: HealthPRO Heritage Rehab & Fitness LLC		
Contact Name:		Complete Address: PO Box 69211
Telephone Number:		Baltimore MD
From (mm/yy): 06/20	To (mm/yy): PRESENT	United States 21264
Name of Previous Practice / Employer: Genesis Rehab Services		
Contact Name:		Complete Address: 1936 Brookdale Road
Telephone Number:		Naperville IL
From (mm/yy): 05/19	To (mm/yy): 03/20	United States 60563-2015
Name of Previous Practice / Employer: Renewal Rehab		
Contact Name:		Complete Address: 1601 N Farnsworth Ave
Telephone Number:		Aurora IL
From (mm/yy): 04/19	To (mm/yy): 03/20	United States 60505

VII. PROFESSIONAL PRACTICE / WORK HISTORY - continued

If your training, practice, military or work experience has been interrupted for more than thirty (30) days by, for example, illness, injury or family medical leave, then please explain below any such gap since completing medical school. Does Not Apply ☐

Explanation of Interruption:	From (mm/yy):	To (mm/yy):
separated from USAF to finish OT degree	07/18	01/19

VIII. PEER REFERENCES

Please list three (3) references, from licensed professional peers who through recent observations have personal knowledge of and are directly familiar with your professional competence, conduct and work. Do not include relatives. At least one reference must be a practitioner in your same professional discipline. **(Please refer to Part Two of this Application for any additional specific reference requirements.)**

Name of Reference:		Complete Address:
Specialty:		
Dates of Association: -		
Telephone Number:	Fax Number:	
Name of Reference:		Complete Address:
Specialty:		
Dates of Association: -		
Telephone Number:	Fax Number:	
Name of Reference:		Complete Address:
Specialty:		
Dates of Association: -		
Telephone Number:	Fax Number:	

IX. PROFESSIONAL LIABILITY INSURANCE

Current Insurance Carrier / Provider of Professional Liability Coverage: Marsh & Mclennan Agency LLC	Policy Number: 003822201	Type of Coverage (check one): ☐ Claims-Made ☐ Occurrence

Name of Local Contact (e.g. Insurance Agent or Broker):	Mailing Address: 1000 Corporate Fort Lauderdale FL 33334
Contact Telephone Number:	
Per claim limit of liability: $200,000.00 / Aggregate amount: $10,000,000.00	

Effective Date (mm/yy): 04/20	Expiration Date (mm/yy): 04/21	Retroactive Date, if applicable (mm/yy):

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? ☒ Yes ☐ No

If yes, please provide details/supporting data. If no, please explain why not on an Explanation Form of the Application.

NOTE: IF YOU ARE COVERED BY A MEDICAL PROFESSIONAL LIABILITY INSURANCE PROGRAM THAT IS A CLAIMS MADE POLICY, YOU ARE REQUIRED TO SHOW EVIDENCE OF PURCHASE OF CURRENT REPORTING ENDORSEMENT COVERAGE (TAIL COVERAGE) OR PRIOR OCCURRENCE/ACTS COVERAGE TO COVER PREVIOUS YEARS OF PRACTICE.

IX. PROFESSIONAL LIABILITY INSURANCE - continued

Please list all previous professional liability carriers within the past ten (10) years (including any carriers during medical training if within the ten year period). Does Not Apply ☐

Insurance Carrier / Provider of Professional Liability Coverage: Integro U	Policy Number: HFF100067-1803	Type of Coverage (check one): ☐ Claims-Made ☒ Occurrence
Name of Local Contact:		Mailing Address: Two Financial Center 60 South Street, Suite 800 Boston MA United States 02111
Contact Telephone Number: (617) 531-6000		
Per claim limit of liability: $3,000,000.00	Aggregate amount: $3,000,000.00	
Effective Date (mm/yy): 12/18	Retroactive Date, if applicable (mm/yy):	Expiration Date (mm/yy): 12/19

Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage (check one): ☐ Claims-Made ☐ Occurrence
Name of Local Contact:		Mailing Address:
Contact Telephone Number:		
Per claim limit of liability: $	Aggregate amount: $	
Effective Date (mm/yy):	Retroactive Date, if applicable (mm/yy):	Expiration Date (mm/yy):

Professional Insurance History: Please answer each of the following questions in full. ***If the answer to any question is "YES", or requires further information,*** **please give a full explanation of the specific details on an Explanation Form and attach to the Application.**

1.	Has your professional liability insurance coverage ever been terminated or not renewed by action of the insurance company? ☐ Yes ☒ No If yes, please provide date, name of company(s), and basis for termination or non-renewal.
2.	Have you ever been denied coverage? ☐ Yes ☒ No. If yes, please provide details.
3.	Has your present professional liability insurance carrier excluded any specific procedures from your insurance coverage? ☐ Yes ☒ No If yes, please identify procedures and provide details.

