PROVIDER CREDENTIALING APPLICATION

Please return this application and any current and applicable supporting documents within thirty (30) days. This application is not complete until all requested information is received.

- ☐ Copy of current unexpired **state license** (*include date issued*)
- ☐ Copy of **board certificate** (*if board certified*)
- ☐ Copy of **ANCC certificate** (*nurses*)
- ☐ Copy of **ACNM certificate** (*nurse midwife*)
- ☐ Copy of **NCCPA certificate** (*physician assistant*)
- ☐ Copy of **AANA certificate** (*nurse anesthetist*)
- ☐ Copy of current unexpired **DEA certificate** (*must indicate current practice location*)
- ☐ Copy of current unexpired state **controlled substances license** (*must indicate current practice location*)
- ☐ Copy of current unexpired **malpractice declaration sheet** (*evidence of professional liability insurance which indicates coverage limits and expiration dates*)
- ☐ Updates **resume/ curriculum vitae** (*use month and year to indicate time for education, training and work history, all gaps in time must be accounted for*)

Please ensure that the attestation and release forms are signed and dated. If the application is not complete, signed and dated, it is not considered complete and will not be processed until all information is received.

Each applicant has the right to review, upon request to the NetCare Life & Health Insurance Company's Credentialing Department, the information submitted and obtained in support of his or her credentialing application.

NetCare
Life & Health Insurance

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Provider Information

Provider Name: _____ Social Security Number: _____

Gender: _____ Date of Birth: _____ Individual NPI: _____

Military Branch: _____ Medicare UPIN: _____

Military Guard/ Reserve/ Member: _____

Specialties

Specialty: _____ Type: _____

Please List Additional Specialties: _____

_____

_____

Board(s)

Specialty Board Name: _____ Board Status: _____ Expiration Date: _____

Certification Date: _____

License(s)

	State:	License Description:	Status:	License # :	Award Date:	Expiration Date:
DEA:						
CSR:						

Insurance

Carrier: _____ Policy # : _____

Coverage End Date: _____

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Hospital Privileges/ Work History

Type: _____ Institution Name: _____ Category: _____

Hospital Privileges/ Updates

Please review the information contained within this section and include updates below; please provide the name, appointment date and staff category below (use separate sheet if needed) :

Hospital Name: _____

Appointment Date: _____ Staff Category: _____

Work History Changes/ Updates

Please review the above information and include updates to your work history below. Please provide the employment dates and place of employment including address (use separate sheet if needed or provide a current CV) :

From: _____ To: _____

Name: _____

Address: _____

City, State, Zip: _____

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Work History Changes/ Updates

IF YOU HAVE ADDITIONAL PRIMARY LOCATIONS NOT LISTED, PLEASE PROVIDE ON A SEPARATE SHEET

Primary Address

Group NPI: _____ Medicare PIN: _____

Tax-ID: _____ Email: _____

W-9 Name: _____ PCM: _____

Group: _____

_____

_____

Primary location in the directory? ☐ Y ☐ N

Start date at this location? _____

Term date: _____

Address #: _____

Phone #: _____ Fax #: _____

Billing Address

Group NPI: _____ Medicare PIN: _____

Tax-ID: _____ Email: _____

W-9 Name: _____ PCM: _____

Group: _____

_____

_____

Primary location in the directory? ☐ Y ☐ N

Start date at this location? _____

Term date: _____

Address #: _____

Phone #: _____ Fax #: _____

Mailing Address

Group NPI: _____ Medicare PIN: _____

Tax-ID: _____ Email: _____

W-9 Name: _____ PCM: _____

Group: _____

_____

_____

Primary location in the directory? ☐ Y ☐ N

Start date at this location? _____

Term date: _____

Address #: _____

Phone #: _____ Fax #: _____

Phone number for Primary Practice location is for Appointments only Fax number for Primary Practice location is for Referrals/ Authorizations only

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A written explanation is required for any question(s) answered "yes." Please provide the explanation on a separate sheet. If you do not provide the information, your application approval will be delayed and could result in denial for non-compliance by the NetCare Life and Health Insurance Co. Credentialing Committee.

