Iowa Department of Human Services

Iowa Medicaid
Universal Provider Enrollment Application

Basic Information

To avoid delays in the enrollment process, you should:

- Complete all required forms listed below.
- If extra space is needed to answer any questions, please attach any additional pages.
- Type or print all information so that it is legible. Do not use a pencil.
- If any field is not applicable, please enter N/A.
- An incomplete form will delay the application approval process.
- Attach all required and current supporting documentation.

Send the completed Provider Application and all applicable attachments to:

Iowa Medicaid Enterprise
Attn: Provider Enrollment
PO Box 36450
Des Moines, Iowa 50315
Or email to: IMEProviderEnrollment@dhs.state.ia.us

Required Forms: Forms are found on the DHS webpage at: http://dhs.iowa.gov/ime/providers/forms.

New enrollees and those with a new Tax Identification Number (ID):

If you are enrolling in the Medicaid program for the first time or already enrolled, but have a new Tax ID, the following forms are required:

- Form 470-0254, Iowa Medicaid Universal Provider Enrollment Application
- Form 470-2965, Iowa Medicaid Provider Agreement General Terms
- Form 470-4202, Electronic Fund Transfer (EFT) Authorization
- IRS Form W-9
- Form 470-5112, Designated Contact Person

Only if applicable:

- Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia
- Form 470-3748, Verification of Ambulance Compliance
- Form 470-5100, Iowa Medicaid Health Home Agreement
- Form 470-3747, Point of Sale (POS) Agreement - Pharmacies only
- LEA Agreement (Local Education Agency)
- I/T Contract (Early Access Service Coordinator)

Adding an individual or sub-part to your organization:

- If the Tax ID is already enrolled and active, the following form is required:
  Form 470-0254, Iowa Medicaid Universal Provider Enrollment Application (Section B)

Instructions for Completing the Iowa Department of Human Services
Iowa Medicaid Universal Provider Enrollment Application

Reason for Application: Check one box.

Managed Care Organization (MCO): Check the box next to each MCO plan that you want your enrollment application submitted to.

Section A: Organizational Data

This section is completed only for Tax Identification Numbers (IDs) enrolling with Iowa Medicaid for the first time.

1. Enter the full name of the practice as it appears on your income tax return.
2. Enter the nine-digit Federal Employer Identification Number (FEIN) of the business or the Social Security Number (SSN) of the individual for which this application is being filed. **Note:** If you are adding an individual to an existing group, enter the FEIN of the group. Check the box to indicate which number you are listing.
3. Enter your Primary Organizational National Provider Identifier (NPI). This is the NPI you will use to bill Iowa Medicaid. If you are not a "health care provider" as defined at 45 C.F.R. §160.103, please complete the Atypical Provider Declaration, form 470-4457, found on the DHS webpage at: http://dhs.iowa.gov/ime/providers/forms.
4. Primary physical location:
   a. Enter the street number of your primary office location.
   b. Enter your suite or apartment number.
   c. Enter the city name.
   d. Enter the state name.
   e. Enter the zip code.
5. Enter the county name.
6. Enter the phone number.
7. Enter the fax number.
8. Check the box that best matches the type of business being enrolled:
   a. Check the appropriate box.
   b. The 340B Drug Pricing Program resulted from the enactment of the Veterans Health Care Act of 1992, which is Section 340B of the Public Health Service Act. A 340B provider is able to acquire drugs through that program at significant discounted rates. Because of the discounted acquisition cost on these drugs, such are not eligible for the Medicaid drug rebate. State Medicaid programs are obligated to ensure that rebates are not claimed on these drugs. Please refer to Informational Letter 699 for more information. If ***yes***, enter the effective date.
9. Mailing address for Medicaid-related correspondence:
   a. Enter the mailing address if it is different from the address provided in box 4.
   b. Enter the city name.
   c. Enter the state name.
   d. Enter the zip code.

10. Enter the email address for Medicaid-related correspondence.

Payment Information

11. Payment method:
    a. Check one box: An Electronic Funds Transfer (EFT) Authorization Form is required if you will be enrolling using a Federal Employer Identification Number (FEIN) of the business. A debit card is only an option if an individual is doing business under a Social Security Number in box 2.
    b. Enter the pay-to address: This address is used for mailing of the debit card and 1099s.

