CREDENTIALING APPLICATION

6995 Union Park Center, Suite 250
Cottonwood Heights, UT 84047

Phone: 801-566-9270
Fax: 801-566-6659

DEMOGRAPHIC DATA

Last Name:_________________________________ **First Name:**____________________**MI** ________

Degree: MD, DO, DC, OD, DDS, DPM, DMD, OTHER________**DOB:** ___________ **Gender: M or F**

Place of Birth:_________________ **U.S. Citizen** __YES __NO **Specialty** ____________________

ID NUMBERS:

Social Security#: _____________________________ NPI #_____________________________

State License #:_______________________________ Yr Issued:___________ Expiration Date:__________

DEA #: ___________________________________ Expiration Date:________________________

Tax ID#:(if app.) _____________________________ UPIN #: __________________________________

Medicare #: ____________ Medipass #:____________________ Medicaid #:_______________________

All other State Medical/Professional Licensure (include State, License #, Expiration Date)

____

OFFICE LOCATION:

Primary Location ___ Group Practice ___ Solo Practice

Name of Group:____

Address:____

City:____ State:_____ Zip:___________________

Phone: ( )_______________ Fax: ( )___________________

Office Manager:_________________________ Contact Info: ___________________________________

Additional Location

Address :____

City:____ State:_____ Zip:___________________

Phone: ( )_______________ Fax: ( )___________________

Other group members/partners:___________________________________

Covering physicians: ___________________________________

Do you accept "walk-ins"? __ YES __ NO

Office open to new patients? __ YES __ NO

Languages spoken in office other than English? ____________

In office lab/x-rays? __ YES __ NO

In office EKG? __ YES __ NO

In office Diagnostic testing?__YES __ NO

HOME ADDRESS:

Address:___________________________________

City:___________________________ State:______ Zip:______________

Phone: ( )__________________ Fax: ( )__________________ Email: __________________

EDUCATION

Professional School(s)

Institution Name:___________________________________

Address:___________________________________

City:___________________________ State:______ Zip:______________

Dates Attended: From____________ To_____________ Degree:____________________

Institution Name:___________________________________

Address:___________________________________

City:___________________________ State:______ Zip:______________

Dates Attended: From____________ To_____________ Degree:____________________

Internship

Institution Name:___________________________________

Address:___________________________________

City:___________________________ State:______ Zip: ______________

Dates Attended: From____________ To_____________ Type: ___ Medical ___ Surgical ___ Rotating/Flexible

Residency

Institution Name:___________________________________

Address:___________________________________

City:___________________________ State:______ Zip:______________

Dates Attended: From____________ To_____________ Specialty ____________________

Fellowship

Institution Name:___________________________________

Address:___________________________________

City:___________________________ State:______ Zip:______________

Dates Attended: From____________ To_____________ Specialty ____________________

Board Certification

Are you Board Certified? ___ YES ___ NO Specialty: ____________________

Date Certified: ____________ Name of Board: ____________________

Subspecialty: ____________________ Are you Certified? ___ YES ___ NO Date: ____________

If not certified, describe your intent for certification, if any, and date of eligibility for certification:

Qualifying Exams

ECFMG/USMLE or FLEX? (please circle one) ___ YES ___ NO

Certification Date: ____________________ Certification Number: ____________________

Do any of the following apply?

a) Dismissed from any training program? ___ YES ___ NO

b) On probation in any training program? ___ YES ___ NO

c) Had disciplinary action taken against you in any training program? ___ YES ___ NO

d) Resigned voluntarily from any training program ___ YES ___ NO

If you checked "yes" to any of the above mentioned, please explain and provide supporting documents if available:
Give name of individuals that can verify explanation whenever possible:

Name:____________________ Phone:____________________

AFFILIATIONS

Hospital Affiliations (**Please list primary admitting facility first)**

1. Name:____________________

   Appointment Dates: ____________________ Staff Status: ____________________

2. Name:____________________

   Appointment Dates: ____________________ Staff Status: ____________________

3. Name:____________________

   Appointment Dates: ____________________ Staff Status: ____________________

Have you voluntarily or involuntarily resigned or been dismissed from any facility? ___ YES ___ NO

If yes, explain: ____________________

If you do not have hospital affiliations, please provide information regarding inpatient coverage arrangements:

GAPS IN TRAINING / WORK HISTORY

Have you had any gaps in training or work history since graduation from professional school that are longer than three months in duration? ________ No ________ Yes

If yes, please explain: ____________________

EMPLOYMENT HISTORY

Please list professional employment history for the past five (5) years.

Activity/Position	Facility Program Location and Phone	Position Held From (date) To (date)

List practice interests, competencies, special procedures and training.

