

RECREREDENTIALING APPLICATION

I. PRIMARY IDENTIFICATION INFORMATION

- Identifying Information

Provider Type(Please select one): <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> DC <input type="checkbox"/> DDS <input type="checkbox"/> DMD				CAQH ID:			
Last Name:		First Name:		Middle Name:		Other Names Used:	
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number:		Languages Spoken other than English:			NPI:	
DOB:	Place of Birth:		Citizenship:			Federal Tax ID:	
Primary Specialty:			Secondary Specialty:			<input type="checkbox"/> PCP <input type="checkbox"/> Specialist	

-Primary Address

Legal Practice name/Name Associated with Tax ID:							
Address:				City:		St:	Zip:
Is this location the correspondence address: <input type="checkbox"/> Y <input type="checkbox"/> N <i>(If NO please see "Additional Locations" section)</i>				Office Phone:		Alt. Phone:	Office Fax:
Physician Email:			Office Email:			Website:	
Office Hours:	<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>	<u>Friday</u>	<u>Saturday</u>	<u>Sunday</u>

- Additional Service Address /Correspondence Address-If you have a correspondence address please list it here

Legal Practice name/Name Associated with Tax ID:							
Address:				City:		St:	Zip:
Is this location the correspondence address: <input type="checkbox"/> Y <input type="checkbox"/> N <i>(If NO please see "Additional Locations" section)</i>				Office Phone:		Alt. Phone:	Office Fax:
Physician Email:			Office Email:			Website:	
Office Hours:	<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>	<u>Friday</u>	<u>Saturday</u>	<u>Sunday</u>

-Billing Address

<input type="checkbox"/> Check if Same as Above	Address:			City:		St:	Zip:
Billing Ph:		Billing Fax:		Billing Email:		Credentialing Email:	

-State License

St:	License Num:		Expiration Date:	
St:	License Num:		Expiration Date:	

-Federal DEA Certificate and State Narcotics Registration

St:	Certificate Num:	Expiration Date:	Please list schedules held: <input type="checkbox"/> 2 <input type="checkbox"/> 2n <input type="checkbox"/> 3 <input type="checkbox"/> 3n <input type="checkbox"/> 4 <input type="checkbox"/> 5
St:	Certificate Num:	Expiration Date:	Please list schedules held: <input type="checkbox"/> 2 <input type="checkbox"/> 2n <input type="checkbox"/> 3 <input type="checkbox"/> 3n <input type="checkbox"/> 4 <input type="checkbox"/> 5

-Primary Admitting Hospital

Primary Admitting Hosp Name:	Dept:	Privileges: <input type="checkbox"/> Current <input type="checkbox"/> Pending	
Address:	City:	St:	Zip:

-Additional Hospital Privileges

Primary Admitting Hosp Name:	Dept:	Privileges: <input type="checkbox"/> Current <input type="checkbox"/> Pending	
Address:	City:	St:	Zip:

-Board Certification

Board Certified: <input type="checkbox"/> Y <input type="checkbox"/> N	Certifying Board:	Certificate Num:
Original Cert Date:	Most Recent Recertification Date:	Certification Expiration Date:
Are you pursuing Board Certification? <input type="checkbox"/> Y <input type="checkbox"/> N	If Yes, give details of plans to take boar exam	
	If no, please explain:	

-Additional Board Certifications/Other Certifications

Board Certified: <input type="checkbox"/> Y <input type="checkbox"/> N	Certifying Board:	Certificate Num:
Original Cert Date:	Most Recent Recertification Date:	Certification Expiration Date:

II. EDUCATION & EMPLOYMENT INFORMATION

-Education/Post Graduate Education

PLEASE LIST ALL OF YOUR SCHOOLING AND PROFESSIONAL TRAINING (STARTING AND ENDING) MONTH AND YEAR FORMAT.

