

Mountainside Hospital Physician Referral Questionnaire

If you do *not* wish to participate in the physician referral program please see the instructions at the bottom of the last page.

General Physician Information:

Name: _____
First
MI
Last
(Jr./Sr.)

Title: MD DO DDS Ph.D. Other: _____

Gender: Male Female Birth Date: ____/____/____

In what year did you begin practicing? _____ Since what year have you resided in this area? _____

Situations where you would NOT like to receive a referral _____

Personal information that you would like referral candidates to know about you, not provided for elsewhere in this questionnaire

Formal Education:

Institution Name

Year Grad.

Medical degree		
Internship(s):		
Residency(ies):		
Fellowship(s):		

Areas of Interest

Credentials/additional training/education that you would like referral candidates to know about (other than medical degree, internship, residency, and fellowship programs). _____

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Specialty(ies):	Board Certified? Y/N	Accept referrals for this specialty? Y/N

Office Information: (The following information is needed for each additional office. You may copy this sheet.)

Group Practice Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Closest cross streets: _____

Is this your Primary office location (Y/N)? _____

Voice Phone Number: (_____) _____ - _____ Fax Phone Number: (_____) _____ - _____

Physicians e-mail address: _____

What time zone is in effect at this office (Eastern, Central, Mountain, Pacific, etc.) _____

Does this location honor Daylight Savings Time (Y/N)? _____

What days/hours will someone be at this office to assist with scheduling?

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

From: _____

To: _____

Please indicate with a (Y/N) whether or not you generally see patients during the time frames indicated below.

Note: Specific appointment time availability will be determined at the time the referral is made.

Weekdays: [____] Evenings: [____] Saturdays: [____] Sundays: [____]

What is the average waiting period (in days) for scheduling an acute care appointment? _____

Does this location have: Public transportation (Y/N) ? _____ Handicap access (Y/N) ? _____

What is the average new patient fee for a patient's first visit to this location? _____

What foreign languages, if any, are spoken at this location?

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Insurance Participation Please check the insurances below that are accepted at your office(s)

