PROVIDER APPLICATION

General Information:

Name:_____ _____ _____

Last Name *First Name* *MI* *Degree*

Have you ever used another name (including maiden name):_____

Date of Birth:_____ Gender: M - F Social Security Number:_____

NPI Number:_____ CAQH Number*:_____

Email Address: _____

Non-English languages you speak:_____ Ethnicity/Race:_____

Type of practice: PCP ___ Spec ___ Both ___ Telemedicine? Yes ___ No ___

Specialty Preferred Listing:_____ Open to new patients? Yes ___ No ___

Board Certified: Yes____ No_____ Board Name:_____ Date:_____

Internal Medicine, Family Practice, and/or Pediatrics:

Do you want to be listed as a Primary Care Provider? Yes ____ No ____

Nurse Practitioners/Physicians Assistants - do you have an independent panel? Yes___ No___

***If you participate with CAQH – no need to continue**
Submit only the above information

Primary Practice Location:

Corporate Name as shown on W-9):_____

Federal Tax ID Number:_____

Group Name:_____

Street:_____ Suite:_____

City:_____ State:_____ Zip:_____

County:_____ Telephone:_____ Fax:_____

Do you have 24 hour telephone coverage? Yes___ No___ Type of Coverage: _____

Is your office accessible by public transportation? Yes____ No___

Is your office handicapped accessible? Yes____ No___ Accepting New Patients? Yes____ No_____

Office Days/Hours:_____

Office Manager/Credentialing Coordinator & Number:_____

Billing Address:

Corporate Name:_____ DBA:_____

Street:_____ Suite:_____

City:_____ State:_____ Zip:_____

Telephone:_____ Fax:_____ Email:_____

Group Tax ID: _____ Group NPI: _____ W9 attached? Yes ___ No ___

Education & Training:

Medical Education:

Institution Name:_____

City:_____ State:_____ Country:_____

Degree:_____ Dates Attended:From:_____To:_____

Internship:

Institution Name:_____

City:_____ State:_____ Country:_____

Degree:_____ Dates Attended:From:_____ To:_____ Program Completed: Yes_ _ No_____

Residency:

Specialty_____

Institution Name:_____

City:_____ State:_____ Country:_____

Degree:_____ Dates Attended:From:_____ To:_____ Program Completed: Yes_ _ No_____

Fellowship:

Specialty_____

Institution Name:_____

City:_____State:_____ Country:_____

Degree:_____ Dates Attended:From:_____ To:_____ Program Completed: Yes_ _ No_____

Type of Practice:

Group Practice:_____ Individual Practice:_____ Hospital Based Only:_____

(If you are a member of a group practice, please attach roster)

Age range of patients you will see:_____

Are you a member of the Military Reserve or National Guard? Yes____ No____

If yes, which branch of the military?_____

Are you a TRICARE Authorized Provider? Yes____ No____

Hospital Affiliations:

Do you have hospital Privileges? Yes___ No____ (If no, type of admitting arrangements?)_____

Primary Admitting Facility:_____ From:_____ To:_____

Type of Appointment:_____ Specialty:_____

Licenses & Certificates:

Primary State License Number:_____State:_____ Expiration Date:_____

List any additional licenses (including current license(s) and history of licensure in all jurisdictions)

_____

Federal DEA Number:_____ Expiration Date:_____

CDS Registration Number (CT/NJ only):_____ Expiration Date:_____

Professional Liability Information:

Current Professional Liability Carrier:_____
Policy Number:_____ Effective/Expiration Date:_____
Amount of coverage per occurrence_____ Amount of coverage aggregate: _____
Include list of claims history: _____

Work History:

Previous Practices:

From: (mo/yr)	To: (mo/yr)	Practice Name:	Address:
_____	_____	_____	_____
_____	_____	_____	_____

Gaps in training or work history that are longer than three months? Yes____ No____
Gap start date_____ Gap end date_____
Explanation:_____

We also ask that you submit a current copy of your CV

Professional Questions:

Please Note: If you respond "yes" to any of the questions listed below; a detailed explanation is required.

1. Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? Yes ___ No ____

2. Has there been any challenge to your licensure, registration or certification? Yes ___ No ____

3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? Yes ___ No ____

4. Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?
   Yes ___ No ____

5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?
   Yes ___ No ____

6. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, Fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?
   Yes ___ No ____

7. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?
   Yes ___ No ____

8. Have any of your board certifications or eligibility ever been revoked? Yes ___ No ____

9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?
   Yes ___ No ____

10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?
    Yes ___ No ____

11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?
    Yes ___ No ____

12. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?
    Yes ___ No ____

13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?
    Yes ___ No ____

14. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?

Yes ___ No ____

15. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?

Yes ___ No ____

16. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?

Yes ___ No ____

17. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*

Yes ___ No ____

18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?

Yes ___ No ____

19. Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?* (If yes, provide information for each case.)

Yes ___ No ____

20. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?

Yes ___ No ____

21. In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*

Yes ___ No ____

22. Have you ever been court-martialed for actions related to your duties as a medical professional?

Yes ___ No ____

23. Are you currently engaged in the illegal use of drugs? Yes ____ No ___

("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? Yes ___ No _____

25. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?

Yes ___ No ____

26. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?

Yes ___ No ____

Disclosure questions- Answer all questions. For any "Yes" response, provide an explanation.

Additional Practice Locations:

Corporate Name as shown on W-9): _____

Federal Tax ID Number:_____

Street:_____

City:_____State:_____Zip:_____

County:_____Telephone:_____Fax:_____

Do you have 24 hour telephone coverage? Yes No Type of Coverage:__

Is your office accessible by public transportation? Yes No___

Is your office handicapped accessible? Yes No___

Languages Spoken:_____

Office Hours:_____

Office Manager Name/Number:_____

Credentialing Coordinator/Number:_____

****

Corporate Name as shown on W-9):_____

Federal Tax ID Number:_____

Street:_____

City:_____State:_____Zip:_____

County:_____Telephone:_____Fax:_____

Do you have 24 hour telephone coverage? Yes No Type of Coverage:__

Is your office accessible by public transportation? Yes No___

Is your office handicapped accessible? Yes No___

Languages Spoken:_____

Office Hours:_____

Office Manager Name/Number:_____

Credentialing Coordinator/Number:_____

Consent to Release Information/Attestation

I hereby understand and agree that, as part of the credentialing application process for participation with US Family Health Plan (hereinafter, referred to as "USFHP") I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by USFHP for determining initial and ongoing eligibility for Participation. USFHP and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that USFHP has its own criteria for acceptance, and I may be accepted or rejected. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that USFHP will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with USFHP is not an application for employment with USFHP and that acceptance of my application by USFHP will not result in my employment by USFHP.

Authorization of Investigation Concerning Application for Participation. I hereby authorize USFHP including, without limitation, their representatives and/or designated agents; and USFHP designated professional credentials verification organization, to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow USFHP to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to USFHP information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, USFHP. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to USFHP. I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless USFHP for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of USFHP in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue USFHP for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such USFHP in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to USFHP and SVCMC affiliates. USFHP retains the right to allow access to the application information for purposes of a credentialing audit their auditors to the extent required in connection with an audit of the credentialing processes and provided that their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at USFHP. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by USFHP or grounds for my termination of Participation at or with USFHP. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I hereby attest that information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify USFHP within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by USFHP, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that USFHP will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to USFHP. I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Print Name:_____

Signature:_____ **Date:**_____