# NETWORK PROVIDER APPLICATION

Please complete and return this application with the following supporting documents:

- A copy of your state license to operate;
- Certificate(s) of Insurance proving current general liability and professional liability/medical malpractice insurance coverage and amounts of coverage;
- A copy of your organization's W-9 form (most recent IRS version); and
- If you or any of the facilities or practice sites in your system participate in one or more state-sponsored or state-affiliated patient compensation funds, please include (a) the name of the fund(s), (b) a list of your service or practice sites participating in each such fund, (c) your certificate(s) of coverage, and (d) the declaration page(s) for your underlying primary coverage(s), general and professional liability.
- Please also attach a current curriculum vitae for each proposed practitioner.

**NOTE:** *If you require more space than is provided by any of the boxes on this form, please submit additional pages as needed.*

**This application does not constitute a contract.**
Please furnish the information below. Indicate "N/A" if an item is not applicable.

## I. GENERAL INFORMATION

Please provide the following general information about your organization:

Organization Name

State License Number | Expiration Date

Tax ID | NPI

Street Address 1

Street Address 2

City | State | ZIP (00000-0000)

Primary Contact Name | Title

Primary Contact Phone | Primary Contact E-mail

Parent company or organization (if applicable): _____

## II. LIABILITY COVERAGE

| **A. Does your organization maintain the following types of insurance coverage?** | **Yes** | **No** | **N/A** |
|---|---|---|---|
| 1. Commercial general liability for bodily injury/property damage and contractual liability | ☐ | ☐ | ☐ |
| If so, in what amounts? $_____ (occurrence) $_____ (aggregate) | | | |
| 2. Professional liability and/or medical malpractice insurance | ☐ | ☐ | ☐ |
| If so, in what amounts? $_____ (occurrence) $_____ (aggregate) | | | |

| **B. Has your organization experienced any of the following:** | **Yes** | **No** | **N/A** |
|---|---|---|---|
| 1. Malpractice liability insurance cancellation in the past five (5) years? | ☐ | ☐ | ☐ |
| 2. General liability insurance cancellation in the past five (5) years? | ☐ | ☐ | ☐ |
| 3. Revocations or suspensions as a Medicare or Medicaid Provider? | ☐ | ☐ | ☐ |
| 4. State licensing investigations or actions? | ☐ | ☐ | ☐ |

If you answered "Yes" to any question(s) in Section B, please provide an explanation below, as well as any additional relevant information about your organization:

## III. DELIVERY SITES

Please provide the following information for each site your organization proposes to provide services in connection with the NFL Concussion Settlement. Please include a separate entry for each proposed site:

**Name of Facility 1**

Street Address

City | State | ZIP (00000-0000)

Primary Telephone Number | Scheduling Telephone Number | Fax Number

State License Number | NPI Number

**Name of Facility 2**

Street Address

City | State | ZIP (00000-0000)

Primary Telephone Number | Scheduling Telephone Number | Fax Number

State License Number | NPI Number

**Name of Facility 3**

Street Address

City | State | ZIP (00000-0000)

Primary Telephone Number | Scheduling Telephone Number | Fax Number

State License Number | NPI Number

## IV. PRACTITIONERS

Please provide the following information for each practitioner that your organization proposes to provide services covered under the NFL Concussion Settlement. Please include a separate entry for each practitioner.

Qualified BAP Providers must be one of the following:

- A clinical neuropsychologist certified by the ABPP or ABCN in the specialty of Clinical Neuropsychology; or
- A board-certified neurologist.

Qualified MAF Physicians must be one of the following:

- A board-certified neurologist;
- A board-certified neurosurgeon; or
- A board-certified neuro-specialist physician.

All practitioners seeking to serve as a Qualified BAP Provider or Qualified MAF Physician must meet the following requirements:

- Possess a current, active, unrestricted state license;
- Hospital staff privileges not revoked or restricted within the past five (5) years;
- Is covered by proper insurance under state law;
- Not excluded from participation in any federal or state health care program; and
- Medical license not subjected to any disciplinary action or any restrictions within the past five (5) years.

