SC Uniform Managed Care Provider Credentialing Application

I. PERSONAL INFORMATION

Solo Practice or Group Practice

Name: Last First M.I. Suffix Degree

Maiden and/or other name:

(List W-9 Name if different)

Place of Birth: (City) , (State) Date of Birth:

If you are not a U.S. Citizen, do you have authorization to work in the U.S.? Yes No

Male Female (*OPTIONAL). This information will not be used by the Managed Care Organization in making its determination regarding your participation*.

Social Security Number: NPI: UPIN Number:

Practice Name:

Tax ID Number: Group NPI:

E-mail address of practitioner:

II. MEDICAL LICENSE/REGISTRATION

A. If you are a family practitioner, do you offer OB care? Yes No

B. Do you speak any foreign language fluently that you would like added to the directory? Yes No

If yes, please specify:

C. ECFMG Number:

Current Professional License Number(s) (indicate if not applicable): NA

1. SC Medical License Number: Issue Date: Expiration Date:

2. Additional Medical State Licenses and Numbers:

State: License Number: Issue Date: Expiration Date:

State: License Number: Issue Date: Expiration Date:

State: License Number: Issue Date: Expiration Date:

3. DEA No.: Expiration Date: SC Cont. Drug Perm. No.: Expiration. Date:

History of Previous Licensure in all Jurisdictions (indicate if not applicable): NA

State: License Number: Issue Date: Expiration Date:

State: License Number: Issue Date: Expiration Date:

State: License Number: Issue Date: Expiration Date:

III. EDUCATION/TRAINING/HOSPITAL PRIVILEGES

1. Medical School Institution:

City: State: Country:

Date of Entry: Graduation Date (MMYY): Degree:

Internship Institution: Specialty:

City: State: Country:

Program Completed: Yes No Date of Entry (MMYY): Completion Date (MMYY):

Residency Institution: Specialty:

City: State: Country:

Program Completed: Yes No Date of Entry (MMYY): Completion Date (MMYY):

Fellowship Institution: Specialty:

City: State: Country:

Program Completed: Yes No Date of Entry (MMYY): Completion Date (MMYY):

2. CME REQUIREMENTS:

Number of CME credits completed in the last two years:

3. HOSPITAL STAFF PRIVILEGES

Name:

Address:

Department: Dates of Affiliation: From (MMYY): To (MMYY):

Status of Privileges: % of Admissions:

Additional Hospital Name:

Address:

Department: Dates of Affiliation: From (MMYY): To (MMYY):

Status of Privileges: % of Admissions:

Additional Hospital Name:

Address:

Department: Dates of Affiliation: From (MMYY): To (MMYY):

Status of Privileges: % of Admissions:

If you do not admit please describe arrangements to provide hospital care:

Provider Initials: **Date:**

IV. MEDICAL SPECIALTIES

MEDICAL SPECIALTIES	CERTIFYING BOARD	DATE CERTIFIED	EXPIRATION DATE
Primary			
If not Board certified, do you plan to take certifying exam?	Yes, Date		No
Secondary			
If not Board certified, do you plan to take certifying exam?	Yes, Date		No

Under which specialty do you wish to be listed in the Directory?

Are you applying for participation as:

Primary Care Physician: Specialist: Non-Physician Practitioner:

V. MALPRACTICE INFORMATION

You are required to maintain malpractice insurance of an adequate and acceptable amount reflective of your specialty as a prerequisite for participating in a managed care organization. Please *attach* a copy of your most recent malpractice insurance binder.

List current and previous malpractice insurance carrier(s) for past five years:

CARRIER NAME/ADDRESS	POLICY NUMBER	EFFECTIVE DATE	EXPIRATION DATE	AMOUNT OF COVERAGE

VI. Five Year Work History *(CV can not be used in lieu of completing this section)*

NAME OF PREVIOUS/CURRENT EMPLOYER(S)	DATE OF EMPLOYMENT (MM/DD/YY-MM/DD/YY)
1.	
2.	
3.	
4.	
5.	

Please provide an explanation of any gaps in employment:

Signature: Date:

RUBBER STAMPED AND ELECTRONIC SIGNATURES ARE NOT ACCEPTABLE

Please print name:

VII. PLEASE ANSWER THE FOLLOWING QUESTIONS
(This section must be completed by practitioner)

Managed Care Organizations must have complete liability information and written explanations to begin the credentialing process. *(If you answer "Yes" to any of the questions listed below, please enclose a detailed explanation.)*

Question		
1. Do you have any pending misdemeanor or felony charges?	Yes	No
2. Have you ever been convicted of a felony?	Yes	No
3. Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited?	Yes	No
4. In the past five years and up to and including the present, have you had any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?	Yes	No
5. Considering the essential functions of a practitioner in your area of practice, in the past five years and up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients?	Yes	No
6. Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board?	Yes	No
7. Has your DEA certification or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?	Yes	No
8. Have any of your privileges or memberships at any hospital or institution ever been denied, suspended, reduced, revoked, not renewed or otherwise limited?	Yes	No
9. Has your participation in Medicare, Medicaid, or any other government program ever been limited, curtailed or have you voluntarily excluded yourself from any of these programs?	Yes	No
10. Has your participation in an Insurance Company network ever been limited or terminated?	Yes	No
11. In the past five years and up to the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?	Yes	No
12. In the past five years and up to and including the present, have you had or do you have any mental or physical condition or do you take any medications that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice:	Yes	No
13. Has any malpractice carrier ever made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf or are any medical malpractice suits pending against you?	Yes	No
14. Has your professional liability insurer ever placed conditions or restrictions on your coverage or ability to obtain coverage?	Yes	No

(THE ABOVE INFORMATION WILL BE HELD STRICTLY CONFIDENTIAL.)

