



P.O. Box 3458
Valdosta, GA 31604
(229)247-5153

**PRE-APPLICATION QUESTIONNAIRE
FOR MID-LEVEL PROVIDERS**

(OPTOMETRISTS, CERTIFIED REGISTERED NURSE ANESTHETISTS, PHYSICIAN'S ASSISTANTS, NURSE PRACTITIONERS, CERTIFIED NURSE MID-WIVES, ANESTHESIA ASSISTANTS, PHYSICAL THERAPISTS, OCCUPATIONAL THERAPISTS, SPEECH THERAPISTS & SPEECH PATHOLOGISTS)



Date:

Name As It Appears on Medical License:

Name of Practice:

Designation:

Office Physical Address:

Office Mailing Address:

Office Telephone Number:

Office Fax Number:

Office Manager/Credentialing Contact:

Residence Address:

Residence Telephone Number:



	Yes	No
Do you have a current, unrestricted license or certification to provide professional medical services in Georgia?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a license or certification revoked or suspended by any state licensing agency?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have current professional liability insurance coverage with minimum limits of \$1,000,000/\$3,000,000?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payor fraud or program abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been required to pay civil penalties any fraud or abuse listed above?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been excluded or precluded from participation in Medicare, Medicaid or other federal or state governmental health programs?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had medical staff appointment clinical privileges or clinical functions denied, revoked, resigned, relinquished or terminated by any healthcare facility or health plan for reasons related to clinical	<input type="checkbox"/>	<input type="checkbox"/>

competence or professional conduct?	Yes	No
Have you ever been convicted of, or entered a plea of guilty or no contest to any crime against children, any misdemeanor relating to controlled substances, illegal drugs, insurance or healthcare fraud or abuse or violence, or any felony?	<input type="checkbox"/>	<input type="checkbox"/>
Do you practice under the supervision of or in association with a SGPN participating provider? Name of Provider _____	<input type="checkbox"/>	<input type="checkbox"/>



This completed Questionnaire must be returned with copies of the following documents:

- (a) Current Georgia license(s) or certification;
- (b) Current DEA registration (if applicable)
- (c) Certificate of coverage from professional liability insurance carrier that shows effective and expiration dates; and
- (d) A current, dated curriculum vitae or resume with complete professional history for minimum of 5 yr history in chronological order (month & year)



I request an application to become a Participating Provider. I certify that I meet the prerequisites for receiving an application to become a Participating Provider. I understand that the information requested on this Pre-Application Questionnaire is necessary for South Georgia Physician Network to make an administrative determination as to whether I am eligible to receive an application. The Pre-Application Questionnaire does not constitute an application. I understand that a determination that I am ineligible to receive an application does not give rise to any procedural rights.

I hereby release from any and all liability, and agree not to sue, South Georgia Physician Network, LLC, and its representatives for their actions in connection with evaluating the information provided on this Questionnaire and determining whether or not I am eligible to receive an application.

Date

Signature