Pharmacies Only

12. Pharmacies only enter:
    a. The National Council for Prescription Drug (NCPDP) number.
    b. Acknowledgement: If you are a pharmacy that is located outside of the state of Iowa, check one box.

Independent Labs Only

13. Independent labs enter:
    a. The 10-digit Clinical Laboratory Improvement Amendments (CLIA) certification code. Please attach a copy of your current CLIA certification.
    b. The effective date.
    c. The termination date.

Note: If you are enrolling more than one location, please attach CLIA certification for each location.

14. Leave blank. (For future use.)

15. Leave blank. (For future use.)

Page 9 is a listing of Iowa Medicaid provider types. Use this list to identify your provider type code, if an application fee is applicable and to determine whether additional certifications are required for enrollment. Enter the type code in box 16 of the application. Attach the required additional certification to your application.

Note: Only the individuals or institutional categories listed by the business on this form are eligible for Medicaid reimbursement.

Section B: Identifying Information

Managed Care Organization (MCO): Check the box next to each MCO plan that you want your enrollment application submitted to.

Section B is used to enroll individual/group professional or institutional categories (from the listing) that are part of the business and subject to the Iowa Medicaid Provider Agreement. Additional copies of Section B must be completed for each individual within the organization who is being enrolled.

16. Enter the type code from the list on page 9.

17. Enter the licensee or “doing-business-as” name. For individuals that are part of an organization, list the individual’s name.

18. a. Tax ID: Enter the Tax ID of the entity to which payment will be made.
    b. Social Security Number (SSN): Enter the nine-digit SSN for the individual entered in box 17. No entry is required if provider is an organization.
    c. Date of birth: Enter the DOB for the individual entered in box 17. No entry is required if it is an organization.

19. Enter the requested effective date of the enrollment.

20. Enter the physical address of the service location. Note that each service location must be listed for which medical records are stored, or where MediPASS patients are seen. Print additional pages of Section B as needed to indicate more than three service locations.
    a. Enter the primary service address.
    a1. Enter the phone number, fax number, and email address of the service location for which the application is being made.
    b. Enter an additional service location, if any.
    b1. Enter the phone number, fax number, and email address of the additional service location.
    c. Enter a third additional service address, if any.
    c1. Enter the phone number, fax number, and email address of the additional service location.

21. Enter the pay-to address. The address is only needed if the NPI being enrolled will be the pay-to provider.

Note: Electronic Funds Transfer (EFT) Authorization Form is required if you will be enrolled using a Federal Employer Identification Number (FEIN) of the business and the NPI in box 23a will be the pay-to NPI. This address is used for mailing the debit card and 1099s.

22. Enter the mailing address.

23. Enter the NPI.
    a. Enter the NPI of the individual or organization named in box 17.
    b. Enter the taxonomy code of the billing provider. **Note:** If the individual listed in box 17 is a member of a group, this box is not required and may be left blank.

24. Primary professional license or certification number:
    a. Enter the primary professional license or certification number and attach a copy of your license or certification documents, as listed on page 9 for the type code listed in box 16.
    b. Enter the 10-digit CLIA Certification code. If you are providing lab services which require CLIA certification, submit a copy of your current CLIA certification.
    c. Enter the state in which this license or certification was issued.
    d. Enter the initial effective date of the license listed in box 24a.
    e. Enter the license expiration date for the license listed box 24a.
    f. Enter the effective date for the CLIA certificate listed in box 24b.
    g. Enter the expiration date for the CLIA certificate listed in box 24b.

25. Enter the Drug Enforcement Agency (DEA) number. If the provider does not have a DEA number, enter N/A. If the provider is a physician, the number must be entered.

26. For physicians only: Enter the primary specialty, if applicable.

27. For physicians only: Enter the secondary specialty, if applicable.

28. For physicians only: Are you a physician who qualifies for the "Increased Medicaid Payment for Primary Care"? To qualify, eligible providers must be board certified. Refer to CMS guidance under Informational Letter 1194 for full details and qualification information. If you have already been approved, please mark ***yes***; attach explanation and a copy of your certification.

