

Please attach the following documents to this completed application and return.

- ___ Copy of current state(s) license
- ___ Copy of current DEA (federal) certificate
- ___ Copy of other applicable narcotic certificate
- ___ Copy of current professional liability insurance (face sheet)
- ___ Copy of participation in State Compensation Fund (if applicable)
- ___ Copy of current Curriculum vitae
- ___ Copy of W-9 form



Practitioner Initial Application Form

INSTRUCTIONS

Please complete all sections of this application. If a section is not applicable, mark it N/A. Please print or type information. If there are any questions, please contact the representative listed on the cover letter accompanying this application.

GENERAL INFORMATION

CAQH Number _____

Name _____
First MI Last Degree

Any other name under which you have been known? _____

Birth date _____ Social Security Number _____ Gender M F

Medicare Provider Number _____ Medicaid Provider Number _____ UPIN _____ NPI _____

Please indicate the participation status for which you are applying:

Primary Care Provider Family Practice Internal Medicine Pediatrics General Practice

Specialty Care Provider Please indicate specialty _____

Other Health Professional Please indicate type: _____

Are you Board Certified? Yes No **Name of Specialty Board** _____

If not board certified by any division of ABMS, AOA, ABPS, ABOPM, or ADA, please attach a brief statement on why you have not taken your boards and if you plan to do so.

Practice Interests:

Provide additional areas of professional practice interest, activities, procedures, diagnoses or populations.

PRIMARY OFFICE INFORMATION

Type of Practice Solo Multispecialty Group Single Specialty Group Hospital-based

Include your specialty and/or subspecialties listed above in the Directory for this location? Yes No

Date you started at this practice Mo/Yr _____

Office Name _____ Tax ID Number _____

Address _____

City/State/Zip _____ County _____

Telephone number _____ Fax _____ E-mail _____

Office Manager/Contact _____ Phone _____

Emergency/After hours contact phone number _____

I treat work-related injuries/illness (if yes, please complete workers' Compensation Questionnaire) Yes No

Are you currently accepting new patients at this location? Yes No

What hours are you available to see patients in this office?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From/To							

Age group(s) treated 0-11 years 12-18 years 19-65 years over 65 all ages

List foreign languages spoken by provider _____

List foreign languages spoken by office staff _____

Is this office accessible by public transportation? Yes No

What is the average waiting time to obtain an appointment in your office for:

Elective visits _____ Physical Exams _____ Urgent Problems _____

The American with Disabilities Act includes certain requirements for public accommodations to ensure effective communication. Is a sign language interpreter or teletype available in this office for your hearing impaired patients? Yes No

SECONDARY OFFICE INFORMATION

Type of Practice Solo Multispecialty Group Single Specialty Group Hospital-based

Include your specialty and/or subspecialties listed above in the Directory for this location? Yes No

Office Name _____ Tax ID Number _____

Address _____

City/State/Zip _____ County _____

Telephone number _____ Fax _____ E-mail _____

Office Manager/Contact _____ Phone _____

Emergency/After hours contact phone number _____

I treat work-related injuries/illness (if yes, please complete workers' Compensation Questionnaire) Yes No

Are you currently accepting new patients at this location? Yes No

What hours are you available to see patients in this office?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From/To							

Age group(s) treated 0-11 years 12-18 years 19-65 years over 65 all ages

List foreign languages spoken by provider _____

List foreign languages spoken by office staff _____

Is this office accessible by public transportation? Yes No

What is the average waiting time to obtain an appointment in your office for:

Elective visits _____ Physical Exams _____ Urgent Problems _____

The American with Disabilities Act includes certain requirements for public accommodations to ensure effective communication. Is a sign language interpreter or teletype available in this office for your hearing impaired patients? Yes No

Additional Offices: Yes No If yes, attach a list of additional offices with same information as requested for primary office.

CREDENTIAL OFFICE AND ADDRESS

Same as Primary office Yes If No, please complete the following.

Contact Person _____ Phone _____
Address _____ Fax _____
City/State/Zip _____ e-mail _____

BILLING OFFICE AND ADDRESS

Same as Primary office Yes If no, please complete the following. If claims are to be paid to each office where services are rendered, please indicate on a separate page.

Name _____ Phone _____
Address _____ Fax _____
City/State/Zip _____ Federal TIN _____
Contact Person _____

The American with Disabilities Act includes certain requirements for public accommodations to ensure effective communication. Is a sign language interpreter or teletype available in this office for your hearing impaired patients? Yes No

PARTNERS IN GROUP/CALL COVERAGE

Please list all members of your group and indicate if they participate with First Health. Attach a separate page if necessary.

