Northwest Vision Associates, Inc.

Physician Pre-Application

The NVA pre-application process is used to determine if a doctor meets criteria to apply to NVA. Completed pre-application information is reviewed by the NVA Credentialing Committee. In general, only practitioners who answer "Yes" to each of the pre-application questions shall be eligible to apply. If you answer "No" to a question, the NVA Credentialing Committee will consider the information you provide in explanation of the "No" answer and will determine whether your answer provides a compelling reason to grant an exception.

The cost to submit a pre-application is $50. **This amount is not refundable. Pre-applications received without payment or incomplete pre-applications shall be returned. Please send only single-sided documents.**

After completing its review, NVA will notify you if you are eligible to submit a full application. **You then have sixty (60) days to submit a full application.** After sixty (60) days your eligibility will expire and NVA will close your application file.

Respond to each item below**. If you answer "NO" to a question or if an explanation of your answer is needed to ensure completeness, please attach a separate sheet to this form.**

___ **YES** ___ **NO** I hold a current, valid and unrestricted medical/professional license as an Ophthalmologist (MD or DO) or an Optometrist (OD) in the state(s) where I practice. (Ophthalmologists are required to have a valid DEA license and Optometrists are required to be TPA certified.)

___ **YES** ___ **NO** **At every office in which I practice** I am a solo practitioner **or** I practice with other doctors who belong to NVA **or** I practice with other doctors who have been approved by NVA to submit a full application to NVA **or** I practice with other doctors who are in the process of submitting a pre-application or have submitted a full application to NVA.

___ **YES** ___ **NO** **At every office in which I practice** I own my patient records, or am employed by or contracted by one or more NVA doctors who own the patient records for the practice.

___ **YES** ___ **NO** I agree to provide services in offices where vision materials are dispensed.

___ **YES** ___ **NO** **At every office in which I practice** I own the frame inventory and lens materials I dispense (including but not limited to spectacle lenses and contact lenses) or am employed or contracted by one or more NVA doctors who own the frame inventory and lens materials dispensed at that location. The frame inventory includes a minimum of 250 frames of varying styles, colors, and gender.

___ **YES** ___ **NO** **For all of the offices in which I practice** I carry a minimum of $1,000,000 per occurrence/$3,000,000 annual aggregate professional liability coverage at all times, or be employed by an NVA panel provider doctor who covers the employed or contracted doctor at these minimum limits. The practitioner must have their insurance agent update the NVA credentialing department with a new certificate of insurance upon the annual renewal of the policy.

___ **YES** ___ **NO** **For all of the offices in which I practice** I have access to the office and records 24/7. I will provide coverage for emergency or urgent care situations 24/7. (Note: A voice mail message on the main telephone number for the practice telling patients to call 911 **DOES NOT** meet this requirement. A voice mail message must name an optometrist or ophthalmologist and a number to call after- hours or must direct the patient to at least one doctor who provides call coverage on your behalf when you are unavailable.)

___ **YES** ___ **NO** **Upon request I will provide NVA with a valid and current email address for the practice which will allow NVA to reach me.**

___ **YES** ___ **NO** **For all of the offices in which I practice** I provide services in an office that is a sole proprietorship, Professional Corporation, Corporation, LLC or partnership. Ownership must be by one or more physicians who also belong to NVA. Practitioner must agree to all policies and procedures of NVA.

___ **YES** ___ **NO** **Upon approval** I will refer patients seen under NVA contracts to other NVA-participating physicians, when appropriate.

___ **YES** ___ **NO** **Upon approval** I agree to sign the NVA contract I receive as a part of my application. Current NVA doctors who are signing this form to obtain approval for a new office location must hold a current, valid NVA contract and be a provider in good standing with NVA.

_____ **Check here if you have ever APPLIED to NVA**. In what year did you apply?: _____

_____ **Check here if you have been an NVA member**. In what year did your membership end? _____
Why did your membership end? (e.g., retirement, move, quit practicing, etc.): _____
_____

Physician's Name (please print): _____ , OD / MD (?) **Date:** _____

Northwest Vision Associates, Inc.

WHY are you applying to NVA? _____

_____

If you provide services in multiple office locations, and want those locations approved for NVA, you must copy this sheet and submit one for <u>each</u> office location.

PRACTICE NAME: _____

PHYSICAL ADDRESS: _____
(street) **(city)** **(state)** **(zip)**

MAILING ADDRESS: _____
(street) **(city)** **(state)** **(zip)**

EMAIL ADDRESS OF CREDENTIALING CONTACT (REQUIRED): _____

PRACTICE TAX ID: _____ **PHONE NUMBER:** _____ **FAX NUMBER:** _____

PRACTICE TYPE: Sole Proprietorship Partnership Corporation (C,S, LLC) Professional Corp. (PC)
Franchise/Other (describe) _____

DATE YOU BEGAN PROVIDING SERVICES AT <u>THIS</u> LOCATION: _____

List ALL practice owners including yourself for the practice above or attach a sheet with this information.

	<u>Name</u>	**<u>Ownership Percent</u>**	**<u>Description</u>**	
1.	_____	_____	Physician	Non-Physician
2.	_____	_____	Physician	Non-Physician
3.	_____	_____	Physician	Non-Physician
4.	_____	_____	Physician	Non-Physician
5.	_____	_____	Physician	Non-Physician

If you are NOT an owner, what is your status at this office? Independent contractor Employee

Which <u>BEST</u> describes the <u>setting</u> of this location:

_____ This is a free-standing, professional office _____ This is an office inside a medical office complex

_____ This is an office which is inside of or shares an entrance with a department store or optical retailer

_____ Other (describe) _____

My signature below certifies that the information included on this NVA Pre-application form is true, correct, not misleading and complete. I agree to notify NVA immediately if any information on this form changes.

Physician's Signature: _____ **Date:** _____

Physician's Name (please print): _____

If you have questions about completing this form contact NVA Credentialing at 541.735.3900.

Mail one signed <u>original</u> of this form with your payment of $50.00 (payable to "NVA") to:

Northwest Vision Associates
Credentialing Department
233 Calle del Verano
Palm Desert, CA 92260

Physician's Name (please print): _____ , OD / MD (?) **Date:** _____