Professional Claims History: ***(If the answer to any of these questions is "Yes," please complete a separate Professional Liability Claims Information Form for each. A Professional Liability Claims Information Form has been provided as Schedule B to this Application. Please make additional copies as necessary.)***

1.	Have there *ever been* any professional liability (i.e. malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you? ☐ Yes ☒ No
2.	Are any professional liability (i.e. malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you *currently pending*? ☐ Yes ☒ No
3.	Are you aware of any formal demand for payment or similar claim submitted to your insurer that did not result in a lawsuit or other proceeding alleging professional liability? ☐ Yes ☒ No

X. HEALTH STATUS

Please answer each of the following questions in full.

1.	Do you currently have any physical or mental condition(s) that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are submitting this Application? ***If the answer to this question is "YES," please give full explanation of the specific details on an Explanation Form and attach to the Application.*** (**Note**: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current participation in aftercare programs for alcohol or drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.)	☐ Yes ☒ No
2.	**Are you able to perform** all the essential functions of the position for which you are applying, safely and according to accepted standards of performance, with or without reasonable accommodation? If reasonable accommodation is required, please specify such on **an attached Explanation Form.**	☐ Yes ☒ No

XI. ATTESTATION QUESTIONS

This section to be completed by the Practitioner. Modification to the wording or format of these Attestation Questions will invalidate the Application.

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on an Explanation Form and attach to the Application.

For the purpose of the following questions, the term "adverse action" means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial, or non-renewal of membership, clinical privileges, academic affiliation or appointment, or employment. "Adverse action" also means, with respect to professional licensure registration or certification, any previously successful or currently pending challenges to such licensure, registration or certification including any voluntary or involuntary restriction, suspension, revocation, denial, surrender, non-renewal, public or private reprimand, probation, consent order, reduction, withdrawal, limitation, relinquishment, or failure to proceed with an application for such licensure, registration or certification.

A.	To your knowledge, have you ever been the subject of an investigation or **adverse action** (or is an investigation or **adverse action** currently pending) by:	
	• a hospital or other healthcare facility (e.g. surgical center, nursing home, renal dialysis facility, etc.)?	☐ Yes ☒ No
	• an education facility or program (medical school, residency, internship, etc.)?	☐ Yes ☒ No
	• a professional organization or society?	☐ Yes ☒ No
	• a professional licensing body (in any jurisdiction for any profession)?	☐ Yes ☒ No
	• a private, federal, or state agency regarding your participation in a third party payment program (Medicare, Medicaid, HMO, PPO, PHO, PSHCC, network, system, managed care organization, etc.)?	☐ Yes ☒ No
	• a state or federal agency (DEA, etc.) regarding your prescription of controlled substances?	☐ Yes ☒ No
B.	To your knowledge, have you ever been the subject of any report(s) to a state or federal data bank or state licensing or disciplining entity?	☐ Yes ☒ No
C.	Has your application for clinical privileges or medical staff membership or change in staff category at any hospital or healthcare facility ever been denied in whole or in part or is any such action pending?	☐ Yes ☒ No
D.	Have you ever resigned from a hospital or other health care facility medical staff to avoid disciplinary action, investigation or while under investigation or is such an investigation pending?	☐ Yes ☒ No
E.	Have you ever been suspended, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in any *federal or state* health insurance program (for example, Medicare or Medicaid)?	☐ Yes ☒ No
F.	Have you ever been suspended, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in any *private* health insurance program?	☐ Yes ☒ No
G.	Has any professional review organization under contract with Medicare or Medicaid ever made an adverse quality determination concerning your treatment rendered to any patient?	☐ Yes ☒ No
H.	Have you ever been convicted of or entered a plea for any criminal offense (excluding parking tickets)?	☐ Yes ☒ No
I.	Are any criminal charges currently pending against you?	☐ Yes ☒ No
J.	Have you ever been arrested for or charged with a crime involving children?	☐ Yes ☒ No
K.	Have you ever been arrested for or charged with a sexual offense?	☐ Yes ☒ No
L.	Have you ever been arrested for or charged with a crime involving moral turpitude?	☐ Yes ☒ No
M.	Are you currently using illegal drugs or legal drugs in an illegal manner?	☐ Yes ☒ No

