

PRACTITIONER CREDENTIALING APPLICATION

This is the uniform credentialing application adopted by the following organizations: Physicians Plus Insurance Corporation, Unity Health Plans, Dean Health Plan, UW Health/University Community Clinics, Rural Wisconsin Health Cooperative, Community Physicians Network and Security Health Plan.

Prior to submitting this application it is required that you contact the provider relations department of each managed care organization you are applying to. Completion of this application does not imply or assure acceptance by any of the above organizations. Applicants are subject to each organization's approval for participation in their network. Applicants will be notified of the credentialing decision within 60 calendar days of the committee's decision

Please:

- ❖ Type or print legibly.
- ❖ Complete all items.
- ❖ Incomplete applications are returned for completion.
- ❖ Keep a copy for your records.
- ❖ **NOTE:** When applying to a Health Maintenance Organization: If this application was completed more than 180 days prior to today's date, information on the application must be updated and a new "Authorization for Release of Information" must be completed. Please review carefully and provide any current information you may have.

Name _____ DOB _____
Last First Middle

Title: MD, DO, DDS, DPM, DC, PhD, CICSW, CADC, ACSW Other: _____
(circle one)

Residence Address _____
Street

City State Zip
Telephone _____ Social Security Number _____

Gender: ___ Male ___ Female

PROFESSIONAL INFORMATION:

Please attach copies of professional licenses and DEA certificate with effective/expiration dates

State License #: _____ Expiration Date: _____
Active Inactive Restricted Suspended (Circle One)

State License #: _____ Expiration Date: _____
Active Inactive Restricted Suspended (Circle One)

DEA # _____ Expiration Date: _____

Federal Tax ID # _____ UPIN # _____

ECFMG # (If Applicable): _____ NPI # _____

Medicare Provider # _____ Medicaid Provider # _____

1. What is your Medicare Status? Participating Non-Participating (Circle One)

2. Do you currently accept Medicaid Patients? Yes No (Circle One)

Primary Office Name/Address: _____

Office Name

Street

City

State

Zip

Telephone: _____ Fax _____

Office Manager _____

Language 1: _____ Language 2: _____

Start date with this Clinic: _____ **Clinic Status:** Full-Time ____ Staffing ____ Consultant ____
Float ____ * Locum Tenens ____
* (Locum length of stay) _____

Describe your after hours coverage. Please list any practitioner names, office location, and telephone numbers where they can be reached.

Branch Office: _____
Office Name Telephone

Street

City

State

Zip

Billing Office: _____
Office Name Telephone

Street

City

State

Zip

Billing Manager: _____

EDUCATIONAL AND PROFESSIONAL EXPERIENCE:

Account for all time from Undergraduate school to present. Please include Month and Year.

College or University:

Institution
Degree

Indicate Month and Year

City

State

Special Awards or Honors

Institution
Degree

Indicate Month and Year

City

State

Special Awards or Honors

EDUCATIONAL AND PROFESSIONAL EXPERIENCE CONTINUED ON NEXT PAGE

EDUCATIONAL AND PROFESSIONAL EXPERIENCE CONTINUED

Medical School:

—	Institution Degree	Indicate Month and Year
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City	State	Special Awards or Honors
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Internship:

—	Program Name	Specialty	FROM	TO
			Indicate Month and Year	

Complete Address

Please indicate both the Month and Year attended

Residency:

—	Program Name	Specialty	FROM	TO
			Indicate Month and Year	

Complete Address

—	Program Name	Specialty	FROM	TO
			Indicate Month and Year	

Complete Address

If your residency was not successfully completed, please explain:

FELLOWSHIPS/PRECEPTORSHIP:

Please indicate both the Month and Year attended

—	Program Name	Specialty	FROM	TO
			Indicate Month and Year	

Complete Address City, State, Zip

PROFESSIONAL SOCIETY MEMBERSHIPS/FELLOWSHIPS:

MEDICAL SPECIALTY:

