Provider Referral Program Application

Advanced Practice Provider (APP) Profile Information

Last name	First name	MI	Title	NPI	
Supervising physician for A	APP Specialty			Years in	practice
Language(s) other than En French Gujarati	glish that you, the provider, speak: Hindi Spanish Telegu	Urdu Vietnamese	Other:		NA
Referral Program Participation NO, I don't wish to participate in the BayCare Provider Referral Program at this time. YES, I wish to participate in the BayCare Provider Referral Program and I understand that to be included I must (initial each of the following criteria): Be a member of BayCare Physician Partners, LLC, and maintain active licensure with the Florida Department of Health. Be in good standing as defined by the Health Care Quality Improvement Act*. Offer to schedule appointments for new patients. Provide updated practice information annually and upon request by BayCare in order to direct the appropriate patient referrals to my office. *See full definition located on the criteria flyer		let us know Choice Ac I'll offer four wec YE NO Preferred I'll offer physical YE NO Urgent Sa I'll offer who've be have bee follow-u YE NO **For same-	ES, I'll offer Choice Ac O, I don't offer Choice Access Appointment to schedule appointment exam patients within ES, I'll offer Preferred D, I don't offer Preferred ame-Day Appointment to schedule same-day been seen in an urgent en referred by the atter	date any of the folks tenents for new pation access appointment Access appointment Access appointment three business de Access appointment ed Access appointment t/emergency care inding provider for me-day appointment same-day appointment must be seen in your office	ents within ts. ents. ent care and ays. ents. tments. for patients setting and or immediate ents. tments.
Practice Office Info	rmation	•	concierge provider? nt age range:	Group Yes to Yes	Solo No —— No
Address				Suite #	
City		State		Zip	
Office phone		Office ma	nager name		
Office manager direct pho	one	Office ma	nager email		

Practice/Office Information

	App	ointme	nt sche	eduling	hours
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Monday	to	Saturday	to
Tuesday	to	Sunday	to
Wednesday	to	Is your office closed	d fan lun ah.
Thursday	to	•	ours: to
Friday	to		

Insurance – For New Patients

Select the payment types and insurance plans which you're currently accepting *for new patients ONLY*:

Commercial Plans (Plans in bold require selection of one or more sub category):

Aetna	
HMO	PPO
AvMed	
BayCare Emp	loyee-Cigna
Cigna	
Evolutions H	ealthcare Systems

First Health
Florida Blue
BlueCare (HMO)
myBlue (HMO)
SimplyBlue (HMO)

Blue Choice (PPO)
Blue Options (PPO)
BlueSelect (PPO)
FEP Federal (PPO)
State Employees (PPO)

Galaxy Health Network MultiPlan/PHCS/Beech Street Provider Network of America United Healthcare None

Government Plans:

CHAMPVA
Hillsborough County Health Plan

Pinellas County Health Plan
Polk County Health Plan

VACCN None

Medicaid:

Aetna Better Health
Clear Health Alliance
Florida Healthy Kids

Humana
Medicaid-Original
Molina Healthcare

SMI/Sunshine Health United Healthcare None

Medicare:

AARP/Uni	ited Healthca	
Aetna		
HMO	PPO	
BayCarePlus		
CarePlus Health Plans		

Cigna Healthspring
Florida Blue
BlueMedicare Classic HMO
BlueMedicare Choice PPO
Freedom Health

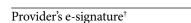
Humana
HMO PPO
Medicare-Original
Optimum HealthCare
Simply Healthcare
Solis Health Plans

Ultimate Health Plans
Unicare
United Healthcare
WellCare Health Plans
None

Health Exchange:

Aetna Ambetter Select (Ambetter-Select) Bronze, Silver or Gold AvMed Florida Blue
BlueSelect HMO PPO
myBlue Blue Options
Molina Marketplace
None

To complete the application, save to your desktop and email to **providerreferralprogram@baycare.org.**



Date



[†]I agree, and it is my intent, that my electronic signature/initials are the legally binding equivalent of a traditional handwritten signature/initials, and certify my acknowledgment and agreement to be bound by the terms and documents accompanying my electronic signature/initials.