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

**********PART TWO**********

GEORGIA ASSOCIATION OF HEALTH PLANS

I. Personal Identification

Last Name (include suffix; Jr., Sr., III): Adams	First: Lin	Middle: Marlisha
Are you eligible to work in the United States?	☐ Yes ☐ No	

II. Practice Location Information

Physician group name/practice name to appear in directory: HealthPRO Heritage Rehab & Fitness LLC

Group/Corporate name as it appears on W-9, if different from Physician group/practice name: HealthPRO Heritage Rehab & Fitness L

III. License and Other Identification Information

National Provider Identifier (NPI) when available. 1518421171

Are you a Participating Medicare Provider?	☐ Yes ☒ No
Are you a Participating Medicaid Provider?	☐ Yes ☒ No

IV. Professional/Medical Specialty Information - Primary Specialty:

Based on your contracted agreement do you wish to be listed in the directory under your primary specialty? ☐ Yes ☐ No	Specify: ☐ HMO ☐ PPO ☐ POS

V. Professional/Medical Specialty Information - Secondary Specialty:

Based on your contracted agreement do you wish to be listed in the directory under your secondary specialty? ☐ Yes ☐ No	Specify: ☐ HMO ☐ PPO ☐POS

VI. Professional/Medical Specialty Information - Additional Specialty:

Based on your contracted agreement do you wish to be listed in the directory under an additional specialty? ☐ Yes ☐ No	Specify: ☐HMO ☐ PPO ☐POS

Additional areas of professional/practice interest or focus:

VII. Hospital/Affiliations

Do you have hospital admitting privileges?	☐ Yes ☒ No
Do you admit patients and follow them in an inpatient care setting?	☐ Yes ☒ No

Primary hospital where you have admitting privileges:

Name:	Address:
Contact:	Phone #:
Are your admitting privileges Full Unrestricted?	☐ Yes ☐ No
Are privileges temporary?	☐ Yes ☐ No

Of the total number of your admissions to all hospitals in the past year, what percentage is to this specific hospital? (N/A is a potential option for hospital based physicians.)

Other hospital(s) where you have admitting privileges: ***(Use additional sheets if necessary.)*** N/A ☐

Name:	Address:
Contact:	Phone #:
Are your admitting privileges Full Unrestricted?	☐ Yes ☐ No
Are privileges temporary?	☐ Yes ☐ No

Of the total number of your admissions to all hospitals in the past year, what percentage is to this specific hospital? (N/A is a potential option for hospital based physicians.)

VIII. Work History

Are you currently on active military duty or on military reserve?	☐ Yes ☒ No

IX. Other Practice Information

Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.

Site Address: 12200 CRABAPPLE RD ALPHARETTA GA 3	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-5:00 PM Tuesday : 8:00 AM-5:00 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-	
Do you want to list site in the directory?	☐ Yes ☒ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No

BILLING INFORMATION:

E-mail for billing contact:		Department name if hospital based:	
Who check should be payable to:		Billing representative's name:	
Do you accept new patients into your practice? (specify for each health plan)	☒ Yes ☐ No	Accept new patients from physician referral only?	☒ Yes ☐ No
Accept all new patients?	☒ Yes ☐ No	Accept new Medicare patients?	☒ Yes ☐ No
Accept existing patients with change of payor?	☒ Yes ☐ No	Accept new Medicaid patients?	☐ Yes ☒ No
Practice limitations: (patient ages, sex)			
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice?	☐ Yes ☒ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.	
Availability of interpreters (specify languages):			
Do you provide handicap accessibility for each of the following areas: Building	☐ Yes ☐ No	Parking ☐ Yes ☐ No	Restroom ☐ Yes ☐ No
Is the site accessible by public transportation?	☐ Yes ☐ No	If yes, indicate types of transportation.	
Does your site provide childcare services? (for each site)		☐ Yes ☐ No	
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?		☐ Yes ☐ No	
Does your office qualify as a minority business enterprise?		☐ Yes ☐ No	
Do you or someone in your office have the following additional certifications? (show expiration dates.)			
BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:	
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:	
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:	
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:	
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:	
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:	
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:	
CPR classification	☐ Yes ☒ No	Expiration date:	
Other (Please list on an Explanation Form(s))			

Additional office services provided:

Laboratory services provided	☐ Yes ☐ No	Flexible sigmoidoscopy	☐ Yes ☐ No
Radiology Service	☐ Yes ☐ No	Tympanometry/audiometry screening	☐ Yes ☐ No
EKGs	☐ Yes ☐ No	Asthma treatment	☐ Yes ☐ No
Care of minor lacerations	☐ Yes ☐ No	Osteopathic manipulation	☐ Yes ☐ No
Pulmonary function	☐ Yes ☐ No	IV hydration/treatment	☐ Yes ☐ No
Allergy injections, allergy skin testing	☐ Yes ☐ No	Cardiac stress tests	☐ Yes ☐ No
Office gynecology (routine pelvic/pap)	☐ Yes ☐ No	Physical therapy	☐ Yes ☐ No
Drawing blood	☐ Yes ☐ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☐ No	Surgical procedures	☐ Yes ☐ No
Is anesthesia administered in your office?	☐ Yes ☐ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

X. Required Attachments or Supplemental Information – Hard Copy or Scanned

Copy of state controlled dangerous substance (CDS) certificate.
Copy(ies) of W-9 for verification of each tax identification number used.
Copy of workers compensation certificate of coverage, if applicable.

Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, preceptorship, or other clinical education program? ☐ Yes ☒ No

XI. Attestation and Signature – Part II *By signing this application, I certify, agree, understand and acknowledge the following:*

1. The information in this entire application is complete, current, correct, and not misleading
2. Any misstatements or omissions (whether intentional or unintentional) on this application may constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement.
3. A photocopy of this application, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.
4. I have reviewed the information in this application on the most recent date indicated below and it continues to be true and complete.
5. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.
6. No action will be taken on this application until it is complete and all outstanding questions with respect to the application have been resolved.
7. This attestation statement and application must be signed no more than 180 days prior to the credentialing decision date..

Signature:	
Printed Name:	**Date:**

IX. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 22320 Classic Court Lake Barrington IL 6001	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☐ Yes ☒ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☒ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No / Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:
Other (Please list on an Explanation Form(s))		

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

XII. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 504 N River Road Naperville IL 60563-4043	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☐ Yes ☒ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☐ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No	Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:

Other (Please list on an Explanation Form(s))

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

XII. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 6700 South Keating Avenue Chicago IL 6062	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☐ Yes ☒ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☐ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No	Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:

Other (Please list on an Explanation Form(s))

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

XII. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 1040 Dixie Highway Chicago Heights IL 6041	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☐ Yes ☒ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☐ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No	Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:

Other (Please list on an Explanation Form(s))

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

XII. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 3300 Charles J Miller Road McHenry IL 6005	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☐ Yes ☒ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☐ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No	Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:

Other (Please list on an Explanation Form(s))

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

XII. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 901 Florsheim Drive Libertyville IL 60048-520	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☐ Yes ☒ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☐ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No	Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:

Other (Please list on an Explanation Form(s))

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

XII. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 5333 North Sheridan Road Chicago IL 60640	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☐ Yes ☒ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☐ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No	Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:

Other (Please list on an Explanation Form(s))

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

XII. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 1651 Richfield Avenue Highland Park IL 6003	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☐ Yes ☒ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☐ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No	Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:

Other (Please list on an Explanation Form(s))

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

XII. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 4239 North Oak Park Avenue Chicago IL 606	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☐ Yes ☒ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☐ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No	Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:

Other (Please list on an Explanation Form(s))

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

XII. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 1546 W. Water Street Blue Island IL 60406-5	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☐ Yes ☒ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☐ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No	Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:

Other (Please list on an Explanation Form(s))

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

XII. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 401 West Lake Street Northlake IL 60164-2	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☐ Yes ☒ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☐ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No	Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:

Other (Please list on an Explanation Form(s))

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

XII. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 5520 Lincoln Avenue Morton Grove IL 60053	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☐ Yes ☒ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☐ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No	Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:

Other (Please list on an Explanation Form(s))

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

XII. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 1000 Sunset Ridge Rd Northbrook IL 60062-	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☐ Yes ☒ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☐ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No	Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:

Other (Please list on an Explanation Form(s))

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

XII. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 55 South Greely Palatine IL 60067-6174	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☐ Yes ☒ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☐ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No	Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:

Other (Please list on an Explanation Form(s))

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

XII. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 1936 Brookdale Road Naperville IL 60563-20	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☐ Yes ☒ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☐ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No	Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:

Other (Please list on an Explanation Form(s))