Name	Specialty	Participation with First Health	
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

24-hour, 7-days-a-week coverage is required. Please describe after-hour arrangements and list your covering physicians by name. Covering physicians should be participating providers in the plan or agree to the fees and administrative procedures of the network. Please list all of the physicians that provide call coverage for you. If they are all in your practice group you may attach a sheet of letterhead that lists each physician with his/her specialty.

Name	Specialty	Participation w/First Health	
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Address _____		Phone _____	
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Address _____		Phone _____	
_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Address _____		Phone _____	

Please notify the Plan in writing of any changes within 30 days.

Does the above call coverage also apply to your hospitalized patients? Yes No If no, explain:

EDUCATION and TRAINING

Please provide the following information and account for all time from medical school to present. A curriculum vitae which includes the information requested may be attached in lieu of completing these two sections. If a CV is substituted dates (mo/yr) in chronological order must be included. Work history must be identified from completion of education/training through present. **Please explain any gaps of 6 months or more in writing.**

Medical School

Institution Name _____

Address _____

Attended from (Mo/Yr) _____ to (Mo/Yr) _____ Degree Awarded _____

Foreign Medical School Graduates

ECFMG Number _____

Are you certified by the Education Council for Foreign Medical Graduates? Yes No

Internship/PGY I

Institution Name _____ Affiliated Hospital _____

Address _____

Attended from (Mo/Yr) _____ to (Mo/Yr) _____ Type of Residency _____

Did you complete program? Yes No If no, when will you complete program? Mo/Yr _____

Residency #1

Institution Name _____ Affiliated Hospital _____

Address _____

Attended from (Mo/Yr) _____ to (Mo/Yr) _____ Type of Residency _____

Did you complete program? Yes No If no, when will you complete program? Mo/Yr _____

Residency #2

Institution Name _____ Affiliated Hospital _____

Address _____

Attended from (Mo/Yr) _____ to (Mo/Yr) _____ Type of Residency _____

Did you complete program? Yes No If no, when will you complete program? Mo/Yr _____

Fellowship Training

Institution Name _____ Affiliated Hospital _____

Address _____

Attended from (Mo/Yr) _____ to (Mo/Yr) _____ Specialty _____

Did you complete program? Yes No If no, when will you complete program? Mo/Yr _____

WORK/PRACTICE HISTORY

Practice Name _____

Location _____

From (Mo/Yr) _____ To (Mo/Yr) _____

Practice Name _____

Location _____

From (Mo/Yr) _____ To (Mo/Yr) _____

If you need additional space, please continue on a separate piece of paper.

LICENSURE

Medical and/or Professional (list all states in which you currently practice)

License Number _____ State _____

License Number _____ State _____

License Number _____ State _____

NARCOTIC(S) CERTIFICATION

DEA (Federal) Number _____ Exp. Date _____

Other applicable narcotic certificate:

Certificate Number _____ State _____ Exp. Date _____

If you do not possess a DEA certificate, please provide a brief explanation of why you do not need one.

PROFESSIONAL LIABILITY INSURANCE

Your current professional liability insurance certificate (face sheet) showing carrier name, liability limits, and expiration date of policy should be supplied.

If applicable, do you participate in the state compensation fund? Yes No

HEALTH CARE FACILITY AFFILIATIONS

Please list all health care facilities (official name) with which you currently have clinical privileges. Please provide the complete mailing address for each facility.

Primary Facility Name _____ Address _____

Additional Facility _____ Address _____

Additional Facility _____ Address _____

Additional Facility _____ Address _____

CONFIDENTIAL/PERSONAL INFORMATION

1. Have there ever been any misdemeanor or felony criminal charges brought against you? Yes No
In answering this question, you may disregard most traffic offenses, but you should answer affirmatively if you have been charged with driving a motor vehicle under the influence of intoxicating liquor or narcotic substance, regardless of whether that charge was later reduced to a lesser offense.
2. Have you ever had your board certification, involuntarily revoked, or failed to recertify? Yes No
3. Have you ever had any of the following items involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items?
- A. State license Yes No
 - B. DEA registration or other applicable narcotic registration Yes No
 - C. Hospital or other health care facility staff membership or clinical privileges Yes No
 - D. Professional organization membership Yes No
 - E. Medicare, Medicaid, local, state, and/or federal government program participation Yes No
 - F. HMO, PPO, or other health plan participation Yes No
 - G. Other regulatory agency (OSHA, etc) Yes No
4. Do you have any physical or mental health condition, with or without accommodation, which in any way impairs your ability to practice or in any way poses a risk of harm to your patients? Yes No
5. Are you currently involved in illegal drug use? Yes No

If you answered "Yes" to questions 1-5, please explain completely on a separate sheet of paper and attach to this application.