Are you providing Primary Care? Yes _____ No _____

Primary Specialty _____

Are you Board Certified: Yes _____ No _____

If yes, name of board _____ Year _____ Exp. _____

Secondary Medical Specialty: _____

PROFESSIONAL CAREER PRESENT AND PAST:

Are you Board Certified: Yes _____ No _____

If yes, name of board _____ Year _____ Exp. _____

Current Practice **From** _____ **To** _____
Indicate Month and Year

Complete Address _____ City _____ State _____ Zip _____

Practice **From** _____ **To** _____
Indicate Month and Year

Complete Address _____ City _____ State _____ Zip _____

Practice **From** _____ **To** _____
Indicate Month and Year

Complete Address _____ City _____ State _____ Zip _____

If there have been interruptions in your professional career, please provide the following:

Dates: From _____ To _____ Activity _____

HOSPITAL PRIVILEGES:

Reason: _____

List all hospitals and professional practice affiliations in chronological order (most recent first) where you have had hospital STAFF PRIVILEGES. Attach additional pages if necessary.

Hospital Name

Street Address _____ City _____ State _____ Zip _____

Staff Category _____ Department _____ **From** _____ **To** _____
Indicate Month and Year

Type of Privileges: _____ **Active** _____ **Other (explain)** _____
(check one)

HOSPITAL PRIVILEGES CONTINUED ON NEXT PAGE

HOSPITAL PRIVILEGES CONTINUED

Hospital Name

Street Address _____ City _____ State _____ Zip _____

Staff Category _____ Department _____ **Indicate Month and Year**

Type of Privileges: _____ **Active** _____ **Other (explain)** _____
(check one)

Hospital Name

Street Address _____ City _____ State _____ Zip _____

Staff Category _____ Department _____ **Indicate Month and Year**

PROFESSIONAL LIABILITY CARRIER:

Type of Privileges: _____ **Active** _____ **Other (explain)** _____
(check one)

Please submit a copy of the declaration page of your present malpractice liability policy showing the effective/expiration dates and the extended limits of coverage.

Carrier _____
Name _____ Address _____
Policy # _____ Telephone# _____
Effective Date _____ Expiration Date _____

Maximum allowable malpractice amount per claim (\$)
: _____

Aggregate maximum allowable malpractice amount per year (\$): _____

- | | | |
|---|-----|----|
| Do you participate in the Wisconsin Patient Compensation Fund? | Yes | No |
| 1. Has your professional liability insurance ever been denied, suspended, canceled, or not renewed? | Yes | No |
| 2. Has any claim or suit for any alleged malpractice been brought against you? | Yes | No |
| 3. Have you ever been found negligent in any malpractice suit or action? | Yes | No |
| 4. Has any malpractice claim settlement ever been paid by you or paid on your behalf? | Yes | No |
| 5. Do you have any legal action pending regarding any malpractice claims? | Yes | No |

If YES, on any of the previous five questions, please attach the following information for each malpractice claim:

- ❖ Date and details of the incident(s) leading to the suit or settlement
- ❖ Date of suit or settlement
- ❖ Professional liability insurer involved
- ❖ Your status in any suit or other legal actions (primary defendant, codefendant, other)
- ❖ Subsequent events, including patient outcome

DISCIPLINARY ACTIONS:

- ❖ Current status of suit or other
- ❖ Amount reserved by carrier for each claim, or amount paid as an out-of-court settlement or amount of jury award or court setting.

Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? **If yes, please provide full explanation on a separate sheet with supporting documents.**

- | | (Circle One) | |
|--|---------------------|----|
| | Yes | No |
| 1. Medical license/ State Certification in any state? | Yes | No |
| 2. Other professional registration/license (e.g., DEA)? | Yes | No |
| 3. Membership on any medical/hospital staff? | Yes | No |
| 4. Clinical Privileges? | Yes | No |
| 5. Any other type of professional sanction? | Yes | No |
| 6. Governmental (Medicare/Medicaid) or third party payer sanctions? | Yes | No |
| 7. Have you ever been convicted of a Felony? | Yes | No |
| 8. As a medical practitioner, has your employment ever been terminated | | |