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

XII. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address: 10300 Village Circle Dr Palos Park IL 60464-	Type of service provided: ☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements: Please see Attached Supplemental Page	
List names of partners in your practice:	
After hours, back office phone number for health plan business use only:	
Office business hours, hours that patients are seen: Monday : 8:00 AM-4:30 PM Tuesday : 8:00 AM-4:30 PM Wednesday : 8:0	
Evening or weekend hours: Saturday : None-None Sunday : None-None	
Do you want to list site in the directory?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☒ Yes ☐ No
BILLING INFORMATION:	
E-mail for billing contact: Jane.Mancu@GenesisHCC.com	Department name if hospital based:
Who check should be payable to: Genesis Eldercare Rehabilitati	Billing representative's name: Billing Manager
Do you accept new patients into your practice? (specify for each health plan) ☒ Yes ☐ No	Accept new patients from physician referral only? ☐ Yes ☐ No
Accept all new patients? ☐ Yes ☐ No	Accept new Medicare patients? ☐ Yes ☐ No
Accept existing patients with change of payor? ☐ Yes ☐ No	Accept new Medicaid patients? ☐ Yes ☐ No
Practice limitations: (patient ages, sex)	
Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? ☐ Yes ☐ No	If yes, provide name, address, state license, specialty, if contracted as a PCP.
Availability of interpreters (specify languages):	
Do you provide handicap accessibility for each of the following areas: Building ☐ Yes ☐ No	Parking ☒ Yes ☐ No	Restroom ☒ Yes ☐ No
Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)	

BLS (Basic Life Support)	☐ Yes ☒ No	Expiration date:
ACLS (Advanced Cardiac Life Support)	☐ Yes ☒ No	Expiration date:
ALSO (Advance Life Support in OB)	☐ Yes ☒ No	Expiration date:
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☒ No	Expiration date:
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☒ No	Expiration date:
NALS (Neonatal Advanced Life Support)	☐ Yes ☒ No	Expiration date:
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☒ No	Expiration date:
CPR classification	☐ Yes ☒ No	Expiration date:

Other (Please list on an Explanation Form(s))

Additional office services provided:

Laboratory services provided	☐ Yes ☒ No	Flexible sigmoidoscopy	☐ Yes ☒ No
Radiology Service	☐ Yes ☒ No	Tympanometry/audiometry screening	☐ Yes ☒ No
EKGs	☐ Yes ☒ No	Asthma treatment	☐ Yes ☒ No
Care of minor lacerations	☐ Yes ☒ No	Osteopathic manipulation	☐ Yes ☒ No
Pulmonary function	☐ Yes ☒ No	IV hydration/treatment	☐ Yes ☒ No
Allergy injections, allergy skin testing	☐ Yes ☒ No	Cardiac stress tests	☐ Yes ☒ No
Office gynecology (routine pelvic/pap)	☐ Yes ☒ No	Physical therapy	☒ Yes ☐ No
Drawing blood	☐ Yes ☒ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☒ No	Surgical procedures	☐ Yes ☒ No
Is anesthesia administered in your office?	☐ Yes ☒ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

EXPLANATION FORM

Please make as many copies of this page as needed to fully respond to each question. For each response/explanation, please provide your name and Social Security Number, together with the corresponding page and section number from the Application.

NAME: Lin Marlisha Adams	**SS#:** 100-92-5852

Section # IV EDUCATION, TRAINING AND PROFESSIONAL EXPERIENCE	**Page #**
J. CONTINUING MEDICAL EDUCATION	Page 5 Question IV. J.

PROFESSIONAL MEDICAL ASSOCIATIONS

Association Name :

Geographic Range :

Association Name :

Geographic Range :

Association Name :

Geographic Range :

PROFESSIONAL MEDICAL ASSOCIATIONS

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PROFESSIONAL MEDICAL ASSOCIATIONS

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Geographic Range :

Additional Work History

Name of Previous Practice / Employer: Select Rehab		
Contact Name:		Complete Address: 4600 Frontage Rd Hillsdie IL United States 60162
Telephone Number:		
From (mm/yy): 01/19	To (mm/yy): 03/20	
Name of Previous Practice / Employer: United States Air Force		
Contact Name:		Complete Address: 2400 East Dr. Scott AFB IL United States 6225
Telephone Number:		
From (mm/yy): 03/04	To (mm/yy): 07/18	

Provider: Lin Marlisha Adams , OT

Provider CAQH ID: 14468464

Date Generated: 08/22/2020

Last Attestation Date: 08/13/2020

List of Authorized Plans

Affiliated:
Bright Health Management, Inc.
Peach State Health Plan

AND to any healthcare organization that in the future represents to CAQH either that I am a participating provider or that I am in the process of being credentialed as a participating provider.

Note: Please refer to the online CAQH Proview for the most current version.