Commercial / Indemnity

Medicare

Medicare Assignment

Medicaid

Workers Comp

Champus

- | | | | | | |
|--------------------------|-----|----------------------------------|--------------------------|-----|----------------------------------|
| <input type="checkbox"/> | EPO | AARP | <input type="checkbox"/> | POS | ALLSTATE |
| <input type="checkbox"/> | EPO | ADVANCED HEALTHCARE SYSTEMS | <input type="checkbox"/> | POS | AMERICAN BANKERS INSURANCE GROUP |
| <input type="checkbox"/> | EPO | AIG | <input type="checkbox"/> | POS | AMERICAN POSTAL WORKERS |
| <input type="checkbox"/> | EPO | ALLSTATE | <input type="checkbox"/> | POS | AMERIHEALTH |
| <input type="checkbox"/> | EPO | AMERICAN BANKERS INSURANCE GROUP | <input type="checkbox"/> | POS | ANTHEM HEALTH & LIFE |
| <input type="checkbox"/> | EPO | AMERICAN POSTAL WORKERS | <input type="checkbox"/> | POS | ATLANTIC HOME CARE AND HOSPICE |
| <input type="checkbox"/> | EPO | ANTHEM HEALTH & LIFE | <input type="checkbox"/> | POS | CIGNA HEALTHCARE |
| <input type="checkbox"/> | EPO | ATLANTIC HOME CARE AND HOSPICE | <input type="checkbox"/> | POS | CNA PHCS |
| <input type="checkbox"/> | EPO | CORESOURCE | <input type="checkbox"/> | POS | CORESOURCE |
| <input type="checkbox"/> | EPO | ETHIX | <input type="checkbox"/> | POS | CORESOURCE PHCS |
| <input type="checkbox"/> | HMO | AARP | <input type="checkbox"/> | POS | ETHIX |
| <input type="checkbox"/> | HMO | ADVANCED HEALTHCARE SYSTEMS | <input type="checkbox"/> | POS | GUARDIAN PHCS |
| <input type="checkbox"/> | HMO | AETNA | <input type="checkbox"/> | POS | HORIZON BCBSNJ |
| <input type="checkbox"/> | HMO | AIG | <input type="checkbox"/> | POS | INDENDENCE BC MAGELLAN |
| <input type="checkbox"/> | HMO | ALLSTATE | <input type="checkbox"/> | POS | JOHN ALDEN PHCS |
| <input type="checkbox"/> | HMO | AMERICAN BANKERS INSURANCE GROUP | <input type="checkbox"/> | POS | KEYSTONE HEALTH PLAN |
| <input type="checkbox"/> | HMO | AMERICAN POSTAL WORKERS | <input type="checkbox"/> | POS | LIBERTY MUTUAL NO FAULT |
| <input type="checkbox"/> | HMO | AMERIHEALTH | <input type="checkbox"/> | POS | LINCOLN NATIONAL |
| <input type="checkbox"/> | HMO | ANTHEM HEALTH & LIFE | <input type="checkbox"/> | POS | MAGELLAN |
| <input type="checkbox"/> | HMO | ATLANTIC HOME CARE AND HOSPICE | <input type="checkbox"/> | POS | MASS MUTUAL |
| <input type="checkbox"/> | HMO | CIGNA HEALTHCARE | <input type="checkbox"/> | POS | MEDICHOICE NETWORK INC |
| <input type="checkbox"/> | HMO | CORESOURCE | <input type="checkbox"/> | POS | MMH EMPIRE BCBSNY |
| <input type="checkbox"/> | HMO | ETHIX | <input type="checkbox"/> | POS | PHOENIX |
| <input type="checkbox"/> | HMO | HORIZON BCBSNJ | <input type="checkbox"/> | POS | PRIVATE HEALTHCARE SYSTEMS |
| <input type="checkbox"/> | HMO | KEYSTONE HEALTH PLAN | <input type="checkbox"/> | POS | PROVIDENT LIFE |
| <input type="checkbox"/> | HMO | MAGELLAN | <input type="checkbox"/> | POS | PRUDENTIAL |
| <input type="checkbox"/> | HMO | PRUDENTIAL | <input type="checkbox"/> | POS | TIME FORTIS |
| <input type="checkbox"/> | HMO | QUALCARE | <input type="checkbox"/> | POS | WELLCHOICE EMPIRE HMO PPO POS |
| <input type="checkbox"/> | HMO | TIME FORTIS | <input type="checkbox"/> | PPO | AARP |
| <input type="checkbox"/> | HMO | WELLCHOICE EMPIRE HMO PPO POS | <input type="checkbox"/> | PPO | ADVANCED HEALTHCARE SYSTEMS |
| <input type="checkbox"/> | IND | AARP | <input type="checkbox"/> | PPO | AETNA |
| <input type="checkbox"/> | IND | ADVANCED HEALTHCARE SYSTEMS | <input type="checkbox"/> | PPO | AIG |
| <input type="checkbox"/> | IND | AETNA | <input type="checkbox"/> | PPO | ALLSTATE |
| <input type="checkbox"/> | IND | AIG | <input type="checkbox"/> | PPO | AMERICAN BANKERS INSURANCE GROUP |
| <input type="checkbox"/> | IND | ALLSTATE | <input type="checkbox"/> | PPO | AMERICAN POSTAL WORKERS |
| <input type="checkbox"/> | IND | AMERICAN BANKERS INSURANCE GROUP | <input type="checkbox"/> | PPO | AMERIHEALTH |