29. a. Check the ***yes*** box if there has ever been disciplinary action against this provider's license by a licensing board in any state and attach an explanation. Check ***no*** if there has not been any disciplinary action.

    b. Check the ***yes*** box if Medicare or any state health program has ever sanctioned the provider and attach an explanation. Check ***no*** is there have not been sanctions.

    c. Check the ***yes*** box if convicted of a criminal offense and attach an explanation. In your explanation, clearly identify any convictions related to your involvement in any program under Medicare, Medicaid or the Title XXI services program. Check ***no*** if there have not been any convictions.

30. Group linkage information: If the individual referenced in box 17 will be linked to a group, enter the group information here. **Note:** If the NPI, taxonomy, and zip code provided do not match a group already enrolled in Iowa Medicaid, the application will be returned for corrections. Section B must be completed to enroll a group.
    a. Enter the organization NPI with which the individual profession is associated. This is the NPI under which payments will be made.
    b. Enter the organizational taxonomy code.
    c. Enter the organizational zip code.

31. Check ***yes*** or ***no*** if you are enrolled in another state's Medicaid or CHIP program. If ***yes***, please list the states and the program.

32. Check ***yes*** or ***no*** if you are enrolled with Medicare.

    Certify: Print name of owner/registered/authorized agent, date, signature, and title.

Section C: Additional Information: Individual Providers Only

Note: Council for Affordable Quality Healthcare (CAQH) users do not need to complete this section. All other providers must complete boxes 33 through 53 unless optional is shown below.

33. Provide the home address of the provider (optional).

34. Provide all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

35. Include any additional completed training.

36. Provide the undergraduate school name and information.

37. Provide the professional school name and information.
38. Provide practice interest information for the provider (optional).
39. Credentialing contact information (optional).
40. Office contact information.
41. Disclose the office hours for the location.
42. List all non-English languages spoken at the office location.
43. Check ***yes*** or ***no*** regarding ADA accessibility requirements.
44. Disclose practice status on accepting new Medicaid and Iowa Wellness patients.
45. If ***yes*** to 44, complete 45.

    Provide information on any mid-level practitioners that care for patients within the practice. If more than three, send information on an attachment.
46. Mid-Level Practitioners. Check ***yes*** or ***no***. If ***yes***, please provide information in the boxes provided.
47. Please check ***yes*** or ***no*** to all services that apply at this location (optional).
48. Please check ***yes*** or ***no***. If ***no***, please explain.
49. Provide applicable malpractice insurance information. If ***yes***, then complete all fields.
50. Provide 10 years of work history starting with graduation (optional). Please check ***yes*** or ***no*** for active military duty or reserve.
51. List three professional references.
52. Complete all disclosure questions. If ***yes*** to any, include a brief description.

Note: If a new Tax ID is being enrolled with Iowa Medicaid for the first time, the Ownership and Control Disclosure must be completed online before your Tax ID will be activated. To start this task, it is necessary to designate a contact person for your organization using form 470-5112. This will provide access to the online tool used to disclose ownership and control.

Section A: Organizational Data

Reason for Application: Check one box.

☐ **NEW** enrollee in Medicaid (the Tax Identification or Social Security Number has not been enrolled in Medicaid)	☐ **CHANGING** to a new Tax Identification Number (already enrolled, but have a new Tax Identification Number)

Please indicate which MCOs the IME should share your application with:

☐ Amerigroup Iowa ☐ AmeriHealth Caritas Iowa

☐ UnitedHealth Care Plan of the River Valley

By checking the box above I authorize the Iowa Medicaid program to share this application and all information contained herein with each MCO indicated.

Practice Information

1. Legal Name (as it appears on your income tax return)

2. Taxpayer Identification Number (TIN): Enter the nine-digit Federal Employer Identification Number (FEIN) of the business **or** the Social Security Number (SSN) of the individual for which this application is being filed. This is the number under which all income will be reported to the Internal Revenue Service for Federal 1099 purposes.

