Physician Workers' Compensation Correspondence

To meet requirements in the finalized Medical Provider Network (MPN) Regulations through California Senate Bill 863, this form is intended to be used as a tool to communicate to HealthSmart, whom serves as a contracting agent/leased network to several MPN Applicant.

Please access this form at any time there is a change to the physician/group's practice information or workers' compensation treatment status by selecting and completing one or both of the available form actions, certifying your action by electronic signature at the end of the form and either directly submitting this form to HealthSmart or by forwarding the completed form back to HealthSmart via email to (west.region@healthsmart.com) or via fax at 214-574-2368.

ACTION: ◯ Practice Information Changes/Updates ◯ Acknowledgement

Practice Update(s) and Workers' Compensation Treatment Acknowledgement:

Please enter Physician/Group practice Information below:

Physician/Group Name: Degree: Specialty:

Address: Suite Number: City/State/Zip:

Office Phone Number: Office Fax Number: Tax ID:

1. Does Physician/Group treat Workers Compensation injuries?

◯ Yes ◯ No

Please affirm response to Question 1 above by selecting one of the following:

◯ My practice/group is open to treating workers' compensation patients. I understand that I am eligible to be part of the MPNs listed on the website using the link under HealthSmart MPN Clients below, and where selected, I will be included as a Participating Provider in the applicable HealthSmart affiliated MPN until this acknowledgement is terminated in writing by my submission to HealthSmart via certified U.S. mail, email or facsimile; or for a specific client should I elect to exclude a specific MPN client's access to my contract with HealthSmart.

◯ My practice/group does not accept workers' compensation patients.

◯ *Specialists ONLY if applicable:* My practice/group accepts workers' compensation patients by referral only.

2. If yes to question 1, what percentage of Physician's practice is dedicated to treating work-related injuries:

◯ 0%-25% ◯ 26%-50% ◯ 51%-75% ◯ 76%-100%

3. List Subspecialties and/or focus on a specific area of care or body part that should be included in our Provider Directory (i.e., for Orthopedists, Hand)

_____

_____

CERTIFICATION AND SIGNATURE PAGE TO FOLLOW

Person Completing Form: ◯ Physician ◯ Employee of Physician ◯ Representative of Group

Name: _____ Phone: _____

Title/Position: _____

Certification:
By my electronic signature below, I understand, agree and affirm that the information represented is true and correct and that my signature submitted by electronic mail or facsimile is as valid as an original. I hereby acknowledge and agree that I have read and understand the contents of this Physician Worker's Compensation Correspondence and am affirming that the information represented by me on this form is true and correct as of the signature date specified below. I further understand and acknowledge that Physician's workers' compensation treatment status as selected above is true and correct and shall be binding and incorporated into Physician's contract with HealthSmart as of the date indicated below, unless future notification representing otherwise is sent to HealthSmart via facsimile, email or mail. I further understand, where applicable, that Physician may at any time elect to be excluded from a HealthSmart MPN client's MPN upon sixty (60) days' notice to HealthSmart. I further agree to promptly notify HealthSmart of any changes to the information that has been communicated and certified through this form.

_____ _____

Signature of Person Completing and Certifying the Form **Date**

Submit Now

By clicking submit this form will automatically be emailed to HealthSmart. If you prefer to print, sign and send the document back to HealthSmart, please email completed and certified form to west.region@healthsmart.com or fax to 214-574-2368. Please keep a copy of the completed and certified form for your records.