6. Will you participate, to the extent feasible, in the committee system and review function of our organization? Yes No
7. Would you be available, if needed, to provide educational programs in your specialty for members of First Health? Yes No
8. Do you understand that subject to proper confidentiality restrictions and authorizations, your office medical records might be subject to on site review by First Health representatives for peer review, utilization review, and quality assurance purposes? Yes No

9. Affiliations with other health plans? Please list:

MEDICAL MALPRACTICE CLAIMS HISTORY

1. In the past five years, has your professional liability insurance coverage ever been denied, cancelled, or not renewed? Yes No
2. Are you or have you ever been involved in a malpractice suit(s), grievance(s) filed with county or state medical society or licensing agency, or arbitration proceeding(s)? Yes No
3. In the last five years, has your current or any previous professional liability carrier ever made an out-of-court settlement or paid a judgment of professional liability claim on your behalf? Yes No

If you answered 'Yes' to questions 1-3 please supply the following information. Copy this page and complete for each occurrence. A prepared statement which includes the requested information is acceptable.

What was/is your role in the case?

___ Primary defendant ___ Co-defendant ___ Other, please explain

Case number _____ Carrier name _____

Date of incident ___/___/___ Date filed ___/___/___ Date closed ___/___/___

What is the case status?

___ Dropped ___ Settled out of court ___ Dismissed ___ Pending

___ Found for defendant ___ Found for plaintiff ___ Other, please explain

If pending, when was the last contact with the Plaintiff's attorney? _____

If damages were paid, either by settlement or court award, what was the amount?

Attributed to your involvement \$ _____ Paid by all parties \$ _____

Please explain in detail (if an item does not apply please state N/A).

1. What is the alleged harm to the patient?
2. What were you alleged to have done incorrectly or failed to do?
3. Describe the patient's illness and related effects of the alleged harm?
4. Describe any other details you believe are pertinent to the case.
5. Identify any other parties named in the suit.

All information is held in strict confidence and used for credentialing purposes only. Failure to supply requested information may prevent your application from being accepted.

CONSENT FOR RELEASE OF INFORMATION/RELEASE FROM LIABILITY

I hereby affirm and attest that all statements, answers, attached copies, and information contained in this application are correct and complete to the best of my knowledge, information, and belief. I understand that falsification, misrepresentation, or omission of any fact(s) requested will be sufficient cause for denial of this application and/or subsequent termination of any participating privileges granted upon the basis of this application.

I hereby give permission to First Health, its affiliates and the employees, agents and representatives thereof to obtain information about my professional education, training, licensing, competence, ethics, character and other qualifications. I consent to the release of such information, whether in the form of transcripts, records, tapes, letters, photocopies/duplications of any of the foregoing, or verbal statements, by hospital administrators, chiefs of clinical departments of hospitals in which I have served on staff, state licensing boards or regulatory bodies (by whatever name known in their respective jurisdictions), physicians, clinics, or other individuals or organizations who or which possess information about me. Such information may be released to the above named entity and its affiliates or to representatives of such entity and its affiliates.

I hereby release from liability and agree to hold harmless any person or entity who or which provides the above described information as authorized herein.

I hereby release from liability and agree to hold harmless all employees, agents and representatives of the above named entity and its affiliates for their acts performed and statements made in connection with obtaining, reviewing and evaluating my credentials and qualifications. I further acknowledge my cooperation by consenting to the production of such information about me as a provider of services to their members or enrollees. The determination of whether I am qualified to serve as a provider of services is the reason such information is needed for review and evaluation by the above named organization and their representatives.

In the event I am accepted for participation in First Health, I hereby consent to First Health's inspection of my patient records relating to First Health enrollees as necessary for its peer, utilization, and quality review processes and agree to be bound by First Health's provider agreement, credentialing plan and provider manual.

I further agree that a photocopy of this document will serve as a duplicate original.

Print name _____

Signature _____

Date _____

HealthCare practitioners have the rights to:

- Request status of application
- Correct erroneous information
- Review information submitted to support the credentialing application
- Notification of these rights