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) _____

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 _____

...Continued from page 1

EDUCATION

UNDERGRADUATE

Name of School _____ Dates Attended: From _____ To _____

School Complete Address _____

Major _____ Degree Awarded _____ Graduation Date _____

PROFESSIONAL SCHOOL

Name of School _____ Dates Attended: From _____ To _____

School Complete Address _____

Major _____ Degree Awarded _____ Graduation Date _____

OTHER GRADUATE SCHOOL

Name of School _____ Dates Attended: From _____ To _____

School Complete Address _____

Major _____ Degree Awarded _____ Graduation Date _____

POST-GRADUATE TRAINING (internships, residencies, fellowships, preceptorships)

Institution Name _____

Institution Complete Address _____

Dates Attended: From _____ To _____ Date Completed _____

Type _____ Program Director _____

Institution Name _____

Institution Complete Address _____

Dates Attended: From _____ To _____ Date Completed _____

Type _____ Program Director _____

Institution Name _____

Institution Complete Address _____

Dates Attended: From _____ To _____ Date Completed _____

Type _____ Program Director _____

...Continued from page 1

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:

BOARD CERTIFICATIONS

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

Certifying Board Name _____

Board Certification Number _____

Certified? ○ Yes ○ No Date Certified _____ Expiration Date _____

Recertified? ○ Yes ○ No Date Certified _____ Expiration Date _____

(If eligible) Anticipated Certification Date _____

Certifying Board Name _____

Board Certification Number _____

Certified? ○ Yes ○ No Date Certified _____ Expiration Date _____

Recertified? ○ Yes ○ No Date Certified _____ Expiration Date _____

(If eligible) Anticipated Certification Date _____

...Continued from page 1

HOSPITAL 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 PRACTICE

Nature of Practice ○ Solo ○ Group ○ Partnership

Principal Associate _____

Complete Address _____

City, State, Zip _____

Inclusive Dates: From _____ To _____

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 Amount: Per Occurrence_____ 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

...Continued from page 1

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 or 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

...Continued from page 1

EXPLANATION

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

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** _____

SPECIFIC CONSENT TO INFORMATION EXCHANGE AND CONDITIONS OF CONSIDERATION IN CONNECTION WITH SELECT HEALTH PANEL PARTICIPATION

I am applying or reapplying for panel participation with Select Health. The scope of such application or reapplication is determined by other documents. Such application(s) or reapplication(s) involve Select Health and its affiliated companies. Such companies and their governing boards, officers, administrators, and employees, are referred to in this document as "Select Health." I understand that Select Health is required to compile information so that it can make a fully informed decision about me and my relationship or potential relationship with Select Health. This document is intended to facilitate that process. For convenience in this document, I refer to the process of obtaining verification of my credentials, of checking my background, and of considering me for initial or continuing panel participation as the "Process." I intend that this document apply to the Process for each Select Health panel for which I am applying or reapplying. I understand that the Process may involve Intermountain Health entities providing assistance to Select Health.

1. I have received or have had the opportunity to request, and I have had the opportunity to review, information for each Select Health panel for which I am applying or reapplying. I acknowledge that such documents apply to me both in connection with the Process and in connection with my panel participation, if granted.
2. On all application(s) and forms to Select Health, I have provided true, complete, and accurate information in connection with the Process. I represent to Select Health that such information provides an accurate, fair, and complete picture of my professional background, training, and experience for all the periods of time specified on the forms I have filled out. I acknowledge that any material omission or misstatement of information on such documents may be grounds for terminating my relationship with Select Health.
3. If granted or extended panel participation, I agree to abide by the requirements, rules, and regulations of each Select Health panel with which I am involved. I understand that my professional practice is subject to state and federal laws and regulations, and that persons, institutions, and entities involved in the Process may be protected by state and federal laws designed to encourage and protect good faith peer review and quality assurance activities.
4. I understand that it is necessary for Select Health to obtain detailed information about me in order to complete the Process. I understand that such information may be private, sensitive, privileged, and otherwise confidential. It is my request, and I hereby give my consent, that such information be disclosed to Select Health and received by them in the manner described in this document.

