



Florida Health Care Plans



An Independent Licensee of the Blue Cross and Blue Shield Association

Check the one that applies:

- | | | |
|---|------------------------------|-------------------------------|
| <input type="checkbox"/> M.D. | <input type="checkbox"/> DPM | <input type="checkbox"/> CRNA |
| <input type="checkbox"/> DO | <input type="checkbox"/> DC | <input type="checkbox"/> PA |
| <input type="checkbox"/> DMD/DDS | <input type="checkbox"/> PhD | <input type="checkbox"/> ARNP |
| <input type="checkbox"/> Other/Specify: _____ | | |

Specialty	Start Date	email address
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Last Name	First Name	Middle Name	Maiden Name
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Group Name/Practice Partners (if applicable)	Social Security Number	Birthdate
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Office Address	City	State	Zip Code	Telephone #	Office Manager
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Residence Address	City	State	Zip Code	Telephone #
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Current Hospital Affiliations

Please respond to the following questions:

1. Do you possess a current license to practice medicine in your specialty in the State of Florida? Yes No
 If yes, please enter license number: _____
 NPI number: _____
 If no, do you have currently pending an application for license to practice medicine in your Specialty in the state of Florida? N/A Yes No
2. Have you completed an approved postgraduate training program? Yes No
3. Can you provide documentation of Board certification? Yes No
4. In case of D.O. physicians, can you provide documentation that your D.O. training is Equivalent to the M.D. Board requirements? N/A Yes No
5. Do you carry professional liability insurance coverage in the minimum amount required By Florida law (\$250,000/\$750,000)? Yes No
6. Is your residence and office location sufficiently close to the facility to provide continuous Patient care? Yes No
7. Please enter your current Federal DEA number _____

PLEASE REMEMBER TO ATTACH A COPY OF YOUR CURRICULUM VITAE

I acknowledge that this form is not an application but only a screening mechanism to determine eligibility for participation with Florida Health Care Plans. I understand that completion of this form, and provision of the requested information, is in no way a guarantee that I will receive an application, or be granted any rights or Medical Staff appointment with Florida Health Care Plans.

Date	Signature of Applicant
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