1. Has your license to practice medicine in any jurisdiction been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, otherwise limited or restricted, or been made subject to a program of probation, or have you been issued a citation or letter of reprimand by the licensing agency, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced in the last three years? ☐ **Y** ☐ **N**

2. Has your medical staff membership or medical staff status at any hospital or comparable facility, been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care of professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced in the last three years? ☐ **Y** ☐ **N**

3. Have your admitting or clinical privilege(s) at any other hospital, or at any comparable acute or long term care facility, or ambulatory surgery center or comparable facility, been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care of professional conduct reasons, or have formal or informal proceedings, or investigations toward any of those ends ever been commenced in the last three years? ☐ **Y** ☐ **N**

4. Have you voluntarily or involuntarily relinquished medical staff membership or status, admitting or clinical privileges, withdrawn an application for membership or privileges at any hospital or comparable acute or long term care facility, or ambulatory surgery center or comparable facility, after notification of the actual or imminent commencement of a formal or informal review, or investigation of your practice, credentials or professional conduct in the last three years? ☐ **Y** ☐ **N**

5. Has your membership, participation, privileges, contractual affiliation or other status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization or any other comparable health care entity been denied, revoked, voluntarily or involuntarily terminated, suspended, restricted or limited based upon patient care of professional conduct grounds, or have formal or informal proceedings, or investigations toward any of those ends been commenced in the last three years? ☐ **Y** ☐ **N**

6. Have you voluntarily or involuntarily relinquished membership, participation, privileges, a contractual affiliation or other comparable status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization or any other comparable health care entity after notification of the actual or imminent commencement of a formal or informal review or investigation, of your practice or professional conduct in the last three years? ☐ **Y** ☐ **N**

7. Has your membership or status in any state or local professional society or other comparable medical organization been denied, revoked, voluntarily or involuntarily terminated, suspended or restricted based upon patient care of professional conduct concerns, or have formal or informal proceedings, or investigations toward any of those ends been commenced in the last three years? ☐ **Y** ☐ **N**

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8. Has your status as a participating provider in the Medicare, Medicaid, or TRICARE programs been sanctioned, denied, suspended, voluntarily or involuntarily terminated, limited or revoked, or have formal or informal proceedings, or investigations toward any of those ends been commenced in the last three years? ☐ Y ☐ N

9. Has a letter of concern or reprimand been issued to you? ☐ Y ☐ N

10. Have you been denied professional liability insurance or has your policy been canceled in the last three years? ☐ Y ☐ N

11. (a) Have you been named in a complaint based on allegations of professional negligence or professional misconduct or have you received notice of intent to commence litigation of that type in the last three years? ☐ Y ☐ N
(b) With regard to any suit, has it resulted in a judgment, settlement or other final disposition, or is it still pending?

12. Does your professional liability coverage exclude you from performing any specific procedure(s) or practicing portions of your specialty for which you are requesting privileges? ☐ Y ☐ N

13. Has your specialty board certification or eligibility been denied, revoked, voluntarily or involuntarily terminated, suspended, or have formal or informal proceedings or investigations toward any of these ends been commenced in the last three years? ☐ Y ☐ N

14. Has your Drug Enforcement Agency or other controlled substances authorization been denied, revoked, voluntarily or involuntarily terminated, suspended or restricted or have formal or informal proceedings, or investigations toward any of those ends been commenced in the last three years? ☐ Y ☐ N

15. Have you been convicted of a criminal offense (other than a minor traffic violation, felony, fraud, narcotics offense, moral or any type of ethical crime in the past three years? ☐ Y ☐ N

16. Are you now or have you been addicted to a controlled substance or alcohol in the past three years? If the answer is yes, please provide the name, address and full description of any rehabilitation program in which you are now participating or in which you have participated as well as the name and title of the individual who can describe your care and participation in that program. ☐ Y ☐ N

17. Has a letter of concern or reprimand been issued to you? ☐ Y ☐ N

18. Do you have any mental or physical impairment or disability that could, without reasonable accommodation, that may significantly affect your ability to practice medicine or provide care to accepted standards of professional performance or poses a threat to the health or safety of your patients? ☐ Y ☐ N

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Attestation and Release

I attest to the fact that all the information submitted by me in this application is true and accurate to the best of my knowledge and belief.

I authorize NetCare Life and Health Insurance Co., its professional staff and legal representatives for the purpose of evaluating my professional competence, character, criminal history and ethical conduct, to contact and consult with administrators and members institution, professional society, school, employer, law enforcement agency, or practice with which I have been associated. In addition, I consent to the inspection by NetCare Life & Health Insurance Co., its professional staff and legal representatives of all records and documents, including health records at other treatment facilities that may be material for evaluation of my professional qualifications. I also release from liability all individuals or organizations for their acts performed in good faith and without malice that initiate and respond to the inquires authorized for use by NetCare Life & Health Insurance Co. I agree that a photocopy of this authorization be accepted with the same authority as the original.

Signature: _____ **Date:** _____