   The information that may be disclosed shall include information about me that bears upon any of the following: my education, post-graduate specialty training, board certification, experience, competence, professional conduct, ethics, ability to work with others, quality assurance data and information, hospital and other affiliation(s) (such as other professional practice settings or participation with other health plans), utilization data, clinical privileges, disciplinary actions, malpractice coverage, claims history, judgments and settlements paid, litigation experience, state licensure, and controlled substance licensure. I intend that this consent include all information that reflects on my ability to safely, competently, and professionally perform the professional activities and/or panel participation I have requested with Select Health.

   I intend that this consent extend to all persons, institutions, and entities that have such information about me, including colleges, universities, professional societies, hospitals, specialty boards, practice groups, clinics, insurance companies, partnerships, professional corporations, and employers, and to persons and committees associated with any of these. In connection with the Process, I also give my consent for all such persons, institutions, and entities to express their evaluation of me and to make recommendations about my professional skills, conduct, and ability to perform the obligations for which I have applied. I also give my consent for Select Health and their officers, agents, committees, and employees involved in the Process to receive and act upon all such information, evaluations, and recommendations in connection with the Process.

...Continued from page 1

5. I understand and agree that the information obtained about me by Select Health in the course of the Process or in connection with my relationship with Select Health may be shared with other Intermountain Health personnel, facilities, or entities engaged in any similar Process or any professional relationship involving me within Intermountain Health in the future. However, I do not by this document consent to any release of information outside of Intermountain Health. Beyond the consent described in this document, I do not consent to any general or public disclosure of any of the confidential, peer review information, evaluations or recommendations identified above. By signing this document, I do not give up any rights I have under the medical staff bylaws, fair hearing plans, or similar procedural documents of any Intermountain Health entity.
6. I recognize that the free exchange of the information identified in this document is a necessary part of the credentialing, recredentialing, contracting, affiliation, and paneling processes for Select Health. I also recognize that the possibility or the threat of litigation and liability tends, as a practical matter, to discourage the exchange of these types of information. It is my intention to induce and encourage other persons, institutions, and entities to do the things identified in this document by removing the threat of litigation and liability as a result of their good faith actions to provide and receive information about me in the manner described in this document. To that end, I intend that the persons, institutions, and entities identified above, both within and outside of Select Health, will rely on this document as my consent to their action(s), as my release of them from liability in connection with the Process, and as my promise not to subject them to legal claims and lawsuits as a result of their good faith efforts to fairly and accurately provide the information that is requested of them, which I acknowledge to be for my benefit to facilitate the Process. I intend that this paragraph will apply to persons, institutions, and entities supplying information, evaluations, and recommendations to Select Health, and also to all persons, committees, and entities involved in the Process for Select Health.
7. I understand that signing this document is an important part of the Process and that any change in this document as provided to me will cause my application or request to be incomplete and will delay the Process.
8. I intend that a copy of this document may be relied upon as if it were the original.
9. This document shall be effective for a period of three years following its executions.

Date _____ Signature _____

Name _____

Address Line 1 _____

Address Line 2_____

City, State, Zip _____

Area Code/Phone Number _____

CONFIDENTIAL PROFESSIONAL MALPRACTICE CLAIMS HISTORY

Instructions: Download this fillable form and type in the information (do not handwrite responses). Use a separate form for each case/claim. Your response must contain enough clinical detail to allow proper peer review and evaluation. Failure to provide complete information will result in a delay in processing your application. Attach additional pages if necessary (see below):

- **For a New Applicant:** If you have ever experienced (previous or pending) malpractice claims, lawsuits, settlements, arbitration proceedings, or notices of intent to commence action against you arising from your medical training or your medical practice, you must complete this form for each case. Make copies of the form as necessary.
- **For Reapplicants**: List cases/claims (as requested above) that have occurred during the past three years, and provide updated information about any claims that were pending at the time or your last application. Make copies of the form as necessary.

Specific Malpractice Allegations:

Circumstances Surrounding Event (including patient outcome and applicant's specific involvement):

Patient Age _____ Incident Date: _____ Location of incident _____

Primary Defendant(s) _____

Other Defendants(s) _____

Date Claim Filed: _____ Malpractice Carrier _____

Current Status or Disposition of Case
(e.g., Still Pending, No Settlement, Settled Out of Court, Went to Trial [and results], etc.)

Amount of Settlement or Judgment (if applicable) _____

I certify that the information herein is true and complete. I understand that the information herein becomes a part of my application and/or reapplication as submitted.

Practitioner Signature _____ Date _____

Practitioner Name (Please print or type.) _____

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