

Renewal - 1.039600

Name	ELIZABETH M KONTARINES
Credential	1.039600

Fee Details

Renewal Application Fee	\$575.00
	\$575.00

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

As part of this renewal application, you will be asked to enter your National Provider Identification (NPI) number. Please make sure you have that information available before proceeding. If you do not have your NPI number with you, you can find it online at <https://npiregistry.cms.hhs.gov/>. You will also be asked to enter information regarding your practice location, specialty and patients served.

The purpose of the questions is to allow the Department of Public Health to collect valuable workforce and patient care data that is critical in identifying and addressing healthcare workforce shortage and patient care issues.

Thank you for assisting the Department in this important initiative.

Demographic Information-Renewal

1. Please provide your Date of Birth
01/16/1968
2. Gender
Female
3. Ethnicity: Please choose one
Not Hispanic or Latino
4. Race:
White

Email Address Verification

Please be advised that the Department will no longer be mailing hardcopy licenses and renewal notices. Rather, licenses and renewal notices will be sent via email. You will receive an electronic copy of your license via email within a few days of completing this transaction. Renewal notices will be sent via email approximately 60 days prior to your license expiration date. After you complete this transaction, please select the 'My Account' link at the top right of the homepage and make sure that your email address on file is correct. If it is not correct, please update it. Thank you.

5. By entering a date in this field, I confirm that I will verify that the Department has my correct email address on file.
11/30/2016

Medical Education

6. Medical School
St. Georges University School of Medicine
7. Year of Graduation
1997

Specialty/Board Certification

8. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS.

Specialty	Subspecialty		Certifying Board	Certification Date
Obstetrics and Gynecology	Subspecialty	Certification Date	American Board of Obstetrics and Gynecology	01/07/2002
Obstetrics and Gynecology	Subspecialty	Certification Date		

Current Workforce Status in Medicine

9. What is your current work status in medicine?
Full Time - (40 hours or more per week)
10. In the next 12 months, do you plan to (please mark all that apply):
None
11. If 100% of your primary professional position is not direct patient care, please indicate which of the following apply:
12. If your response to the previous question was other, please enter additional comments here.
Resident education

National Provider Identifier

The National Provider Identifier (NPI) is a 10-digit identifier required on all HIPAA standard electronic transactions. NPIs have replaced all separately issued identifiers, including Medicaid PINs and Medicare UPINs, on HIPAA standard electronic transactions. In the past, health plans assigned an identifying number to each provider with whom they conducted electronic business. Since providers typically work with several health plans, they were likely to have a different identification number for each plan. The NPI has been put in place so that each provider has one unique, United States federal government-issued identifier to be used in transactions with all health plans with which the provider conducts business.

13. Please enter your NPI number here (if you do not know your NPI number, you may retrieve it at <https://npiregistry.cms.hhs.gov>. If you do not have an NPI number, please enter ten (10) zeros):
1659381747

Physician Renewal Practice Location

14. Please indicate the name and address of your primary practice location as well as languages spoken at that location. Please note that you can add additional practice locations but you may only select one (1) primary practice location.

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
Womens Health Associates	27 Hospital Ave			Danbury	Connecticut	06810	Yes	

15. Approximately how many physicians are associated with your practice?
4
16. Is the primary site where you spend most time providing direct patient care a JCAHO/NCQA recognized patient care centered medical home?
No
17. Please select the best choice for the type of ownership of your practice.
Private practice

Practice Ownership - Organization

18. Please enter the name of the organization/person that owns the practice where you work.
Joint partnership
19. City
Danbury
20. State (two letter abbreviation)

CT

New Patients

21. Please select the best response that describes your patient care practice status:
I can accept some new patients; my practice is far from full
22. Are you accepting new patients covered by:
Both

Primary Source of Payment

What percent of your patients have the following source of payment?

23. Medicare
less than 10%
24. Medicaid
26 - 50%
25. Self-Pay
less than 10%
26. Private Insurance
26 - 50%
27. Other
None
28. Does your practice offer sliding fee scale based on ability to pay?
No
29. Approximately what percentage of your patients use sliding fee schedules?
None

Populations Served

Please approximate the percentage of patients at your primary practice location that are:

30. Homeless
None
31. Migrant/Seasonal Farm Workers
Less than 10%
32. Native Americans
Less than 10%

Connecticut Prescription Monitoring and Reporting System

All prescribing practitioners possessing a Connecticut controlled substance registration (CSP) issued by the Connecticut Department of Consumer Protection (DCP) must register with the Connecticut Prescription Monitoring and Reporting System (CPMRS) online at www.ctpmp.com.

After you have completed this renewal transaction, please visit the DCP's website at www.ct.gov/dcp and select 'Programs & Services' then 'Prescription Monitoring Program' for information regarding registration.

33. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.
11/30/2016

Physician Attestation

34. Within the last year, have you been convicted of a felony?

No

35. If yes, please provide details here

36. Within the last year, have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority?

No

37. If yes, please provide details here

38. I attest that I am in compliance with the mandatory continuing education requirements and that I am in compliance with the mandatory professional liability insurance coverage requirements.

Yes

39. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.

11/30/2016

Important Note

To continue processing your renewal, please click "Add to Invoice" on the NEXT screen (read the rest of this information first).

On the top right of the invoice screen, select "**Pay Invoice**".

PLEASE NOTE THAT WHEN ENTERING YOUR CREDIT CARD NUMBER, DO NOT ENTER SPACES OR DASHES AS IT WILL RESULT IN A FAILED TRANSACTION.

Thank you for processing your renewal online.

Review