Indicate type: ☐ FEIN or ☐ SSN (check one) ***List the number here:***

3. For Healthcare Providers: Primary Organizational NPI

4a. Primary Physical Location*			**4b.** Suite Number
4c. City	**4d.** State	**4e.** Zip Code	**5.** County
6. Phone Number		**7.** Fax Number	

8a. Check Appropriate Box

☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership ☐ Limited Liability Company (LLC)

☐ Individual ☐ Corporation ☐ Nonprofit Corporation ☐ Cooperative

☐ Other _____

8b. Is your organization a participating "340B" provider? ☐ Yes Effective date:_____ ☐ No

9a. Mailing Address (Medicaid-related correspondence, if different from above)

9b. City	**9c.** State	**9d.** Zip Code

10. Email Address for Medicaid-Related Correspondence

Payment Information

11a. Payment Method: ☐ *Electronic Funds Transfer ☐ **Debit Card **NOTE: *EFT REQUIRES COMPLETION OF AUTHORIZATION FORM (470-4202).** **** Debit Card is <u>only</u> an option if an individual is doing business under a Social Security Number (in box 2).**

11b. Pay-to Address (only used for debit card mailing and 1099s)		
Address		Suite Number
City	State	Zip Code

For Pharmacies Only

12a. Enter the National Council for Prescription Drug Programs (NCPDP) Number
12b. Acknowledgement for pharmacies located outside the state of Iowa: According to the Iowa Administrative Code 657-19.2(155A), a pharmacy located outside of Iowa shall apply for and obtain, pursuant to provisions of 657-8.35(155A), a nonresident pharmacy license from the board prior to providing prescription drugs, devices, or pharmacy services to an ultimate user in this state. Please complete the acknowledgement below. **Check one:** ☐ **The rule listed above does not apply to the pharmacy that is applying to be a provider with the Iowa Medicaid Program.** ☐ **The rule listed above does apply to this pharmacy; please attach a copy of the Iowa nonresident pharmacy license.**

For Independent Lab Only

13a. 10-digit Clinical Laboratory Improvement Amendments (CLIA) Number	
13b. Effective Date	**13c.** Termination Date

14. Leave Blank (For future use.)
15. Leave Blank (For future use.)

Master Provider Listing

Use this list to identify your provider type code. Enter the type code in box 16.

- Declare all individual professionals and institutional categories (from the listing below) that are part of this business and subject to the Iowa Medicaid Provider Agreement.
- Attach current certification documents as indicated on the list below.
- Only the individuals or institutional categories listed by the business on this form are eligible for Medicaid reimbursement.
- **Categories in bold below are considered Moderate or High risk and subject to a pre/post enrollment site visit and other enhanced screening requirements.**

Type Code	Category	Primary Certification	Additional Certification
1	General Hospital	CMS certification	License *CLIA
2	Physician MD	License	*CLIA
3	Physician DO	License	*CLIA
4	Dentist	License	
5	Podiatrist	License	
6	Optometrist	License	
7	Optician		
8	Pharmacy	License	Medicare enrollment
9	**Home Health Agency**	CMS certification	
10	**Independent Lab**	CLIA certificate	Medicare enrollment
11	**Ambulance**	License	
12	**Medical Supplies**	Medicare enrollment	
13	Rural Health Clinic	CMS certification	
14	ESRD	CMS certification	
15	**Physical Therapist**	License	Medicare enrollment
16	Chiropractor	License	Medicare enrollment
17	Audiologist	License	
18	Skilled Nursing Facility	DIA/CMS certification	License
19	**Rehab Agency**	CMS certification	
20	Intermediate Care Facility	DIA/CMS certification	License
21	**Community Mental Health**	Bureau of Community Services	
22	Family Planning	Dept Public Hlth approval	
23	Residential Care Facility	License (DIA)	
25	ICF/ID State	DIA/CMS certification	License
26	Mental Hospital	CMS certification	License
27	Community-Based ICF/ID	DIA/CMS certification	License
29	Psychologist	License	NRHSPP cert
30	Screening Center	Dept Public Health approval	
31	Hearing Aid Dealer	License	
32	Occupational Therapists	License	Medicare enrollment
34	Orthopedic Shoe Dealer		
35	Maternal Health Center	DHS approval	
36	Ambulatory Surgical Center	CMS certification	
38	Certified Nurse Midwife	License	Board cert *CLIA
39	Birthing Center	DHS approval	
40	Area Education Agency	IA Dept of Education Agreement	
41	Psych Medical Inst. Children (PMIC)	DIA license	
42	Case Manager	DHS approval	
44	CRNA	License	Board cert
45	**Hospice**	CMS certification	*CLIA
48	Clinical Social Worker	License	Medicare enrollment
49	Federal Qualified Health Center (FQHC)	CMS certification	HRSA grant
50	Nurse Practitioner	License	Board cert *CLIA
52	Nursing Facility - Mentally Ill	DIA/CMS certification	License
54	County Relief	DHS approval	
55	Lead Investigation Agency	Dept Public Hlth approval	
56	Local Education Agency	IA Dept of Education Agreement	
57	Early Access Service Coordinator	IA Dept of Education Agreement	
58	PACE	CMS PACE agreement	
62	Behavioral Health	License	
63	Behavioral Hlth Intervention Srvs (BHIS)	Magellan enrollment welcome letter	
64	Habilitation Services	Applicable certification/accreditation	
67	Assertive Community Treatment (ACT)	License	
69	Independent Speech Pathologist	License	
71	Health Home	TransforMED self-assessment or NCQA recognition	Health home agreement
72	Public Health Agency	Board of Health Jurisdiction letter	
76	Accountable Care Organization		ACO agreement
99	Waiver	HCBS application required	