| <input type="checkbox"/> | IND | AMERICAN POSTAL WORKERS | <input type="checkbox"/> | PPO | AMERIHEALTH MAGELLAN |
| <input type="checkbox"/> | IND | AMERIHEALTH | <input type="checkbox"/> | PPO | ANTHEM HEALTH & LIFE |
| <input type="checkbox"/> | IND | ANTHEM HEALTH & LIFE | <input type="checkbox"/> | PPO | ATLANTIC HOME CARE AND HOSPICE |
| <input type="checkbox"/> | IND | ATLANTIC HOME CARE AND HOSPICE | <input type="checkbox"/> | PPO | CIGNA HEALTHCARE |
| <input type="checkbox"/> | IND | CIGNA HEALTHCARE | <input type="checkbox"/> | PPO | CNA PHCS |
| <input type="checkbox"/> | IND | CORESOURCE | <input type="checkbox"/> | PPO | CORESOURCE |
| <input type="checkbox"/> | IND | ETHIX | <input type="checkbox"/> | PPO | CORESOURCE PHCS |
| <input type="checkbox"/> | IND | FIRST TRENTON | <input type="checkbox"/> | PPO | ETHIX |
| <input type="checkbox"/> | IND | HORIZON BCBSNJ | <input type="checkbox"/> | PPO | GREAT WEST |
| <input type="checkbox"/> | IND | MMH EMPIRE BCBSNY | <input type="checkbox"/> | PPO | GUARDIAN PHCS |
| <input type="checkbox"/> | IND | PRUDENTIAL | <input type="checkbox"/> | PPO | HORIZON BCBSNJ |
| <input type="checkbox"/> | IND | UNITED HEALTHCARE | <input type="checkbox"/> | PPO | HORIZON HEALTHCARE INS OF NY |
| <input type="checkbox"/> | IND | WELLCHOICE EMPIRE HMO PPO POS | <input type="checkbox"/> | PPO | JOHN ALDEN PHCS |
| <input type="checkbox"/> | MCD | MEDICAID DENTAL | <input type="checkbox"/> | PPO | KEYSTONE HEALTH PLAN |
| <input type="checkbox"/> | MCD | MEDICAID HEALTHSTART | <input type="checkbox"/> | PPO | LIBERTY MUTUAL NO FAULT |
| <input type="checkbox"/> | MCD | MEDICAID NJ | <input type="checkbox"/> | PPO | LINCOLN NATIONAL |
| <input type="checkbox"/> | MCD | MEDICAID NY | <input type="checkbox"/> | PPO | MAGELLAN |
| <input type="checkbox"/> | MCD | MEDICAID OUT OF STATE | <input type="checkbox"/> | PPO | MASS MUTUAL |
| <input type="checkbox"/> | MCD | UNIVERSITY HEALTH PLAN MEDICAID | <input type="checkbox"/> | PPO | MMH EMPIRE BCBSNY |
| <input type="checkbox"/> | MCR | AETNA | <input type="checkbox"/> | PPO | PHOENIX |
| <input type="checkbox"/> | MCR | AMERIHEALTH MANAGED MEDICARE | <input type="checkbox"/> | PPO | PRIVATE HEALTHCARE SYSTEMS |
| <input type="checkbox"/> | MCR | FIRST OPTION HEALTH PLAN | <input type="checkbox"/> | PPO | PROVIDENT LIFE |
| <input type="checkbox"/> | MCR | MEDICARE IME | <input type="checkbox"/> | PPO | PRUDENTIAL |
| <input type="checkbox"/> | MCR | OXFORD ADVANTAGE MEDICARE | <input type="checkbox"/> | PPO | QUALCARE |
| <input type="checkbox"/> | MCR | UNITED HEALTHCARE | <input type="checkbox"/> | PPO | TIME FORTIS |
| <input type="checkbox"/> | POS | AARP | <input type="checkbox"/> | PPO | WELLCHOICE EMPIRE HMO PPO POS |
| <input type="checkbox"/> | POS | ADVANCED HEALTHCARE SYSTEMS | <input type="checkbox"/> | WC | AIG |
| <input type="checkbox"/> | POS | AETNA | <input type="checkbox"/> | WC | FIRST MANAGED CARE OPTION |
| <input type="checkbox"/> | POS | AIG | <input type="checkbox"/> | WC | INSERVCO |

- WC LIBERTY MUTUAL NO FAULT
- WC NJ MANUFACTURERS WORKERS COMP
- WC SCIBAL ASSOCIATES WORKERS COMP
- WC SELECTIVE INS

- WC STATE FARM
- WC TRAVELLERS WORKERS COMPENSATION
- WC WAUSAU INS CO WORKERS COMP
- WC WORKERS COMP OTHER

Payments Types MC Visa Discover Am Ex Cash Check

- No, I do NOT want to participate in the Physician Referral service. Please complete your name on page one. Sign and date the lines below, and return this questionnaire to the address indicated on the cover letter to be removed from the Referral Roster.
- Yes, I want to participate in the Physician Referral service.
I authorize you to release any of the information enclosed in this questionnaire to members of the community who call the Physician Referral Service in need of healthcare services. Please fax back the completed questionnaire to 817-355-5136.

Physician Signature _____

Date _____