OTHER:

by an employer for quality of care or professional conduct reasons?	Yes	No
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Please answer the following:

- | | | |
|---|---------------------|----|
| 1. Are you able to perform the essential functions of your profession with or without accommodation for any condition (physical or mental) that you may have? | (circle one) | |
| | Yes | No |
| 2. Do you currently engage in the illegal use of drugs? | Yes | No |
| Would you be interested in serving on HMO or medical practice committees? | Yes | No |

Please include the following with your application:

- ❖ Copy of License(s)
- ❖ Signed Release of Information Form
- ❖ Copy of DEA Certificate
- ❖ Copy of Liability Face Sheet with effective/expiration dates and amounts
- ❖ Mental Health practitioner only- Documentation of 3,000 hours clinical experience or a letter from *the* Department of Health and Family Services, Bureau of Quality Assurance which indicates completion of 3,000 clinical hours.
- ❖ A copy of your most recent Curriculum Vitae

PRACTITIONER ATTESTATION:

In submitting my application for credentialing to Dean Health Plan, Inc. (DHP) I am agreeing to the following:

I certify that all information in my application is accurate and complete. I also agree to provide additional information and execute additional forms as may be requested by DHP in order to evaluate my professional qualifications, competence and conduct.

As an applicant for credentialing with DHP, I have the right to review the information submitted in support of my credentialing application. I acknowledge that DHP will notify me of any information obtained during the credentialing process that varies substantially from the information provided to DHP by me. I have the right to correct any and all erroneous information in my application. I have the right upon request, to be informed of the status of my credentialing application, by contacting the DHP Provider Service Representative or the Credentialing Department. DHP will reply within two working days as to what materials may be missing from the credentialing application and/or when the application may be expected to be completed for presentation to the Credentialing Committee. Credentialing and Recredentialing of providers will be conducted in a manner that is non-discriminatory.

All information by me in this application is warranted to be true, correct and complete.

Dated

Signature

Name (print)

Dean Health System, Inc.

AUTHORIZATION FOR RELEASE OF INFORMATION

I have applied to be credentialed or recredentialed as a participating practitioner with Dean Health Systems, Inc. (DHS). In order for DHS to completely evaluate my qualifications, I hereby authorize DHS and its authorized representatives and agents to consult with any third party who may have information (including information that otherwise may be privileged or confidential) relating to my professional qualifications, competence and conduct. I also authorize any such third party to release information, related reports and documents to DHS and its authorized representatives and agents upon request and receipt of a copy of this **AUTHORIZED FOR RELEASE OF INFORMATION**.

I understand DHS will use this information solely in conjunction with my application for and status as a participating practitioner, and/or conjunction with my application for and status as a participating practitioner with other managed care organizations, preferred provider organizations and networks, or other health care or insurance organizations that have contracted with DHS and/or its authorized representatives or agents to have DHS provide credentialing and/or recredentialing services, and that the information is not subject to redisclosure except as permitted by Federal or State law.

In consideration of accepting for review my application for credentials, or my application for renewal thereof, or the representation of my status as a participating practitioner with DHS to other managed care organizations, preferred provider organizations and networks, or other health care or insurance organizations that have contracted with DHS, as the case may be, I hereby release from liability Dean Health Systems, Inc. and its directors, officers, employees and authorized representatives and agents and third parties for any acts performed in good faith in providing or receiving information, reports or other documents relating to, or in evaluating my professional qualifications, competence or conduct.

This release from liability shall include, but not be limited to, actions relating to the following:

- My application to be a participating practitioner with DHS or other organizations or networks that have contracted with DHS and/or its authorized representatives or agents;
- Periodic appraisals undertaken for recredentialing, utilization review or otherwise for quality management; and
- Proceedings for restriction, suspension or termination of my status as a participating practitioner, or any other disciplinary action.

This authorization is valid for **180** days and, if I become a participating practitioner with DHS, for the time that I remain a participating practitioner with DHS.

Dated

Signature

Name (print)