Last Name _____ First Name _____ MI _____

Professional Designation (e.g., M.D., Ph.D.) _____ State License Number _____

NPI _____ Specialty _____

No. of Years in Practice as a Healthcare Provider _____ Hours per Month Available To See Settlement Participants _____ Languages Spoken _____

Average wait time for new patient evaluations (number of days from request for appointment until the patient can be seen by the practitioner): _____

Practitioner Education

Practitioner Training

Practitioner Experience with Sports-Related Concussions or Traumatic Brain Injury

Practitioner Board Certification

Location(s) Where the Practitioner Provides Services

Is the practitioner an employee of your organization? Yes ☐ No ☐

If you answered "No" to the preceding question, please describe the relationship between the practitioner and the organization and name the practitioner's employer:

**Please see Application Instructions on page 1 for documentation requirements.**

## LIABILITY COVERAGE

| **A. Does the practitioner carry these types of insurance coverage?** | **Yes** | **No** | **N/A** |
|---|---|---|---|
| Professional liability and/or medical malpractice insurance | ☐ | ☐ | ☐ |
| If No, is the practitioner covered by your organization's liability and/or malpractice insurance? | ☐ | ☐ | ☐ |

If Yes, please indicate the following:

Type of insurance: _____ Amounts: $_____ (occurrence) $_____ (aggregate)

Type of insurance: _____ Amounts: $_____ (occurrence) $_____ (aggregate)

Type of insurance: _____ Amounts: $_____ (occurrence) $_____ (aggregate)

| **B. Has the practitioner experienced any of the following:** | **Yes** | **No** | **N/A** |
|---|---|---|---|
| 1. Malpractice liability insurance cancellation? | ☐ | ☐ | ☐ |
| 2. General liability insurance cancellation? | ☐ | ☐ | ☐ |
| 3. Cancellation of any other insurance policies related to the practice of medicine? | ☐ | ☐ | ☐ |
| 4. Revocations or restrictions of hospital staff privileges? | ☐ | ☐ | ☐ |
| 5. Revocations or suspensions as a Medicare or Medicaid Provider? | ☐ | ☐ | ☐ |
| 6. State licensing investigations or actions? | ☐ | ☐ | ☐ |

If you answered "Yes" to any of the preceding questions, please provide details and dates below:

**Please see Application Instructions on page 1 for documentation requirements.**

Percentage of practice related to litigation (expert/consulting engagements) for plaintiffs, defendants and court/administrative bodies, and a description of such practice since July 1, 2011:

**PLAINTIFFS:**

Percentage: _____%

Description:

**DEFENDANTS:**

Percentage: _____%

Description:

**COURT/ADMINISTRATIVE BODIES:**

Percentage: _____%

Description:

**Please see Application Instructions on page 1 for documentation requirements.**

List all engagements as a litigation expert consultant or expert witness arising out of, or relating to, head, brain and/or cognitive injury. Please include any and all engagements (irrespective of date) and list the subject matter, client, and date range. If the engagement included testimony (including, but not limited to, the preparation of an expert report), provide the title, docket number and court of the proceeding:

Does the practitioner specialize in any of the Qualifying Diagnoses?

- ☐ Level 1.5 Neurocognitive Impairment (early Dementia)
- ☐ Level 2 Neurocognitive Impairment (moderate Dementia)
- ☐ Alzheimer's Disease
- ☐ Parkinson's Disease
- ☐ Amyotrophic Lateral Sclerosis ("ALS")

What percentage of your practice is related to each of the Qualifying Diagnoses, meaning what percentage of the patients that you treat or evaluate are diagnosed with each of the Qualifying Diagnoses?

**LEVEL 1.5 NEUROCOGNITIVE IMPAIRMENT (EARLY DEMENTIA):**

Percentage: _____%

Description:

**LEVEL 2 NEUROCOGNITIVE IMPAIRMENT (MODERATE DEMENTIA):**

Percentage: _____%

Description:

**ALZHEIMER'S DISEASE:**

Percentage: _____%

Description:

**PARKINSON'S DISEASE:**

Percentage: _____%

Description:

**AMYOTROPHIC LATERAL SCLEROSIS ("ALS"):**

Percentage: _____%

Description:

Has the practitioner served on or after April 22, 2015 as a litigation expert consultant or expert witness for an Opt Out of the NFL Concussion Settlement, in connection with litigation relating to head, brain and/or cognitive injury? If Yes, please provide details below:

Yes ☐ No ☐

Has the practitioner ever treated or evaluated a current or former NFL player? If yes, please provide how many NFL players were seen, when the evaluation(s) took place, and whether you evaluated the NFL players at the request of an attorney or as part of your usual clinical practice. Provide the name(s) of any attorney(s) who referred NFL players to be evaluated by you. Do not identify any specific NFL players in your response.