Practice Interest/Competencies	Associated Procedures	Training

PROFESSIONAL LIABILITY

Do you maintain current malpractice coverage? ____ Yes ____ No

Carrier Name:____

Address: ______________________________City:_____________ State:_______ Zip: ________

Policy Number: ________________________ Expiration Date: ________________________

Per Occurrence: $ ______________ Per Aggregate: $ ______________

Please list all insurance carriers for the past five (5) years.

Previous Carrier Name:____

Address: ______________________________City:_____________ State:_______ Zip: ________

Policy Number: ________________________ Expiration Date: ________________________

Per Occurrence: $ ______________ Per Aggregate: $ ______________

If you **do not** have malpractice insurance which of the following apply:

__ I maintain an unexpired irrevocable letter of credit in an amount of $______________ (please enclose copies of irrevocable letter of credit).
__ I maintain an escrow account of cash in assets in the amount of $______________ (please enclose a copy of escrow account).
__ Acting in accordance with Texas Statutes (Please attach copy of waiver)

If additional space is needed, please attach a separate sheet with information as indicated above.
Have you had any gaps in training or work history since graduation from professional school that are longer than three months in duration? ________ No ________ Yes

If yes, please explain: ____

IF THE FOLLOWING QUESTIONS ARE ANSWERED IN THE AFFIRMATIVE, PLEASE PROVIDE FULL EXPLANATION ON SEPARATE SHEET, (INCLUDE NAME AND ADDRESS OF ATTORNEY)

MALPRACTICE SUITS

Has your professional liability insurance coverage ever been denied, canceled, reduced, limited, not renewed or terminated by action of an insurance company? ___ YES ___ NO

Have any professional liability suits ever been filed against you? ___ YES ___ NO

Have any judgments or settlements been made against you in professional liability cases? ___ YES ___ NO

Are there any claims pending? ___ YES ___ NO

Date of Claim:___________________________

Nature of Claim:___________________________

Disposition of Claim: Judgment For: o Plaintiff o Defendant o Dropped Amount of Claim: $__________

Explanation:___________________________

Date of Claim:___________________________

Nature of Claim:___________________________

Disposition of Claim: Judgment For: o Plaintiff o Defendant o Dropped Amount of Claim: $__________

Explanation:___________________________

HEALTH STATUS

EXCLUDING QUESTION 1, IF THE FOLLOWING QUESTIONS ARE ANSWERED IN THE AFFIRMATIVE, PLEASE PROVIDE FULL EXPLANATION ON A SEPARATE SHEET.

1. I certify that I am in good health and have no physical or mental limitations which impair my ability to render patient care? ___ YES ___ NO
2. Have you been hospitalized at anytime during the past five (5) years for a condition which impaired your ability to render patient care? ___ YES ___ NO
3. When was your last complete physical examination?___________________________
4. Were there any findings that indicated, in any degree, an inability to render patient care? ___ YES ___ NO
5. Are you currently taking any medication that may affect either your clinical judgment or ability to otherwise render patient care? ___ YES ___ NO
6. Have you been hospitalized or treated at anytime in the past five (5) years for substance or alcohol abuse? ___ YES ___ NO
7. Are you currently under any limitations in terms of your ability or availability to render quality patient care? ___ YES ___ NO
8. Do you have any chronic illness which affects your ability to render quality patient care? ___ YES ___ NO

If yes, please explain:___________________________

DISCIPLINARY ACTIONS

IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED IN THE AFFIRMATIVE, PLEASE PROVIDE FULL EXPLANATION ON A SEPARATE SHEET.

1. Has any action ever been taken against your license to practice in any state or jurisdiction including but not limited to denial, suspension, revocation, restriction, limitation, probation or reprimand, or have you ever voluntarily or involuntarily relinquished your license? ___ YES ___ NO

2. Has an application for privileges or your existing privileges at any hospital ever been denied, suspended, revoked, or have you ever voluntarily or involuntarily relinquished privileges at any hospital in lieu of disciplinary or peer review action or investigation? ___ YES ___ NO

3. Have you ever agreed to have your privileges or medical staff appointment at any hospital limited, reduced, or terminated? ___ YES ___ NO

4. Are you aware of any investigation by a state or any governmental licensing authority concerning your license? ___ YES ___ NO

5. Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (i.e. Medicare, Medicaid, HMO's, PPO's, etc)? ___ YES ___ NO

6. Have you ever been reported to the National Practitioner Data Bank for any adverse action or any malpractice insurance payment? ___ YES ___ NO

7. Have you ever been censured by a Medical Society or other Professional Society or other professional board or association? ___ YES ___ NO

