Advance Practice/Ancillary Provider Network Application

Instructions: Please complete this application in its entirety and return via email to your Credentialing Specialist. If your application is denied, it may be necessary to report the denial to the National Practitioner Data Bank.

If you are uncertain of your eligibility, please contact the Select Health credentialing department at **practitionercontracting@selecthealth.org**.

PERSONAL INFORMATION

Date of application_____

Full Name _____ Maiden Name (if applicable) _____

Personal Email Address _____Date of Birth _____

NPI# _____ SS# _____ Gender ◉ Male ○ Female

RESIDENCE

Address & Suite Number _____ Area Code/Phone Number _____

City, ST, Zip _____ Area Code/Fax Number _____

PRIMARY OFFICE

Address & Suite Number _____ Area Code/Phone Number _____

City, ST, Zip _____ Area Code/Fax Number _____

ALTERNATE OFFICE

Address & Suite Number _____ Area Code/Phone Number _____

City, ST, Zip _____ Area Code/Fax Number _____

Are you currently on active duty in any branch if the United States military? ○ Yes ○ No

If yes, please specify which branch _____

CREDENTIALING CONTACT

Name _____

Email Address _____

Area Code/Phone Number _____

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EDUCATION (COLLEGES, UNIVERSITIES, OR OTHER POST-GRADUATE TRAINING)

Name of School _____ Dates Attended: From _____ To _____

School Complete Address _____

Major _____ Degree Awarded _____Graduation Date _____

Name of School _____ Dates Attended: From _____ To _____

School Complete Address _____

Major _____ Degree Awarded _____Graduation Date _____

Name of School _____ Dates Attended: From _____ To _____

School Complete Address _____

Major _____ Degree Awarded _____Graduation Date _____

PROFESSIONAL LICENSES

Instructions: Please add pages, as needed, if more than three state entries.

State Licenses		
State:	State:	State:
Number:	Number:	Number:
Date issued:	Date issued:	Date issued:
Expiration Date:	Expiration Date:	Expiration Date:
State Controlled Substances		
State:	State:	State:
Number:	Number:	Number:
Date issued:	Date issued:	Date issued:
Expiration Date:	Expiration Date:	Expiration Date:
DEA Registration		
State:	State:	State:
Number:	Number:	Number:
Date issued:	Date issued:	Date issued:
Expiration Date:	Expiration Date:	Expiration Date:

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BOARD CERTIFICATIONS

Instructions: Please add pages, as needed, if more than three board certifications.

Certifying Board Name _____

Board Certification Number _____

Certified? ○ Yes ○ No Expiration Date _____

Recertified? ○ Yes ○ No Expriration Date _____

(If eligible) Anticipated Certification Date _____

Certifying Board Name _____

Board Certification Number _____

Certified? ○ Yes ○ No Expiration Date _____

Recertified? ○ Yes ○ No Expiration Date _____

(If eligible) Anticipated Certification Date _____

OTHER PROFESSIONAL MEMBERSHIPS/CERTIFICATIONS

...Continued from page 3

AFFILIATION(S)/EMPLOYMENT HISTORY

Instructions: Provide a complete chronology since completion of post-graduate training. Include facilities where your application is pending and where medical staff membership has been denied, either voluntarily or involuntarily. Attach additional sheets, if needed.

Are there any gaps in your hospital affiliation chronology? ○ Yes ○ No

If yes, use an additional sheet to explain those gaps.

Name ____________________ Dates: From __________ To __________
Complete Address ____________________
City, State, Zip ____________________ Area Code/Phone ____________________
Dept/Service ____________________ Division Chief ____________________
Staff Category ____________________ Offices Held ____________________

Name ____________________ Dates: From __________ To __________
Complete Address ____________________
City, State, Zip ____________________ Area Code/Phone ____________________
Dept/Service ____________________ Division Chief ____________________
Staff Category ____________________ Offices Held ____________________

Name ____________________ Dates: From __________ To __________
Complete Address ____________________
City, State, Zip ____________________ Area Code/Phone ____________________
Dept/Service ____________________ Division Chief ____________________
Staff Category ____________________ Offices Held ____________________

Name ____________________ Dates: From __________ To __________
Complete Address ____________________
City, State, Zip ____________________ Area Code/Phone ____________________
Dept/Service ____________________ Division Chief ____________________
Staff Category ____________________ Offices Held ____________________

Name ____________________ Dates: From __________ To __________
Complete Address ____________________
City, State, Zip ____________________ Area Code/Phone ____________________
Dept/Service ____________________ Division Chief ____________________
Staff Category ____________________ Offices Held ____________________

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PROFESSIONAL LIABILITY INSURANCE

Instructions: Liability insurance carrier must be an admitted carrier in the state where the applicant will practice. An admitted carrier is a carrier who has filed rates with the state insurance department and is eligible for insurance department participation should the carrier become insolvent. Select Health requires coverage amounts of at least $1,000,000/$3,000,000.

