NORCAL Mutual Insurance Company

CPG ADD HEALTH CARE PROVIDER FORM

Name of Clinic/Organization (please print) _____ **Policy Number** _____

Directions: Please complete this form to request that a health care provider be endorsed onto the clinic's/organization's NORCAL policy. Use the Remarks section if you need additional space or attach additional pages as necessary. Please ensure that you sign and date the form on page 2.

NOTE: If this is a request to add a health care provider who is administering anesthesia (other than topical or by means of local infiltration) or performing deliveries, abortions and/or any procedure specified as an intermediate procedure or surgery, oral surgery or major surgery, he or she must also complete and submit the CPG Health Care Provider Application.

1. Please identify the effective date of the addition:

   _____ 12:01 a.m. Local Time
   Month Day Year

2. Please complete the following regarding the health care provider:

   Name: _____
   Last First Middle

   Date of Birth (mm/dd/yy): _____

   Provider Type: ☐ MD ☐ DO ☐ DDS ☐ DMD ☐ Certified Registered Nurse Anesthetist
   ☐ Certified Nurse Midwife ☐ Direct-Entry/Licensed Midwife ☐ Nurse Practitioner
   ☐ Perfusionist ☐ Physician Assistant ☐ Podiatrist

3. If the health provider is a physician, please identify each medical specialty/field of medicine in which the physician will practice and the percentage of practice that will be devoted to each. **NOTE:** The percentage total must equal 100%.

   Primary specialty/field of medicine: _____ _____ %

   Additional specialty/field of medicine: _____ _____ %

   Additional specialty/field of medicine: _____ _____ %

4. Please complete the following regarding *all* states where the provider is or has been licensed to practice as a health care professional.

State	**License Type** (for example, Physician, PA or RN)	**License Number**	**Current Status**
			☐ Active – Permanent ☐ Active – Temporary ☐ Inactive
			☐ Active – Permanent ☐ Active – Temporary ☐ Inactive
			☐ Active – Permanent ☐ Active – Temporary ☐ Inactive

5. Please identify the status that the health care provider will maintain with the clinic/organization:

☐ Employee ☐ Independent Contractor ☐ Volunteer ☐ Leased Worker ☐ Other (specify): _____

NOTE: A locum tenens health care provider is one who will serve as a *temporary substitute* for a health care provider currently insured under the clinic's/organization's policy.

6. Will the health care provider be a locum tenens? ☐ **Yes** ☐ **No**

If yes, please provide the name(s) and designation(s) of the current health care provider for whom this individual will be serving as a temporary substitute and the applicable date(s):

Name and Designation: _____ Dates (mm/dd/yy): _____

Name and Designation: _____ Dates (mm/dd/yy): _____

Name and Designation: _____ Dates (mm/dd/yy): _____

7. Will the addition of the health care provider change the clinic's/organization's annual number of procedures or surgeries performed or services provided? ☐ **Yes** ☐ **No**

If yes, please complete and submit a CPG Procedures and Services Supplemental Form.

REMARKS

Beneath "Question Number," please indicate the question number and, if applicable, the letter (for example, 2 or 3b):

Page Number	Section Number	Question Number	Remarks

Please provide any additional information material to the risk that has not otherwise been addressed in this form:

REPRESENTATIONS AND WARRANTIES

NOTE: "Warrant" in the following statement is not applicable to Arizona or New Mexico clinics/organizations. By statute, Arizona or New Mexico clinics/organizations are only required to represent the truth of their statements and information.

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my clinic's/organization's or the applicable health care provider's coverage. I agree to notify NORCAL Mutual Insurance Company immediately if the practice changes in any way and of any change in the information contained in this form.

_____ _____

Signature of Clinic's/Organization's Authorized Representative Date

_____

Print Name

Save Document **Print Document** **Clear Document**