8. Have you ever had your Drug Enforcement Administration number (DEA#) restricted, suspended, revoked or otherwise limited or DEA license application refused? ___ YES ___ NO

9. Have you ever been required or agreed to pay civil monetary penalties under Medicare or Medicaid? ___ YES ___ NO

10. Have you ever been convicted of a criminal offense other than minor traffic violations? ___ YES ___ NO

11. Has any hospital or facility ever, as a disciplinary action a) withdrawn permission for you to perform specific procedures, tests, or treatments; b) required that another peer (physician or professional) evaluate any patients before you performed a treatment, procedure or test; c) required another peer (physician or professional) to be physically present when you examined a patient or performed any treatments, procedures or tests; and/or d) initiated any action against you in any of these preceding three areas by formal notice to you or your representatives? ___ YES ___ NO

12. Are you now an active or habitual user of narcotics, barbiturates, hypnotic, amphetamines, cocaine, benzodiazepines, or other controlled or illegal substance? ___ YES ___ NO

13. Are you addicted to the consumption of alcoholic beverages? ___ YES ___ NO

REFERENCES

PLEASE PROVIDE THE NAMES AND COMPLETE ADDRESS, TELEPHONE AND FAX NUMBERS OF PROFESSIONAL REFERENCES FAMILIAR WITH YOUR CURRENT CLINICAL PRACTICE. (cannot be partners or family members)

Name: ____ Phone: ______________

Address: ___________________________________ **Fax:** ______________________

City: _______________________________________ State: _____ Zip: ______________

Name: ____ Phone: ______________

Address: ___________________________________ **Fax:** ______________________

City: _______________________________________ State: _____ Zip: ______________

Name: ____ Phone: ______________

Address: ___________________________________ **Fax:** ______________________

City: _______________________________________ State: Zip: ____________________

ATTESTATION STATEMENT

I hereby agree to abide by the Bylaws, Rules and Regulations of **Wise Provider Networks.** Further I agree to accept the professional obligations therein reflected along with accepting privileges and agree to provide for continuous care for patients. By signature on this application, I attest that my mental and physical capabilities are sound and unchanged since appointment/last reappointment. The information provided on this application is complete, true and accurate to the best of my knowledge.

____ ______________

Signature of Provider Date

Authorization and Liability Release Form

Please Read Carefully Before Signing

General Provisions:

In order to evaluate my application, I agree to the following terms and conditions:

(1) That the information contained in the **Wise Provider Networks** Credentialing Application is true and accurate and that information important to my application has not been falsified and/or omitted intentionally.

I fully understand that any misstatements or omissions from this application constitute cause for denial of appointment.

I understand that this is an application process and does not constitute acceptance or approval by a credentialing committee. I also acknowledge that my cooperation by consenting to the production of such information about me does not guarantee that **Wise Provider Networks** and its affiliates will contract with me as a provider of services. I further understand that the burden of providing the necessary information to process my application is upon me (the applicant).

I agree to notify **Wise Provider Networks** within ten (10) days in the event of (i) any loss or other change in my license, registration, certificate or other authorization to practice in any state; (ii) if I receive notice that any professional liability claim is being brought against me or that any action by any duly authorized body or health care facility seeking to impose discipline, restrictions, or loss of privileges or license has been commenced against me; or (iii) of any judgment or settlement with respect to any professional liability claim involving myself or if any discipline, restrictions, or loss of privileges or license is imposed on myself as described above.

(2) I give full permission and authorization to **Wise Provider Networks** to collect, research, and verify any and all references, licenses, certificates, insurance related matters, appointments and such matters that relates to consideration of my application. This permission extends to and includes the current application and periodic checks as required by the credentialing institution, and for re-credentialing. The aforementioned shall be in effect as long as the applicant is affiliated with the credentialing institution.

(3) I hereby release from liability and hold harmless all employees, previous employees, staff, authorized representatives, management and affiliates of all institutions or individuals or groups for all acts and statements made in connection with collection, verification, review and evaluation of my credentials and qualifications. These institutions, individuals and groups include but are not limited to:

- **Wise Provider Networks**
- Educational Institutions
- Previous Employees
- Governmental and non-governmental agencies
- Public or private record providers
- Interviews
- Insurance Companies
- Peer Reviews

The foregoing immunities from liability shall be in addition to those provided by law:

(4) I, the undersigned, agree to waive any written notice from any present or past organization, individual or employer that prohibits release of information important to my application.

(5) I, the undersigned, agree to accept a "faxed" or photocopy of this authorization to be accepted with the same authority as the original.

____________________________ ____________________________

Applicant Signature | Applicant Printed Name

____________________________ ____________________________

NPI Number | Date

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