

North Carolina Department of Insurance

Uniform Application To Participate as a Health Care Practitioner

Note: Please send completed applications directly to the organizations with which you seek to contract.

The following application is a form approved by the North Carolina Department of Insurance, in accordance with North Carolina General Statute 58-3-230. Every insurer that provides a health benefit plan and credentials providers for its network is required to use this form and the insurer may not require an applicant to submit information that is not required by this form. Only the Commissioner of Insurance is authorized to make changes, deletions or additions to this form.

INSTRUCTIONS

Before submitting the Application, make sure you have completed the following:

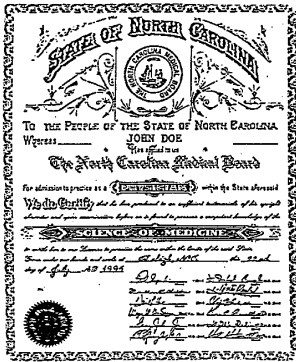
- Include an answer in all spaces. Indicate "N/A", if the question is not applicable.
- The provider has signed and dated the last page of the Application.

Before submitting the Application, make sure you have enclosed the following, if applicable:

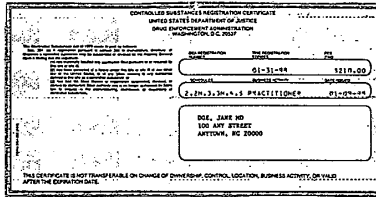
- Copy of the provider's original state(s) license(s) and current registration.
- Copy of current DEA certificate. (Must have a valid date and refer to current address.)
- Copy of South Carolina Controlled Drug Substance Certificate and DEA information.
- Copy of the face sheet of your current professional liability insurance policy, indicating by name, provider(s) covered, coverage amounts, effective date, expiration date, and policy number. Attach previous carrier face sheet.
- Proof of professional liability insurance for non-physician providers who care for patients in your practice.
- Copy of certificate from the Specialty Board.
- Copy of Educational Commission of Foreign Medical Graduate Certificate-ECFMG.
- Letter(s) of reference, recommendation, and/or oversight, *if required*.
- Copy of Curriculum Vitae or work history after graduation from Medical, Dental or other professional school (**CV must account for any gaps of 90 days or more**).
- Copy of CLIA (Clinical Laboratory Improvement Amendments) /ACR (American College of Radiology).
- Copy of W-9 Form.

Examples of documentation to attach to this application:

Original N.C. License



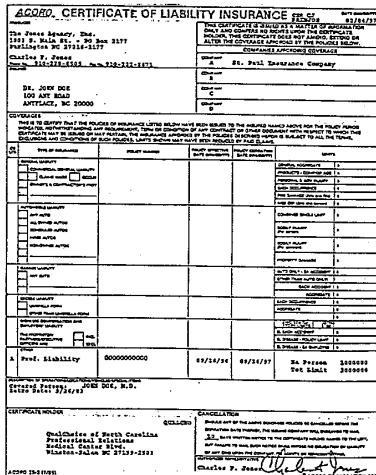
DEA Registration



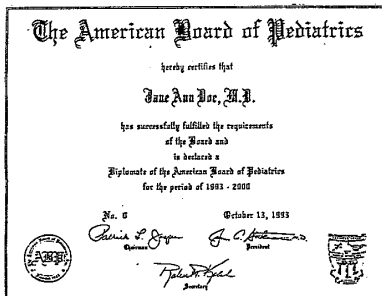
Medical Board Registration



Certificate of Insurance



Board Certification



A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

Additional Office Address or Billing Address, if different (check one) Billing Office

Name _____

Street _____ City _____ County _____ State _____ Zip _____

Handicapped accessible? YES NO Office Phone: (____)____-____/____ Fax (____)____-____/____

Accepting New Patients? YES NO Restrictions: _____

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

6. Name other provider(s) in your practice (if not enough space, please attach additional sheet):

7. Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? YES NO
(If yes, please attach proof of professional liability insurance and proof of employment for those individuals)

8. Name and address of provider(s) who share call with you (if not enough space, please attach additional sheet):

Name _____ Name _____

Address _____ Address _____

9. Arrangements for 24 hour/7 day coverage: _____

10. Administrative Contact: _____

(Name)

(Title)

(Telephone)

