Recredentialing Application

I. PRIMARY IDENTIFICATION INFORMATION

- Identifying Information

Provider Type(Please select one): ☐MD ☐DO ☐DPM ☐DC ☐DDS ☐DMD ☐Other(please specify):___________________			CAQH ID:
Last Name:	First Name:	Middle Name:	Other Names Used:
Gender: ☐M ☐F	Social Security Number:	Languages Spoken other than English:	NPI:
DOB:	Place of Birth:	Citizenship:	Federal Tax ID:
Primary Specialty:	Secondary Specialty:		☐PCP ☐Specialist

-Primary Address

Legal Practice name/Name Associated with Tax ID:			
Address:	City:	St:	Zip:
Is this location the correspondence address: ☐Y ☐N *(If NO please see "Additional Locations" section*	Office Phone:	Alt. Phone:	Office Fax:
Physician Email:	Office Email:	Website:	

Office Hours:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

-Billing Address

☐ 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: ☐2 ☐2n ☐3 ☐3n ☐4 ☐5
St:	Certificate Num:	Expiration Date:	Please list schedules held: ☐2 ☐2n ☐3 ☐3n ☐4 ☐5

-Primary Admitting Hospital

Primary Admitting Hosp Name:	Dept:	Privileges: ☐Current ☐Pending	
Address:	City:	St:	Zip:

-Additional Hospital Privileges

Primary Admitting Hosp Name:	Dept:	Privileges: ☐Current ☐Pending	
Address:	City:	St:	Zip:

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-Board Certification

Board Certified: ☐Y ☐N	Certifying Board:	Certificate Num:
Original Cert Date:	Most Recent Recertification Date:	Certification Expiration Date:
Are you pursing Board Certification? ☐Y ☐N	If Yes, give details of plans to take board exam	
	If no, please explain:	

-Additional Board Certifications/Other Certifications

Board Certified: ☐Y ☐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:	Dates: ___/___ - ___/___	
City:	Degree:	St:	Zip:

-Work History

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. ADITIONAL LOCATIONS

-Additional Service Address

Legal Practice name/Name Associated with Tax ID:			
Address:	City:	St:	Zip:
Do you accept mail at this location: ☐Y ☐N	Office Phone:	Alt. Phone:	Office Fax:

Physician Email:	Office Email:	Website:

Office Hours:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

-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: ☐Y ☐N	Office Phone:	Alt. Phone:	Office Fax:

Physician Email:	Office Email:	Website:

Office Hours:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

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IV.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?

	NO	YES	If YES, details Attached
Medical of Professional License…………………………………………………………………	☐	☐	☐
DEA or CDS/BNDD Registration……………………………………………………………………	☐	☐	☐
Hospital medical staff membership……………………………………………………………..	☐	☐	☐
Clinical privileges or other rights of any hospital medical staff…………………………….	☐	☐	☐
Employment by any hospital, institution, or the military…………………………………….	☐	☐	☐
Professional society membership………………………………………………………………..	☐	☐	☐
Participation in any private, federal, or state health insurance program(i.e………. Medicare or Medicaid)	☐	☐	☐
Participation in a HMO, PPO, or any other managed care organization…………………	☐	☐	☐
Board Certification………………………………………………………………………………………	☐	☐	☐

At any time have you ever been:

	NO	YES	If YES, details Attached
- Convicted of a criminal offense………………………………………………………………………..	☐	☐	☐
- Convicted of a felony………………………………………………………………………………………….	☐	☐	☐
- Convicted of a misdemeanor relating to a health professional, or received probation without a verdict, disposition in lieu if trial, or an accelerated disposition in the disposition of felony charges in any states, territory, or country…………………….	☐	☐	☐

Have you ever at any time or are you currently:

	NO	YES	If YES, details Attached
- Under indictment for any crime…………………………………………………………………………….	☐	☐	☐
- The subject of an investigation by any private, federal, or state health insurance program or state licensing board…………………………………………………………………………….	☐	☐	☐
- Under investigation by any state licensing board or federal agency………………………….	☐	☐	☐
- The subject of any adverse reports to a state or federal databank………………	☐	☐	☐

Have you ever either voluntarily or involuntarily:

	NO	YES	If YES, details Attached
- Withdrawn your application for medical staff membership at any facility………………	☐	☐	☐
- Withdrawn your request for any clinical privileges at any facility……………………………	☐	☐	☐

Health Status:

	NO	YES	If YES, details Attached
- Would you require reasonable accommodation in order to perform the professional duties of the position………………………………………………………………………….	☐	☐	☐
Are you currently using illegal substances or illegally using substances…………………….	☐	☐	☐

V.PROFESSIONAL LIABILITY CARRIER INFORMATION

-Current Insurance Carrier

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

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-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/Bldg#:	City:	St:	Zip:
Coverage To:		Coverage From:		
Procedures excluded from coverage: ____				

-Professional Liability History

	NO	YES	If YES, details Attached
- in the past 10 years has your liability insurance ever been canceled or denied?………	☐	☐	☐
- Do you have any malpractice judgments against you including arbitration in the past 10 years?……………………………………………	☐	☐	☐
Have you had any claim settlements not involving litigation or arbitration paid by you or on your behalf in the last 10 year?...	☐	☐	☐
Are you now a defendant in a pending malpractice suit?..	☐	☐	☐

-Claim Status

If open, amount being sought:	If closed, indicate method of closing:	Amount Settled:
		Date of Settlement:

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.

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VI.SIGNATURE

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.

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.

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.

____ ________________

Provider Signature Date

Initial: ________