Yes ☐ No ☐

Has the practitioner ever been in a salaried position or consulting relationship with the National Football League, NFL Properties, or any NFL Member Clubs? If Yes, please provide details below, including the title of the practitioner's position/role:

Yes ☐ No ☐

Has the practitioner ever served as a neutral physician or consultant for benefits under the NFL Player Disability & Neurocognitive Benefit plan, the Bert Bell/Pete Rozelle NFL Retirement Plan or the 88 Plan? Yes ☐ No ☐
If Yes, please provide details below, including the title of practitioner's position/role:

Has the practitioner ever been convicted of a crime of dishonesty? Yes ☐ No ☐
If Yes, please describe the crime and date of conviction:

## V. BILLING/CLAIMS PROCESS

*Please note: This information pertains only to the Baseline Assessment Program. All services provided by Qualified MAF Physicians are the responsibility of the Retired NFL Football Player and/or his insurer.*

What is your preferred billing process?

- ☐ Electronic claim submission
- ☐ Fax
- ☐ Upload to a secure portal
- ☐ Mail (e.g., CMS1500, UB04)

Does your system contract with a third-party company to manage billing? Yes ☐ No ☐

If "Yes," please provide the following information:

Billing Company Name

Street Address 1

Street Address 2

City | County | State | ZIP (00000-0000)

Billing Contact Name | Phone

Is your billing address different from your mailing address? If so, please provide the billing address:

Name

Street Address 1

Street Address 2

City | County | State | ZIP (00000-0000)

Phone | Fax

Contact Person | Title | Phone | E-mail

**Please see Application Instructions on page 1 for documentation requirements.**

## VI. PAYMENT

*Please note: This information pertains only to the Baseline Assessment Program. All services provided by Qualified MAF Physicians are the responsibility of the Retired NFL Football Player and/or his insurer.*

Do you prefer to be paid by check or ACH deposit?

☐ Check ☐ ACH Deposit

Provide the mailing address to which Explanations of Payment should be mailed:

Street Address 1

Street Address 2

City | County | State | ZIP 00000-0000

Provide the mailing address to which 1099 Statements should be mailed:

Street Address 1

Street Address 2

City | County | State | ZIP 00000-0000

**Please see Application Instructions on page 1 for documentation requirements.**

## VII. INSURANCE PLANS ACCEPTED

*Please note: This information pertains only to the those applying for participation as a Qualified MAF Physician. Anyone applying for participation as a Qualified BAP Provider only may omit this information.*

List the insurance plans accepted by your organization:

**Please see Application Instructions on page 1 for documentation requirements.**

# DECLARATION

The undersigned attests that he or she has the authority to act on behalf of the applicant for the purpose of this application. The applicant, by and through the undersigned, attests that to the best of its knowledge and belief, after reasonable inquiry, all of the information provided on this application and in connection with this application is complete and accurate. The applicant understands that this application does not entitle the applicant to participate in any program or work arising out of the NFL Concussion Settlement activities or any other program. The applicant further understands that any misrepresentations made in this application shall be grounds for immediate disqualification from participation in the programs arising out of the NFL Concussion Settlement. The applicant agrees that entities that in good faith provide information to the BAP Administrator and/or the Claims Administrator to assist them in evaluating and/or verifying the information contained in this application and in any documentation submitted in support of this application shall not be liable for any act or omission related to the provision, evaluation, or verification of such information. The applicant further agrees to notify the BAP Administrator and/or the Claims Administrator in a timely manner of any changes to the information provided on this application.

The applicant hereby authorizes any accrediting body, governmental entity, insurance company, association, organization, entity, or person to release the information requested herein and to provide confirmation of the answers contained herein to the BAP Administrator and/or the Claims Administrator and their affiliates, subsidiaries, and agents. This authorization shall be valid until and unless the applicant withdraws its application. A copy of the signature is as binding as the original.

**Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the information provided in this form, and in any attachments hereto, is true and correct to the best of my knowledge, information, and belief.**

Authorized Signature | Date

Print Name

Organization Name

Street Address 1

Street Address 2

City | County | State | ZIP (00000-0000)

**Please see Application Instructions on page 1 for documentation requirements.**