Care1st/ONECare
Credentialing/Recredentialing
Application

PERSONAL INFORMATION

Last Name	First Name	MI	Degree	Male ☐ Female ☐
List other names you have used				
Primary Professional Specialty				
Secondary Professional Specialty				
DOB	DEA	Tax ID #		
UPIN	Medicare #	AHCCCS I.D		
NPI	SSN			

OFFICE ADDRESS/CREDENTIALING CONTACT INFORMATION

PRIMARY ADDRESS (Physical location where services are performed)	Group Practice Name:				
	Address:		City:	State:	Zip Code:
	Phone:	Fax:	County:	Office Hours:	

ADDITIONAL OFFICE (Indicate other additional offices on an attached sheet)	Group Practice Name:				
	Address:		City:	State:	Zip Code:
	Phone #:	Fax #:	County:	Office Hours:	

CREDENTIALING CONTACT	Name:			
	Address:		City:	State:
	Zip Code:	Phone #:	Fax #:	

LICENSURE INFORMATION

State	License Number	Issue Date / /	Expiration Date / /
Date First Licensed In Arizona / /		License Number	
Date First Licensed in United States / /		License Number	State First Licensed

PROFESSIONAL LIABILITY INSURANCE (attach copy of face sheet of current policy)

Name of Carrier	Policy Number
Address	Amounts of Coverage
Issue Date	Expiration Date

EDUCATION/TRAINING (Put dates in month/year format)

Institution Name	Month/Year Format
Institution Name	Month/Year Format
Institution Name	Month/Year Format

WORK HISTORY (LAST 5 YEARS)

Current	Month/Year Format
Previous	Month/Year Format
Previous	Month/Year Format
Previous	Month/Year Format
Previous	Month/Year Format

CURRENT HOSPITAL AFFILIATIONS

	Status	Dates of staff membership
Primary Admitting Hospital		
Additional Hospital		
Additional Hospital		
Additional Hospital		

CONFIDENTIAL QUESTIONNAIRE (Please answer "yes" or "no" to each of the questions below)

If the answer to any of the following questions is "yes," please attach a separate sheet of paper with a detailed explanation.

		YES	NO
1.	Have you ever had a malpractice lawsuit filed against you?		
2.	Have you ever settled a malpractice lawsuit filed against you? Indicate amounts $ if any.		
3.	Have you ever had a judgment rendered against you in a malpractice lawsuit? ? Indicate amounts $ if any.		
4.	Has your license to practice medicine in any jurisdiction ever been limited, suspended, revoked, denied, or subjected to probationary conditions or have proceedings toward any of those ends ever been instituted against you?		
5.	Have you ever been convicted of, pled no contest to or pled guilty to any crime related to your professional practice?		
6.	Have you ever had an application for membership or privileges at a hospital or other health care facility denied, granted with limitations, limited, suspended, revoked, not renewed, subjected to probationary conditions or have any such actions ever been recommended by a standing medical staff committee or governing board of a hospital or other health care facility?		
7.	Have you ever been denied membership or renewal thereof or been subject to any disciplinary action in any national, state or local medical organizations or professional society or have proceedings toward any of those ends ever been instituted against you?		
8.	Has your specialty board certification or eligibility ever been denied, revoked, relinquished, not renewed, suspended, or reduced or have proceedings toward any of those ends ever been instituted against you?		
9.	Has your Drug Enforcement Administration certificate or any other controlled substances authorization, permit or license ever been denied, revoked, suspended, reduced, or not renewed or have proceedings toward any of those ends ever been instituted against you?		
10.	Have you ever voluntarily relinquished a medical staff membership, a clinical privilege, a professional license or a narcotics registration permit under threat of disciplinary action?		
11.	Have you ever been convicted of a felony?		
12.	Have you ever been expelled or suspended from receiving payment under the Medicare/Medicaid programs?		
13.	Is your physical or mental condition such that it may impair your ability to practice?		
14.	Do you currently have any physical or mental condition which would impair your ability to perform your professional duties with or without accommodation?		
15.	Are you currently engaged in illegal use of controlled dangerous substances?		
16.	Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you?		

DECLARATION

I, do hereby certify under penalty of perjury that all information submitted by me and contained in this application is correct and complete in all material respects to the best of my knowledge and belief. I fully understand that any misstatement in or omission from this application constitutes cause for denial of appointment or cause for summary dismissal from provider membership.

RELEASE OF LIABILITY AND INFORMATION STATEMENT

I, do hereby grant to Care1st Health Plan Arizona, Inc. (Care1st) and/or Medilert-IRIS and/or its authorized agents, permission to consult with hospitals, members of hospital medical staffs, professional liability carriers for claims history and coverage information, managed care organizations and other persons or entities to obtain information concerning my qualifications, including without limitation my professional competence and conduct. I consent to the release to Care 1st Health Plan of Arizona and/or Medilert-IRIS of any and all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions and information that might otherwise be considered confidential or privileged.

I hereby release Care1st and/or Medilert-IRIS, its employees and/or its authorized agents, from any and all liability or expense which is incurred by Care1st and/or Medilert-IRIS, its employees or its authorized agents, due to the release of any of the information described in this Practitioner Application to any purchaser of health care services or to any representatives of local, state and federal governmental agencies.

I release from liability and hold harmless any and all individuals and organizations who provide information to a hospital or its medical staff or their representatives or agents and Institutions and Professional Organizations, concerning my professional competence, ethics, and character when such information is given in good faith and without malice.

I agree to immediately notify Care1st upon any investigation, revocation, reduction, termination, denial, limitation or suspension of my DEA number, professional license, professional liability insurance, participation in the Medicare or Medicaid programs or other certification and/or other credentials authorizing me to practice medicine. I also agree to immediately notify Care1st upon termination, suspension or revocation of my staff privileges at any hospital or health care facility.

Name	Signature	Current Date
Please Print or Type		

FAX TO: Care1st Provider Network Operations 602.778.1875 **QUESTIONS: 602.778.1800 (Options in order 5, 7)**