Universal Provider Application

This application satisfies requirements for credentials verification for Humboldt IPA

Instructions: Please type or print legibly. This application MUST BE COMPLETE for processing. If more space is needed than provided, please attach additional sheets.

Applying as a (please list degree of licensure):

General Information

Last Name | First | Initial | Degree (MD/DO) | Gender ☐ Male ☐ Female

US Citizenship ☐ Yes ☐ No
If 'No' please indicate citizenship: | Birthplace | Birthdate

Name of Spouse/Significant Other (optional)

Home address | City | State | Zip | Phone

Send mail to:
☐ Home ☐ Office

Federal Tax ID # | SSN | Medicare UPIN

Type of Practice
☐ Individual ☐ Private ☐ Partnership; Partner's Name:_____ ☐ Group; Group Name:_____
☐ Comm. Clinic; Name:_____

Are you currently accepting new patients?
☐ Yes ☐ No
If 'Yes' are you accepting: As a PCP? ☐ Yes ☐ No As a Specialist? ☐Yes ☐ No

Office Address

Street | Ste. # | City | State | Zip

Office Manager | Phone | FAX

Office Hours

Primary Location

Secondary Location

Billing Address (if different from Office Address)

Street or P.O. Box | City | State | Zip | Contact Person | Phone #

Education, Training and Work History

Please include Curriculum Vitae, if one is available, in addition to completing this section.

Medical School

Medical School (complete name)		Degree/ Year Graduated	
Mailing Address (Street or P.O. Box)	City	State	Zip

Internship

Institution	Type of internship	Specialty	From(mn/year) to (mn/year)
Mailing Address (Street or P.O. Box)	City	State	Zip

Residencies (Please include preceptorships, teaching appts. and postgraduate education)

Institution	Type of Residency	Specialty	From(mn/year) to (mn/year)
Mailing Address (Street or P.O. Box)	City	State	Zip
Institution	Type of Residency	Specialty	From(mn/year) to (mn/year)
Mailing Address (Street or P.O. Box)	City	State	Zip

Education, Training and Work History (cont)

Fellowships

Institution	Type of Fellowship	From(mn/year) to (mn/year)
Mailing address (Street or P.O. Box)	City	State Zip

Work History (Please list history for the last 10 years & include organization name, address, dates (month/year) and your position. Attach additional sheets if necessary)

Professional References

Please include three (3) physicians familiar with your practice. Only one reference may be an associate.

Physician	Mailing Address	Phone #
Physician	Mailing Address	Phone #
Physician	Mailing Address	Phone #

Credentials

Board Status (This application **WILL NOT BE COMPLETE WITHOUT A COPY** of this certificate)

Certified by boards which are duly organized and recognized by: *an American Board of Specialties member board, or * a board or association with equivalent requirements approved by the Medical Board of California, or * a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in that specialty or subspecialty.

Name of Board (Please list any subspecialty certificates held) Certification date(s)

Have you been recertified? ☐ Yes ☐ No
If yes, please list Name of Board and dates.

Do you plan on recertification? ☐Yes ☐ No
If yes, please list Name of Board and date of next scheduled recertification exam.

Credentials

DEA Certificate (This application **WILL NOT BE COMPLETE WITHOUT A COPY** of this certificate.)

Certificate Number Expiration Date

California State Medical License (This application **WILL NOT BE COMPLETE WITHOUT A COPY** of the license)

California License Number Expiration Date

Licensure in another state? ☐Yes ☐ No
If yes, please list number Location/Expiration Date

Malpractice Insurance (This application **WILL NOT BE COMPLETE WITHOUT A COPY** of your current Certificate of Insurance. Minimum coverage must be $1,000,000/$3,000,000. Please indicate former carriers if you have changed carriers in the last 10 years.)

If you have had any claims/suits filed against you in the last ten (10) years, please complete a Medical Malpractice Claim Information form (enclosed) for each.

Carrier Policy number Expiration Date Amount of coverage

Mailing Address (Street or P.O. Box) City State Zip

Previous carrier (please include address)

Please state your reason for change of carrier

Professional Liability

A. Have any judgments or settlements been made against you in professional liability cases or are any such cases pending? ☐Yes ☐ No
B. Have you been named in any malpractice action in the past ten (10) years? ☐Yes ☐ No
C. Has your malpractice insurance ever been denied or canceled? ☐Yes ☐ No

If you answered "yes" to any question above, please provide details on a separate sheet.

Practice Limitations

A. Has your license to practice medicine in any jurisdiction been limited, suspended, or revoked, or is any such action pending? ☐Yes ☐ No
B. Have your privileges at any hospital been suspended, diminished, revoked, or not renewed, or is any such action pending? ☐Yes ☐ No
C. Have you been denied membership or renewal, or been subject to disciplinary action by any medical organization, or is any such action pending? ☐Yes ☐ No
D. Have you resigned from a hospital's medical staff to avoid disciplinary actions being taken against you, or is any such action pending? ☐Yes ☐ No
E. Has your DEA number ever been revoked or otherwise limited, or is such action pending? ☐Yes ☐ No
F. Have Medicare, Medicaid, PSRO, or PRO authorities, or any other medical reimbursement plans, ever brought formal charges against you for alleged inappropriate fees or quality of care issues? ☐Yes ☐ No
G. Do you have any physical or mental limitations (including drug or alcohol dependency which would interfere with your medical practice? ☐Yes ☐ No
H. Have you ever been convicted of a felony? ☐Yes ☐ No

If you answered "yes" to any of the questions above, please provide details on a separate sheet

Signature _____ Date _____

Hospital Affiliations

Hospital Name	Type of Privileges	Status	☐ Primary Hospital
Hospital Name	Type of Privileges	Status	☐ Primary Hospital
Hospital Name	Type of Privileges	Status	☐ Primary Hospital

Call Group

Please indicate names, phone numbers, and addresses of physicians who handle your calls if you are out of town or become ill. Attach additional sheets if necessary.