Please print this section and complete for each individual professional and institutional category.

Section B: Identifying Information

Please indicate which MCOs the IME should share your application with:

☐ Amerigroup Iowa ☐ AmeriHealth Caritas Iowa

☐ UnitedHealth Care Plan of the River Valley

By checking the box above I authorize the Iowa Medicaid program to share this application and all information contained herein with each MCO indicated.

Reason for Application: Check one box.

☐ **New** group, individual practitioner or institutional category that is part of the Tax ID and subject to the Iowa Medicaid provider agreement.	☐ **Adding New Location**. If you are adding a new location to a Tax Identification Number already enrolled in the Iowa Medicaid program.

16. Type Code	**17.** Licensee or DBA Name	**18a.** Tax ID (for billing entity)	
18b. Social Security Number	**18c.** Date of Birth	**19.** Requested Effective Date of Enrollment*	
20a. Primary Service Address	City	State	9-Digit Zip
20a1. Primary Address Phone Number	Fax	Email	
20b. Additional Service Address	City	State	9-Digit Zip
20b1. Additional Service Address Phone Number	Fax	Email	
20c. Additional Service Address*	City	State	9-Digit Zip
20c1. Additional Service Address Phone Number	Fax	Email	
21. Pay-to Address	City	State	9-Digit Zip
22. Mailing Address	City	State	9-Digit Zip

23a. National Provider Identifier (NPI)	**23b.** Taxonomy Code (if applicable)	
24a. Primary Professional License or Certification Number. **Please attach a copy of your license/certification documents.**	**24b.** 10-Digit CLIA Number	**24c.** State Issued

24d. Initial Effective Date	**24e.** Current Expiration Date	**24f.** CLIA Effective Date	**24g.** CLIA Expiration Date

25. Drug Enforcement Agency (DEA) Number. If the provider does not have a DEA Number, enter N/A.	
26. Primary Specialty* (if applicable)	**27.** Secondary Specialty* (if applicable)

28. Are you a physician who qualifies for the "Increased Medicaid Payment for Primary Care"? ☐ **Yes** ☐ **No**

If *yes*, please include a photocopy of your board certification.

29a. Has there ever been disciplinary action against this provider's license by a licensing board in any state?

☐ **Yes** ☐ **No** **If *yes*, please attach an explanation.**

29b. Has the provider ever been sanctioned by Medicare or any state health program?

☐ **Yes** ☐ **No** **If *yes*, please attach an explanation**

29c. Has the provider been convicted of any criminal offense?

☐ **Yes** ☐ **No** If ***yes***, in your explanation clearly identify any convictions related to your involvement in any program under Medicare, Medicaid or the Title XXI services program. Check ***no*** if there have not been any convictions.

Payment Method Information: EFT is required when billing under a Federal Tax ID Number.
Debit Card is <u>only</u> an option if an individual is doing business under a Social Security Number.

