

For Office Use Only

PCP Name: _____	Date: _____
PCP Facets ID Number: _____	P/R Rep: _____
PCP/Group Affiliation: _____	Effective Date: _____

PEDIATRICIAN — FULL SERVICE BONUS CALCULATION (FSBC) — BREADTH OF SERVICE

In order to update information which Keystone Health Plan Central (KHP Central) has on record regarding the breadth of service which your office provides our members, we need to have you complete the following brief questionnaire. This information is necessary for KHP Central to accurately represent your practice to our members and to adequately compensate you for the services you provide. It is imperative that we have accurate and current information on our primary care physician providers, so please take the time to answer the following questions, sign the questionnaire after reviewing it for accuracy and return it in the enclosed postage-paid envelope.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Does your office draw blood on KHP Central members requiring laboratory tests most or all of the time such tests are necessary?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do your KHP Central members who sustain lacerations, which require suturing, usually have these wounds repaired in your office ?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do the pediatricians in your practice routinely attend C-sections performed on KHP Central members?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do the pediatricians in your practice provide inpatient medical care (other than to newborns) for most non-surgical KHP Central patients who require hospitalization?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does your practice offer at least three hours of available appointment time on weekends (Saturday and/or Sunday)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Answer only one of the following: | | |
| a. Solo practice: Does your office offer at least three hours of available evening appointments (after 5:00 p.m.) per week?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Group practice: Does your office offer at least six hours of available evening appointments (after 5:00 p.m.) per week?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do the pediatricians in your practice manage and treat simple fracture care, including casting, when necessary, in your office ?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your practice perform audiometry, when indicated, in your office ?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does your practice perform tympanometry, when indicated, in your office ?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does your practice provide inhalation nebulizer therapy, when indicated, in your office ?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Is **your practice** currently open to new patients? YES NO

If the answer is "No", please check the appropriate box(es) below:

- | | |
|---|---|
| <input type="checkbox"/> Accept existing patients only. | <input type="checkbox"/> Existing patients only. No newborns. |
| <input type="checkbox"/> Accept dependents of existing patients only. | <input type="checkbox"/> Accept limited number of members. |
| <input type="checkbox"/> Existing patients and newborns only. | <input type="checkbox"/> Closed. |

If your practice has age restrictions, please check ONE appropriate box: (Please do not hand write any other option.)

- | | |
|---|---|
| <input type="checkbox"/> Practice limited to ages 2 and older. | <input type="checkbox"/> Practice limited to ages 14 and older. |
| <input type="checkbox"/> Practice limited to ages 5 years and older. | <input type="checkbox"/> Practice limited to ages 16 and older. |
| <input type="checkbox"/> Practice limited to ages 8 and older. | <input type="checkbox"/> Practice limited to newborns through age 18. |
| <input type="checkbox"/> Practice limited to ages 12 years and older. | <input type="checkbox"/> Practice limited to ages 18 and older. |
| <input type="checkbox"/> Practice limited to ages newborn to age 13. | <input type="checkbox"/> Practice limited to newborns through age 21. |

I attest that I have read and reviewed the questions and answers above and I agree that the information supplied is correct.

Signature of Physician Completing Questionnaire

Date

Please Print or Type Name of Signing Physician

Last Revised 01/07/2008