VIII. AUTHORIZATION

I CERTIFY THAT ALL INFORMATION CONTAINED IN THIS APPLICATION AND ALL ITS ATTACHMENTS ARE ACCURATE, COMPLETE AND TRUE.

I understand that:

A. Any misrepresentation, misstatement or omission of a relevant fact in connection with this application may result in denial of my application or termination of my participation in the Managed Care Organization;

B. It is my responsibility to promptly advise the Managed Care Organization in writing within 30 days of any changes or additions to the information contained in this application;

C. All the information contained in this application, or its attachments, is subject to the Managed Care Organization's investigation and review and;

D. This is an application only and my submission of this application does not automatically result in participation with the Managed Care Organization;

NOTICE: The National Practitioner Data Bank will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating, or omitting a relevant fact in connection with your application, the rejection may be reported to The National Practitioner Data Bank.

I authorize the Managed Care Organization to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been or am currently associated, and with others, including without limit past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further consent to the inspection by agents, employees, contractors, affiliates or other representatives of the Managed Care Organization of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications.

I release from liability the Managed Care Organization and all representatives of the Managed Care Organization for their acts performed in good faith and without malice or negligence in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations who provide information to the Managed Care Organization in good faith and without malice or negligence concerning my professional competence, character and ethics. I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension, or curtailment of participation status, membership and/or privileges of any type to or from the Managed Care Organization.

NAME: ____
(print or type)

SIGNATURE: (Applicant) **DATE:**

Must be signed in ink
EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE.
Rubber Stamped and Electronic Signatures Are Not Acceptable

Practitioners have the right to review information obtained to evaluate their credentialing and recredentialing applications.

SC Uniform Managed Care Office Information

I. GENERAL INFORMATION

A. Do you accept Medicaid patients? Yes Medicaid ID number: No

B. Have you signed an agreement to participate with Medicare in the past twelve months? Yes Medicare Group ID number: No

C. Are you accepting new patients? Yes No

D. Are there any age limitations? Yes, Minimum Age: Maximum Age: No

E. Are there gender restrictions? Males Only Females Only Both/ no restrictions

Please describe any other patient limitations:

II. OFFICE INFORMATION

A. Office Address: (physical)

1. Practice Name: EIN# :
2. Street: City: County: State: (Zip)
3. Appointment Phone: Fax:
4. Office Contact Person:
5. Credentialing Contact Phone Number:
6. List of all practitioners (including physician extenders) who are at this location. Indicate (P) for Participating and (A) for applying by each name: If need more room, attach a separate sheet.

Status	Practitioner

7. Do you offer 24-hour/7-day coverage? Yes No Please describe:

8. List physicians who are not a part of your practice with whom you share call:

9. What hours are you available to see patients in this office:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From/To							

10. After hours phone number:
11. Is your office equipped with telecommunications devices for the deaf (TDD): Yes No
12. Sign language assistance available: Yes No
13. Languages spoken by office staff:
14. Handicap Access: Yes No

B. Billing Address: (if different)

1. Name claims payable to:
2. Street/PO: City: State: Zip:
3. Phone: Fax:

C. Mailing Address: (if different)

1. Street/PO: City: State: Zip:
2. Phone: Fax:

D. Office e-mail address (if any):

E. Practice Web site address (if any):

ATTACHMENT -FOR EACH ADDITIONAL SATELLITE OFFICE LOCATION, DUPLICATE THIS PAGE

A. Satellite Office Address (physical):

1. Practice Name: EIN#:
2. Street: City: County: State: Zip:
3. Phone: Fax:
4. Office Contact Person:
5. Credentialing Contact Phone Number:
6. List of practitioners (including physician extenders) who are billing at this location. Indicate (P) for Participating and (A) for applying by each name. If need more room, attach a separate sheet.

Status	Practitioner

7. Do you offer 24-hour/7-day coverage? Yes No Please describe:
8. List physicians who are not a part of your practice with whom you share call:
9. What hours are you available to see patients in this office:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From/To							

10. After hours phone number:
11. Is your office equipped with telecommunications devices for the deaf (TDD): Yes No
12. Sign language assistance available: Yes No
13. Languages spoken by office staff:
14. Handicap Access: Yes No

B. Billing Address: (if different)

1. Street/PO: City: State: Zip:
2. Phone: Fax:

C. Mailing Address: (if different)

1. Street/PO: City: State: Zip:
2. Phone: Fax:

D. Office e-mail address:

E. Practice Web site address (if any):

STANDARD AUTHORIZATION, ATTESTATION AND RELEASE

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the " List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the " Entity"), and any of the Entity's affiliated entities, 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 the Entity for determining initial and ongoing eligibility for Participation. Each Entity 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 each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) 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 the Entity and/or its Agent(s), 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, the Entity. 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 the Entity and/or its Agent(s). 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 any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or any third party 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 any Entity, any Agent(s), or any third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s), or third party in connection with the credentialing process. This release shall 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 the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentially 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 an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. 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 the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. 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 certify that all 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 the Entity and/or its Agent(s) 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 the Entity, and must be submitted online or in writing, and must n=be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity 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 the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

______________________________ ______________________________

Signature* Name (Print)*

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*REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.