Group Linkage Information*

Individual professionals may be associated with an organization. If that is the case, identify the organization in the boxes below:

30a. Organizational NPI	**30b.** Organizational Taxonomy	**30c.** Organization Location Zip

31. Are you currently enrolled in another state's Medicaid/CHIP program?

☐ **Yes** ☐ **No** **If *yes*, please list the state and what program you are enrolled in:**

32. Are you currently enrolled with Medicare? ☐ **Yes** ☐ **No**

I certify that the information submitted on this enrollment application is, to the best of my knowledge, true, accurate, and complete and that I have read this entire form before signing. I also understand that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Owner/registered/authorized agent print name:	Date:
Owner/registered/authorized agent signature:	Title:

Please send the completed Universal Provider Enrollment Application and all applicable attachments to:

Iowa Medicaid Enterprise, Attn: Provider Enrollment,
PO Box 36450, Des Moines, Iowa 50315
Or email to: IMEProviderEnrollment@dhs.state.ia.us

Section C: Additional Information: Individual Providers Only

If in Section B you indicated that the Iowa Medicaid program is to share your application with one or more of the MCOs and you are an individual, please complete this section.

33. Provider Home Address	City	State	Zip
34. Professional ID/CDS Certification Number	Certifications (please list all)		
35. Training			
36. Undergraduate School Name	Address		
City	State	Zip	
37. Professional School Name	Address		
City	State	Zip	
38. Practice Interests			
39. Primary Credentialing Contact Name	Phone Number	Email	
40. Office Manager or Business Office Contact Name	Phone Number	Email	
41. Office Hours	**42.** List non-English languages spoken by office personnel		

43. Does this office meet ADA Accessibility Requirements? ☐ **Yes** ☐ **No**

44. Practice Status

Are you currently accepting new Medicaid patients? ☐ **Yes** ☐ **No**

Are you currently accepting new Iowa Wellness patients? ☐ **Yes** ☐ **No**

If *yes* to either of the above, please complete the below fields:

45. If ***yes*** to 44, answer questions:

☐ **Yes** ☐ **No** **If *yes*, please explain:**

Gender limitations?

☐ **Yes** ☐ **No** **If *yes*, please explain:**

Age limitations?

☐ **Yes** ☐ **No** **If *yes* please explain:**

46. Do mid-level practitioners (nurse practitioners, physician assistants, etc.) care for patients in your practice?
☐ **Yes** ☐ **No**

IF *YES*, PLEASE PROVIDE THE INFORMATION BELOW:

Practitioner Last Name	Practitioner First Name	M.I.	Practitioner Type
Practitioner License/Certification Number	Practitioner State		
Practitioner Last Name	Practitioner First Name	M.I.	Practitioner Type
Practitioner License/Certification Number	Practitioner State		
Practitioner Last Name	Practitioner First Name	M.I.	Practitioner Type
Practitioner License/Certification Number	Practitioner State		

47. Services provided in this location. Please select ***yes*** or ***no*** to all that apply:

Radiology	☐ **Yes**	☐ **No**	Physical therapy	☐ **Yes**	☐ **No**
Allergy injections	☐ **Yes**	☐ **No**	Allergy skin testing	☐ **Yes**	☐ **No**
Laboratory	☐ **Yes**	☐ **No**	Flexible sigmoidoscopy	☐ **Yes**	☐ **No**
EKGs	☐ **Yes**	☐ **No**	IV hydration treatment	☐ **Yes**	☐ **No**
Drawing blood	☐ **Yes**	☐ **No**	Care of minor lacerations	☐ **Yes**	☐ **No**
Asthma treatment	☐ **Yes**	☐ **No**	Routine office gynecology	☐ **Yes**	☐ **No**
Pulmonary function testing	☐ **Yes**	☐ **No**	Tympanometry audiometry screening	☐ **Yes**	☐ **No**
Age appropriate immunizations	☐ **Yes**	☐ **No**	Cardiac stress test	☐ **Yes**	☐ **No**
Osteopathic manipulation	☐ **Yes**	☐ **No**			

48. Do you have hospital privileges? ☐ **Yes** ☐ **No**

If you do not admit patients, please explain what type of admitting arrangements you do have?

If *yes*, please complete the below fields:

Primary Hospital Name	Service Address	State	9-Digit Zip
Primary Phone Number	Fax	Department Name	
Department Director's Name	Affiliation Start Date	Affiliation End Date	
Full unrestricted privileges? ☐ **Yes** ☐ **No**	Age privileges temporary? ☐ **Yes** ☐ **No**	Of your total annual admission, what percentage is to this hospital?	