PRESENT CARRIER

Carrier Name_____ Policy # _____

Complete Address _____

City, State, Zip _____

Limit Amounts: Per Occurence _____ Aggregate _____

Expiration Date _____

PRIOR CARRIERS

Carrier Name _____ Policy # _____

Complete Address _____

City, State, Zip _____

Tail: ○ Yes ○ No

Carrier Name _____ Policy # _____

Complete Address _____

City, State, Zip _____

Tail: ○ Yes ○ No

DISCLOSURE QUESTIONS

Instructions: If you answer "yes" to any question in the sections below on insurance history, disciplinary actions, and health status, please reference the question and give full details in the explanation area on **page 7**.

INSURANCE HISTORY

1. Have there ever been or are there now any pending malpractice claims, suits, settlements, arbitration proceedings, or notices of intent to commence action involving your medical practice? If yes, you must complete a professional malpractice claims history form for each claim using the included form. ○ Yes ○ No
2. Has your professional liability insurance coverage ever been terminated? ○ Yes ○ No
3. Has your professional liability insurance carrier and / or the amount of your professional liability insurance changed? ○ Yes ○ No
4. Has your professional liability insurance carrier ever excluded any specific procedures from your insurance coverage? ○ Yes ○ No

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DISCLOSURE QUESTIONS, CONTINUED

DISCIPLINARY ACTIONS

5. Have any of the following been, or are currently in the process of being denied, revoked, suspended, refused, limited, investigated, placed on probation, or under other disciplinary action either voluntarily or involuntarily?
   - A. Medical license in any state — ○ Yes ○ No
   - B. Other professional registration / license — ○ Yes ○ No
   - C. DEA registration — ○ Yes ○ No
   - D. Academic appointment — ○ Yes ○ No
   - E. Membership and / or employment in a healthcare setting — ○ Yes ○ No
   - F. Clinical privileges / other rights on any medical staff — ○ Yes ○ No
   - G. Other institutional affiliation or status — ○ Yes ○ No
   - H. Professional society membership or fellowship / board — ○ Yes ○ No
   - I. Professional office — ○ Yes ○ No
   - J. Participation in any private (e.g., HMO), federal, or state health insurance program (e.g. medicare, medicaid)? — ○ Yes ○ No
6. Have you ever been:
   - A. The subject of an investigation/audit by any private, federal or state health insurance program (e.g. Medicare, Medicaid, Champus, etc.)? — ○ Yes ○ No
   - B. Assessed a payback fine or penalty by any private, federal, or state health insurance program? — ○ Yes ○ No
   - C. Convicted of (or plead guilty or no contest to) a class a or b misdemeanor/felony? — ○ Yes ○ No
   - D. Censured by any committee of a state or county medical association with regards to competence, ethics or fees? — ○ Yes ○ No
   - E. The subject of a licensing board inquiry or investigation? — ○ Yes ○ No
   - F. Formally suspended more than twice for delinquent medical records? — ○ Yes ○ No
7. Have you ever withdrawn your:
   - A. Application for medical staff membership at any facility/hospital? — ○ Yes ○ No
   - B. Request for any clinical privilege at any facility/hospital? — ○ Yes ○ No
8. Are you currently enrolled in a provider health (diversion) program? — ○ Yes ○ No
   If Yes, please describe

HEALTH STATUS

9. Do you have any physical or mental health condition(s) that would or may affect your ability to fulfill all the functions and obligations of holding clinical privileges as set forth in the medical staff bylaws and rules and regulations, with or without an accommodation? **(If you would require an accommodation to fulfill such functions and obligations, explain on a separate sheet what accommodations you would require.)** — ○ Yes ○ No
10. Are you dependent on any alcohol, drug, or other substance that may affect your clinical judgment or motor skills? — ○ Yes ○ No
11. Are you taking any medication that may affect either your clinical judgment or motor skills? — ○ Yes ○ No
12. Are you under any limitations, as it pertains to activity or workload? — ○ Yes ○ No
13. Are you presently using any illegal drugs? — ○ Yes ○ No

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EXPLANATION

Instructions: Use this area to clarify each "Yes" answer and to document additional information you wish to provide. Attach an additional page if necessary.

I hereby certify that the information in this application is true and complete and that it fairly and accurately discloses all matters requested. I understand that any omissions, misrepresentations, or inaccuracies in this application constitute cause for denial of my appointment and may be cause for my summary dismissal from the staff panel membership.

I have read and understand the medical staff bylaws and i agree to abide and be bound by such bylaws, by the medical staff and department rules and regulations, and by the hospital rules and policies.

I agree to report any malpractice claims filed against me to Select Health.

I have read and understand and have signed the document entitled specific consent to information exchange & conditions of consideration in connection with select heath panel participation. I intend and agree that all the consents, releases, waivers, and other provisions in that document will apply both to the process of considering and evaluating this application and to my (continued) membership on the staff and / or exercise of clinical privileges and panel participation, if approved and granted.

I understand that Medicare, Medicaid, and Tricare payments to hospitals are based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment, and/or civil penalty under applicable federal laws.

PRACTITIONER SIGNATURE _____**DATE** _____

DISCLAIMER: Decisions on requests are based on Select Health membership access and business needs. All requests are subject to approval by the Select Health Panel Committee.

Select Health