Name	Phone Number
Address	
Name	Phone Number
Address	

Languages Spoken

Please list which languages, other than English, you speak.
If you only speak English please indicate if you have translators available in your office, their names and the language(s) they speak.

General Provisions:

Investigation Consent and Authorization

By applying for membership in HDNFMC and/or in the HDNIPA or any other organization for which HDNFMC is the contracted administrator, I hereby signify my willingness to appear for interviews with regard to my application, and I authorize representatives of HDNFMC to consult with administrators and members of medical staffs of other hospitals, medical associations or institutions, state medical boards, or provincial medical licensing authorities with which I have been associated and with others, including, but not limited to, past and present malpractice insurance carriers, who may have information bearing on my professional competence, character and ethical qualifications.

I further consent to the inspection and release by representatives of HDNFMC and any contracted health plan of all records and documents, including medical records at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out my medical practice and clinical privileges requested, as well as moral and ethical qualifications for membership in HDNFMC.

I present this information as part of the credentialing/quality management processes, in the expectation that its confidentiality and privacy will be preserved and that this information will be released or disclosed only as part of current and future credentialing, peer review, quality assurance processes and according to Federal and/or State regulations or as called for by HMO and/or insurance carrier contracts.

Waiver of Liability

I hereby release from liability all representatives of HDNFMC, and/or representatives of any contracted HMO and/or insurance carrier, for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications; and I hereby release from any liability any and all individuals and organizations who provide information to HDNFMC in good faith and without malice concerning my professional competence, ethics, character and other qualifications for HDNFMC membership. I hereby consent to the release of such information.

Information Release

I hereby further authorize and consent to the release of information by representatives of HDNFMC to hospitals, their medical staff, medical associations, health plans/HMOs and/or insurance carriers per specific contract agreements, upon their request concerning me, as long as such release of information is done in good faith and without malice; and I hereby release HDNFMC, its employees, agents and/or representatives from liability for so doing.

Rights to a Fair Hearing

I understand that I shall be afforded fair procedures in the event that adverse action is taken on this application, or with respect to my participation or eligibility to perform given procedures at any time, for reasons related to my competence or professional conduct. Such procedures shall include reasonable notice of the reasons for any action, an opportunity for rebuttal, an impartial determination and any other rights which may be guaranteed to me by law (e.g. under Business and Professions Code Sections 809 et seq., where applicable). I understand that HDNFMC has Corrective Action and Fair Hearing Procedures, and Credentialing/Recredentialing Procedures for appeal, and I agree to abide by those procedures in contesting any negative findings regarding this application.

Application Approval Conditions

I fully understand and acknowledge that by submitting this application I am asking HDNFMC to consider my request to enter into an HDNFMC Provider Agreement. I have received and read the HDNFMC and affiliated organization Provider Agreements. I have signed the HDNFMC Provider Agreement and agree to abide by the provisions of said agreement. I further understand and acknowledge that HDNFMC is not obligated to accept my application, and that a Provider Agreement, with HDNFMC or any other affiliated organization, would not be effective until HDNFMC has notified me regarding my application status.

In making this application for membership to HDNFMC, I acknowledge that I will abide by HDNFMC's bylaws and the principles of medical ethics of the American Medical Association, and I agree to be bound by the terms thereof if I am granted HDNFMC membership. In making application for membership in affiliated organizations by submitting a signed Provider Agreement specific to that organization, I acknowledge that I will abide by the applicable bylaws, rules and regulations; and I agree to be bound by the detailed explanations of said provider agreements

I understand and agree that, as an applicant to HDNFMC and affiliated organizations, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided which may affect the application or its outcomes.

I understand and acknowledge that a copy of these General Provisions, signed by me, might be sent in lieu of any specific information release form, in the pursuit of information relevant to HDNFMC's application, credentialing/recredentialing and/or quality management processes; and will constitute my consent for information release.

_____

PRINT NAME HERE

_____ _____

SIGNATURE Please use Ink **DATE**

MEDICAL MALPRACTICE CLAIM INFORMATION

Use a separate from for each claim, photocopying the form as needed. Please provide attachments as needed

Many legal claims are made without just cause; however, egregious professional conduct is occasionally revealed by a pattern of malpractice litigation. Our goal is to elicit all information relevant to current professional competence. With that in mind, please provide the following information on each professional liability claim that has been made against you.

Name of Physician_____

Name of Patient_____

Date of occurrence on which claim is based_____**Date claim was filed**_____

Facts of the case (including dates)_____
_____
_____
_____
_____
_____

Names of all the defendants (including hospitals)_____
_____
_____
_____

Describe the claims made by the plaintiff or claimant_____
_____
_____
_____
_____

State the defenses asserted by you_____
_____
_____
_____
_____

What is the current status of the case (including patient outcome)?_____
_____
_____
_____

If the case has been concluded, state resolution details, including the date the case was concluded and any monetary settlements_____
_____
_____
_____
_____

Name of professional liability insurer involved on your behalf_____

Names and address of each attorney representing each party_____
_____

Signature_____**Date**_____

Printed Name_____**SSN**_____