Name of School:	Type:	Dates: ___/___ - ___/___	
City:	Degree:	St:	Zip:
Name of School:	Type:	Dates: ___/___ - ___/___	
City:	Degree:	St:	Zip:
Name of School:	Type:		
City:	Degree:	St:	Zip:
Name of School:	Type:	Dates: ___/___ - ___/___	
City:	Degree:	St:	Zip:

-Work History – Medical School to present or the past five years. Information should be in chronological order, and **include months and years. If there is a 6 month gap or more in your work history please send an explanation as to why there is a break.**

Place of Employment	Dates: ___/___ - ___/___	
City:	Degree:	St: Zip:
Place of Employment	Dates: ___/___ - ___/___	
City:	Degree:	St: Zip:
Place of Employment	Dates: ___/___ - ___/___	
City:	Degree:	St: Zip:
Place of Employment	Dates: ___/___ - ___/___	
City:	Degree:	St: Zip:

III. CONFIDENTIAL INFORMATION

IF YOU HAVE ANY "YES" ANSWERS TO ANY QUESTIONS IN THIS SECTION BELOW AND THOSE IN SECTION V, PLEASE REFERENCE **PROVIDE FULL DETAILS ON A SEPARATE SHEET OF PAPER AND ATTACH TO THE APPLICATION.**

Have any of the following at any time been, or are they currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state?			
	<u>NO</u>	<u>YES</u>	If YES, detailed Attached
Medical of Professional License.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DEA or CDS/BNDD Registration.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital medical staff membership.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical privileges or other rights of any hospital medical staff.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employment by any hospital, institution, or the military.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional society membership.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participation in any private, federal, or state health insurance program(i.e..... Medicare or Medicaid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participation in a HMO, PPO, or any other managed care organization.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Board Certification.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At any time have you ever been:			
	<u>NO</u>	<u>YES</u>	If YES, detailed Attached
- Convicted of a criminal offense.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Convicted of a felony.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Convicted of a misdemeanor relating to a health professional, or received probation without a verdict, disposition in lieu of trial, or an accelerated disposition in the disposition of felony charges in any states, territory, or country.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever at any time or are you currently:			
	<u>NO</u>	<u>YES</u>	If YES, detailed Attached
- Under indictment for any crime.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- The subject of an investigation by any private, federal, or state health insurance program or state licensing board.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Under investigation by any state licensing board or federal agency.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- The subject of any adverse reports to a state or federal databank.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever either voluntarily or involuntarily:			
	<u>NO</u>	<u>YES</u>	If YES, detailed Attached
- Withdrawn your application for medical staff membership at any facility.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Withdrawn your request for any clinical privileges at any facility.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Status:			
	<u>NO</u>	<u>YES</u>	If YES, detailed Attached
- Would you require reasonable accommodation in order to perform the professional duties of the position.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently using illegal substances or illegally using substances.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV. PROFESSIONAL LIABILITY CARRIER INFORMATION

-Current Insurance Carrier

Current Insurance Carrier:				
Address:	Ste/Blgd#:	City:	St:	Zip:
Date of Coverage:	Coverage Expiration:	Coverage Amount:	Policy #:	Type of Coverage:

-Previous Insurance Carrier(s)

For last five (5) years if you have not been with your current carrier for five (5) years

Current Insurance Carrier:				
Address:	Ste/Blgd#:	City:	St:	Zip:
Coverage To:		Coverage From:		
Procedures excluded from coverage: _____				

-Professional Liability History – Claims Status within past 10 years requires FULL DETAILS ON EACH CLAIM ON A SEPARATE SHEET OF PAPER

	<u>NO</u>	<u>YES</u>	If YES, detailed Attached
- In the past 10 years has your liability insurance ever been canceled or denied?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Do you have any malpractice judgments against you including arbitration in the past 10 years?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any claim settlements not involving litigation or arbitration paid by you or on your behalf in the last 10 year?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you now a defendant in a pending malpractice suit?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

-Claim Status --

If open, amount being sought:	If closed, indicate method of closing:	Amount Settled:
		Date of Settlement:
<p>Please summarize the circumstances giving rise to the action. If the action involves patient care, please provide a narrative which describes your care and treatment of the patient. If additional space is necessary, attach adequate clinical detail to allow proper evaluation by a committee of peers. Include 1) condition and diagnosis at time of incident, 2) dates and description of treatment rendered, and 3) condition of patient subsequent to treatment.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>		
<p>I hereby authorize Devon Health Services, Inc. to review my credentials for the purpose of confirming the information contained on my application and/or obtaining other information, which may be material to my addition to the Devon Health Services, Inc. network.</p> <p>I authorize any individuals or entities contacted during this review to give you any and all pertinent information they may have and release all parties from any and all liabilities, claims or law suits in regard to the information contained.</p> <p>By signing this application, I hereby certify that all information contained in this application is true, correct and complete in all respects and agree to promptly notify the "recipient" immediately if there are any changes in the information provided.</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Provider Signature _____ Date</p>		