11. IRS requires reimbursement be made payable to name of practice affiliated with Federal Tax ID Number:

Federal Tax ID Number: _____

Name (if different from practice name) _____

Billing Address (if different from practice address) _____

12. UPIN Number _____ Medicare/Medicaid Number _____ / _____

13. DEA Number _____ Exp. Date _____

(Attach copy to application)

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

COMPLETE ONLY IF LICENSED IN SOUTH CAROLINA

SC Controlled Drug Substance Certificate: _____ Expiration Date: _____
 (attach copy to application)

14. Provide the following information for each state in which you are currently or were previously licensed to practice (If not enough space please attach additional sheet):

STATE	DATE OF LICENSE	LICENSE NUMBER	STATUS: Active,Inactive,Suspended	EXPIRATION DATE
	/ /			/ /
	/ /			/ /
	/ /			/ /
	/ /			/ /

PLEASE ATTACH A COPY OF EACH STATE LICENSE CERTIFICATE

15. Certification of Specialty Boards as applicable:

a. If you are certified by a specialty board, indicate name of board and date of certificate.

_____ Date Certified ____/____/____ Exp. Date ____/____/____
 Primary Specialty Board

_____ Date Certified ____/____/____ Exp. Date ____/____/____
 Secondary Specialty Board

b. Are you listed in the American Board of Medical Specialists? YES NO

c. If you have applied to a specialty board for examination, give the name of board and the date of scheduled examination.

_____ Date ____/____/____

d. If you have not applied to a specialty board, please explain: _____

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

16. List the dates of all current professional memberships in societies, including state and county societies:
FROM – TO

_____	_____
_____	_____
_____	_____
_____	_____

17. List all hospitals where you currently have privileges and indicate the type and status of those privileges:
(Type: active, admitting, associate, consulting, courtesy. Status: pending, provisional, suspended, temporary, visiting)

<u>Hospital</u>	<u>Privilege and Status of Privilege</u>	<u>Estimated % of Admission</u>
_____	_____	_____
(primary admitting facility)		
_____	_____	_____
_____	_____	_____
_____	_____	_____

18. If you do not have admitting privileges, who admits for you?

Name _____	Name _____
Address _____	Address _____
_____	_____
Phone _____	Phone _____

B. EDUCATION AND PRACTICE HISTORY

1. Medical, Dental or other Professional School Attended:

Institution _____

Address _____

City _____ State _____ Zip _____

Degree _____ From ____/____/____ To ____/____/____

Please attach Educational Commission of Foreign Medical Graduate Certificate - (ECFMG), if applicable.

2. Internship:

Institution _____

Address _____

City _____ State _____ Zip _____

Specialty _____ From ____/____/____ To ____/____/____

3. Residency:

Institution _____

Address _____

City _____ State _____ Zip _____

Specialty _____ From ____/____/____ To ____/____/____

4. Other Residency/Fellowship - (specify)

Institution _____

Address _____

City _____ State _____ Zip _____

Specialty _____ From ____/____/____ To ____/____/____

B. EDUCATION AND PRACTICE HISTORY - (Continued)

5. List work history since beginning of medical, dental or other professional school; please be specific.
(If not enough space, please attach additional sheet)

	FROM / TO
_____	____ / ____ / ____
Current practice	(Month / Year) (Month / Year)
_____	____ / ____ / ____
Previous practice	(Month / Year) (Month / Year)
_____	____ / ____ / ____
Previous practice	(Month / Year) (Month / Year)
_____	____ / ____ / ____
Previous practice	(Month / Year) (Month / Year)
_____	____ / ____ / ____
Previous practice	(Month / Year) (Month / Year)

6. List other training and/or education (including CME) within the last three years, if applicable.

7. Have you involuntarily or voluntarily withdrawn or been suspended from any internship, residency or fellowship training program? Please explain:

8. Please explain any incident(s) in which you have involuntarily or voluntarily withdrawn your application for appointment, clinical privileges or reappointment before a decision was made by a hospital or healthcare facility's governing board.

C. PROFESSIONAL INFORMATION

Please circle yes or no for the following questions. Please complete the attached Supplemental Form for any questions to which you answer “yes.” Also, please sign and date this application. If this application does not have the provider’s signature, it cannot be accepted.

	YES	NO
1. Has your license to practice in any jurisdiction ever been limited, restricted, reduced, suspended, voluntarily surrendered, revoked, denied or not renewed; have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license; are you under investigation by any licensing or regulatory agency? <i>(If yes, please complete Supplemental Question No. 1.)</i>	Y	N
2. Has your professional employment or membership in a professional organization ever been subject to disciplinary proceedings, denied, limited, restricted, reduced, suspended, revoked, not renewed, or voluntarily relinquished during or under threat of termination for any reason? <i>(If yes, please complete Supplemental Question No. 2.)</i>	Y	N
3. Has your Drug Enforcement Agency registration or other controlled substance authorization ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your registration during or under the threat of an investigation or are any such actions pending? <i>(If yes, please complete Supplemental Question No. 3.)</i>	Y	N
4. Have you ever been sanctioned or suspended by Medicare or Medicaid? <i>(If yes, please complete Supplemental Question No. 4.)</i>	Y	N
5. To your knowledge, have you ever been reported to the National Practitioner Data Bank or the North/South Carolina Board of Medical Examiners? <i>(If yes, please complete Supplemental Question No. 5.)</i>	Y	N
6. Have you ever been convicted of a felony or misdemeanor, or are you under investigation with respect to such conduct? <i>(If yes, please complete Supplemental Question No. 6.)</i>	Y	N
7. Has a professional liability claim been assessed against you in the past five years, or are there any professional liability cases pending against you? <i>(If yes, please complete Supplemental Question No. 7.)</i>	Y	N
8. Has any liability insurance carrier canceled, refused coverage, or rated up because of unusual risk or have any procedures been excluded from your coverage? <i>(If yes, please complete Supplemental Question No. 8.)</i>	Y	N
9. Have you ever practiced without liability coverage? <i>(If yes, please complete Supplemental Question No. 9.)</i>	Y	N
10. Do you currently have any medical, chemical dependency or psychiatric conditions that might adversely affect your ability to practice medicine or surgery or to perform the essential functions of your position? <i>(If yes, please complete Supplemental Question No. 10.)</i>	Y	N
11. Have your Hospital and/or Clinic privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of an investigation or are any such actions pending? <i>(If yes, please complete Supplemental Question No. 11.)</i>	Y	N

SUPPLEMENTAL FORM

Provider Name: _____ *Provider ID#* _____
(If applicable)

1. License Limited, Reprimanded, etc.

List State(s) where action took place _____

Date(s) license revoked, suspended, etc. From ____/____/____ To ____/____/____

Please explain: _____

2. Employment/Membership Suspended, Limited, etc.

List State(s) where action took place _____

List Professional Organization _____

Please explain: _____

3. Drug Enforcement Agency (DEA) Explanation

List State(s) where action took place _____

Please explain: _____

SUPPLEMENTAL FORM

Provider Name: _____ Provider ID# _____
(If applicable)

4. Medicare/Medicaid Sanction Disciplinary Action(s)

Disciplined Action(s): _____
List State(s): _____ Date(s) of Action From ___/___/___ To ___/___/___
Please explain: _____

5. National Practitioner Data Bank Report(s)

Please explain the NPDB report (if you have a copy please attach): _____

6. Felony or Misdemeanor

Did you serve a sentence? Y N If YES, circle how many years 1 2 3 4 5 6 other _____
Please explain charge and verdict _____

_____ List State(s) _____

SUPPLEMENTAL FORM

Provider Name: _____ *Provider ID#* _____
(If applicable)

7. Named in Professional Liability Judgment, Settlement, etc.

Please explain, include dates & amounts:

8. Canceled, Refused Coverage, etc.

Please list Insurance Carrier(s) _____

Please explain: _____

9. Practiced Without Liability Coverage

Please explain: _____

SUPPLEMENTAL FORM

ProviderName: _____ *ProviderID#* _____
(If applicable)

10. *Medical, Chemical Dependency, or Psychiatric Conditions*

Please explain in detail: _____

11. *Hospital or Clinic Privileges Revoked, Restricted, etc.*

List Hospital(s) _____

Date privileges revoked, suspended, etc. From ___/___/___ To ___/___/___

Please explain: _____

Attestation Statement

(IMPORTANT: Submit Original Only)

This Application is to be signed by each individual provider submitting an application.

Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in _____, I signify my willingness to appear for interview in regard to my application. I authorize _____ to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to _____ materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of _____ of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of _____ for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to _____ in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to _____.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, _____, may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in _____, I hereby consent to _____ for inspection of my patient records relating to _____ enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify _____ in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PROVIDER

SIGNATURE OF PROVIDER

DATE

Please Sign and Complete this Application