Admitting privileges status (e.g. none, full, unrestricted, provisional, temporary)?

49. Do you carry malpractice insurance? ☐ **Yes** ☐ **No** **If *no*, skip this section.**	Carrier or Self-Insured Name	Self-insured? ☐ **Yes** ☐ **No**	
Address	City	State	9-Digit Zip
Original Effective Date	Current Effective Date	Current Expiration Date	
Do you have unlimited coverage with this insurance carrier? ☐ **Yes** ☐ **No**	Amount of Coverage per Occurrence in Dollar Amount	Amount of Coverage Aggregate in Dollar Amount	
Does this policy include tail coverage? ☐ **Yes** ☐ **No**	Please Provide Your Policy Number Here		

50. Include a chronological work history for the past 10 years below
Are you currently on active military duty or military reserve? ☐ **Yes** ☐ **No**

Practice/Employer Name	Phone Number	Email Address	Duration of Employment
Practice/Employer Name	Phone Number	Email Address	Duration of Employment
Practice/Employer Name	Phone Number	Email Address	Duration of Employment
Practice/Employer Name	Phone Number	Email Address	Duration of Employment
Practice/Employer Name	Phone Number	Email Address	Duration of Employment
Practice/Employer Name	Phone Number	Email Address	Duration of Employment
Practice/Employer Name	Phone Number	Email Address	Duration of Employment
Practice/Employer Name	Phone Number	Email Address	Duration of Employment

Please explain any time periods or gaps in training or work history that have occurred since graduation and are greater than three months:

51. Provide three professional references to whom you are not related or are not partners in your practice:

First and Last Name	Phone Number	Email Address
First and Last Name	Phone Number	Email Address
First and Last Name	Phone Number	Email Address

52. Disclosure Questions. Answer all questions ***yes*** or ***no***. For any ***yes***, please include a brief description.

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? ☐ **Yes** ☐ **No**

Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? ☐ **Yes** ☐ **No**

Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? ☐ **Yes** ☐ **No**

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished? ☐ **Yes** ☐ **No**

OTHER SANCTIONS OR INVESTIGATIONS

Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? ☐ **Yes** ☐ **No**

To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? ☐ **Yes** ☐ **No**

Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? ☐ **Yes** ☐ **No**

Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct? ☐ **Yes** ☐ **No**

Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency? ☐ **Yes** ☐ **No**

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? ☐ **Yes** ☐ **No**

Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history? ☐ **Yes** ☐ **No**

ABILITY TO PERFORM JOB

Are you currently engaged in the illegal use of drugs? ☐ **Yes** ☐ **No**

("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? ☐ **Yes** ☐ **No**

Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?
☐ **Yes** ☐ **No**

Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation? ☐ **Yes** ☐ **No**

Attestation and Information Release Authorization

All information provided in the application is complete and accurate to the best of my knowledge, and I shall immediately notify the IME and the MCOs of any changes thereto. I understand this application does not entitle me to participation. I authorize the Plan, its medical director, and appropriate representatives to consult with administrators and members of other institutions where I have been associated; including past and present malpractice carriers who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to the inspection by the MCOs, its medical director and appropriate representatives of all records and documents, excluding medical records of non-members of the MCO plans, that may be material to an evaluation of any professional qualifications and competence to carry out the requested duties, as well as my moral and ethical qualification for participating provider status with MCO. I consent and agree that the MCOs will complete a criminal history background check to determine if I or any subcontracted providers have any history of felony convictions, including adjudication withheld on a felony, plea or nolo contendere to a felony or entry into a pretrial for a felony. I agree to obtain any consents or approvals required for my subcontracted provider to undergo such background checks. I hereby release the MCOs and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I hereby release any individuals and organizations from any liability that provide information to the MCOs or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualification, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the term and the agreement between me, my group, and MCOs, as such terms may be applicable to me.

I understand that as an applicant for participation in the MCOs, I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from the MCOs, I have a right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the credentialing committee, if they so request. I further understand that I may appeal the committee's decision either in writing or by appearance before the credentialing committee, if they so request.

Owner/registered/authorized agent print name:	Date:
Owner/registered/authorized agent signature:	Title: