Practitioner Credentialing Application

To expedite processing of your application, please complete this application in its entirety and attach the following documentation. If you participate in CAQH, please complete page 2 with your demographic information and CAQH ID number.

Copy of ECFMG certificate (if foreign trained)

Copy of current unexpired state license(s)

Copy of current unexpired DEA certificate, if applicable

Copy of current unexpired state controlled substances license (if applicable)

Copy of Board Certificate

Copy of current unexpired malpractice declaration sheet (evidence of professional liability insurance which indicates coverage limits and expiration dates and name of provider must be on the cover sheet or if in a group on a list of provider's letterhead from the insurance company)

Current resume / Curriculum Vitae, (Use month and year to indicate time for education, training and work history. All gaps over 6 months must be explained)

Please type or print legibly and ensure the attestation and release forms are signed and dated by the practitioner. Please do not use whiteout. If the application is not complete, signed and dated, or if whiteout is used, it will not be processed. Please use additional sheets if you need to provide additional information.

The application can be submitted to the contact information (email, fax or by mail) on the cover letter. ***Again, if you participate in CAQH, simply send in page 2 of the application and include your demographic information and CAQH ID.***

Applicants have the right to review the information submitted in support of their credentialing application. Please contact the TriWest Credentialing Department (credentialing@triwest.com) if you would like to review your credentialing documentation.

Pursuant to Department of Veteran Affairs imposed guidelines and procedures, TriWest must adhere to certain specialty specific requirements. Please refer to the TriWest Healthcare Alliance Provider Eligibility Requirements included in contracting introduction email, or contact a Direct Contracting Specialist for more details.

CREDENTIALING APPLICATION

PERSONAL DATA

PROVIDER'S NAME (Last Name, First Name, MI, Degree):	MAIDEN NAME (If Applicable):	SOCIAL SECURITY NUMBER:

DATE OF BIRTH:	GENDER: ❒ M ❒ F	PLACE OF BIRTH (City, State, Country):	FOREIGN LANGUAGES: ❒ Speak ❒ Read ❒ Write

Individual NPI #:	Medicare UPIN:	U.S. Citizen? ❒ Yes ❒ No	If you are not a U.S. Citizen, are you law fully authorized to w orkin the U.S.? ❒ Yes ❒ No

HOME ADDRESS (No., Street):	HOME CITY:	HOME STATE:	HOME ZIP CODE:

HOME TELEPHONE:	EMERGENCY TELEPHONE:

SPECIALTY/BOARD CERTIFICATIONS

LIST ALL SPECIALTIES PRACTICED, BEGIN WITH PRIMARY SPECIALTY

SPECIALTY:	CERTIFIED:	NAME OF BOARD:	DATE(S) CERTIFIED	DATE CERT. EXPIRES:
	❒Yes ❒No ❒Eligible	If eligible, date exam taken:		
	❒Yes ❒No ❒Eligible	If eligible, date exam taken:		
	❒Yes ❒No ❒Eligible	If eligible, date exam taken:		

LICENSE/CERTIFICATION INFORMATION

PLEASE LIST ALL CURRENT AND PREVIOUS LICENSES HELD IN ALL JURISDICTIONS

ATTACH A COPY OF ALL LICENSES

State of Issue:	Number:	Current:	Original Issue Date:	Current Issue Date:	Expiration Date:
		❒ Yes ❒ No			
		❒ Yes ❒ No			
		❒Yes ❒ No			
		❒ Yes ❒ No			
		❒ Yes ❒ No			

DEA (attach copies)

DEA #:	Effect:	Expire:
Controlled Dangerous Substance Reg.		
Therapeutic Agent Reg.		

PRACTICE/OFFICE INFORMATION

BILLING INFORMATION

PRACTICE NAME:	BILLING COMPANY NAME (if different) :		
DATE YOU JOINED GROUP/HOSPITAL:	TAX ID:	GROUP NPI:	MEDICARE PIN:
BILLING ADDRESS:	CITY: STATE: ZIP CODE:		
BILLING PHONE:	BILLING FAX:		
BILLING OFFICE EMAIL:	RECEIVE MAIL AT THIS LOCATION: ❒ Yes ❒ No		
LIST ALL PROVIDERS ASSOCIATED WITH THIS PRACTICE:			

MAILING INFORMATION

PRACTICE NAME:		
PHYSICAL STREET ADDRESS:	CITY: STATE: ZIP CODE:	
OFFICE NUMBER: / OFFICE FAX:	OFFICE E MAIL ADDRESS:	

PRIMARY PRACTICE LOCATIONS - Location #1

PRACTICE NAME (if different than billing practice name):	TYPE OF PRACTICE: ❒Solo ❒Group/Partnership ❒Hospital Based		
DATE YOU JOINED GROUP/HOSPITAL:	TAX ID:	GROUP NPI:	MEDICARE PIN:
PHYSICAL STREET ADDRESS:	CITY: STATE: ZIP CODE:		
OFFICE PHONE: / OFFICE FAX:	OFFICE EMAIL ADDRESS		
FOREIGN LANGUAGE(S) IN OFFICE: ❒ Speak ❒ Read ❒ Write	ARE YOU CURRENTLY ACCEPTING NEW PATIENTS: ❒ YES ❒ NO		
ANY PRACTICE RESTRICTIONS? (SPECIFY)	OFFICE HOURS: MONDAY_____ TUESDAY_____ WEDNESDAY_____THURSDAY_____FRIDAY_____ SATURDAY_____SUNDAY_____		

Please submit additional practice location information on a separate sheet.

EDUCATION AND TRAINING
(ATTACH ADDITIONAL SHEETS IF NECESSARY)

MEDICAL OR PROFESSIONAL EDUCATION

SCHOOL/INSTITUTION:	ADDRESS, CITY, STATE, ZIP:	DATES (Month/Year) :	DEGREE:
		From: ___/_____ To: ___/_____	
		From: ___/_____ To: ___/_____	
		From: ___/_____ To: ___/_____	
		From: ___/_____ To: ___/_____	
		From: ___/_____ To: ___/_____	

POST GRADUATE TRAINING/SUPERVISED EXPERIENCE INTERNSHIP/RESIDENCIES/FELLOWSHIPS

SCHOOL/INSTITUTION:	ADDRESS, CITY, STATE, ZIP:	DATES (Month/Year):	SPECIALTY:	TYPE:
		From: ___/_____ To: ___/_____		❒ Internship ❒ Residency ❒ Fellowship
		From: ___/_____ To: ___/_____		❒ Internship ❒ Residency ❒ Fellowship
		From: ___/_____ To: ___/_____		❒ Internship ❒ Residency ❒ Fellowship
		From: ___/_____ To: ___/_____		❒ Internship ❒ Residency ❒ Fellowship
		From: ___/_____ To: ___/_____		❒ Internship ❒ Residency ❒ Fellowship

ACADEMIC APPOINTMENTS

TITLE:	INSTITUTION/ADDRESS:	DATES OF APPOINTMENT:

MEDICAL STAFF APPOINTMENTS
LIST ALL CURRENT AND PAST APPOINTMENTS
(ATTACH ADDITIONAL LISTING AS NECESSARY)

STATUS/SPECIALTY:	FACILITY/ADDRESS:	DATES OF APPOINTMENT:

CHRONOLOGICAL PROFESSIONAL PRACTICE EXPERIENCE
(MOST RECENT FIRST - ATTACH ADDITIONAL SHEETS AS NECESSARY)

ORGANIZATION/PRACTICE:	PHONE:	FROM: /	TO: /
ADDRESS:	POSITION TITLE:	SUPERVISOR:	
DUTIES/RESPONSIBILITIES:			
ORGANIZATION/PRACTICE:	PHONE:	FROM: /	TO: /
ADDRESS:	POSITION TITLE:	SUPERVISOR:	
DUTIES/RESPONSIBILITIES:			

WORK HISTORY GAPS

Please provide explanation for any gaps in the last 5 years

MALPRACTICE/LIABILITY INSURANCE
(Attach copy of current malpractice certificate)

CURRENT CARRIER:		POLICY #:	
ADDRESS:	CITY: STATE: ZIP:		
AMOUNTS OF COVERAGE:	ISSUE DATE:	EXPIRATION DATE:	

MILITARY INFORMATION

Are you subject to mobilization as a member of a reserve or Guard unit, as an individual mobilization augmentee, or subject to recall to active duty as a retired military provider? ❒ Yes ❒ No

If Yes to above, which Service Status applies? (select one)	Which Service Branch applies? (select one)	
❒ Active Reserve	❒ U.S. Army	❒ U.S. Navy
❒ Active National Guard	❒ Army National Guard	❒ U.S. Coast Guard
❒ Retired Reserve	❒ U.S. Air Force	❒ U.S. Marine Corps
❒ Retired Regular	❒ Air National Guard	❒ Commissioned Corps
❒ Retired National Guard	❒ USPHS Commissioned Corps NOAA	

QUESTIONNAIRE/PERSONAL STATEMENTS

A complete detailed written explanation is required for any question that is answered "yes". If any question does not apply write N/A and a complete detailed written explanation is required.

1	Do you currently have any physical impairment or disability that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?	Yes	No
2	Do you currently have any mental impairment or disability that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?	Yes	No
3	Do you currently have any substance abuse problems that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?	Yes	No
4	Have you received treatment for substance abuse related conditions?	Yes	No
5	Have you been convicted of a felony, fraud, narcotics offense, moral, or any other type of ethical crime?	Yes	No
6	Have you been convicted of a misdemeanor case?	Yes	No
7	In the past 5 years, has your license or certification to practice in any jurisdiction been limited, restricted, revoked, suspended, voluntarily relinquished, terminated, subjected to disciplinary action or otherwise acted upon in an adverse manner?	Yes	No
8	In the past 5 years have you been sanctioned or penalized by any hospital, licensing board, government entity or managed care organization?	Yes	No
9	In the past 5 years, have you been involuntarily refused or denied membership on a hospital medical staff?	Yes	No
10	In the past 5 years, have your specific clinical privileges at a facility in any jurisdiction been denied, limited, suspended, diminished, revoked, withdrawn or denied renewal?	Yes	No
11	In the past 5 years, have you been subjected to disciplinary action by any medical organization?	Yes	No
12	In the past 5 years, have you been subjected to any claim(s) or under investigation for unethical conduct?	Yes	No
13	In the past 10 years, have you been the subject of a malpractice claim or are there currently pending malpractice claims, suits, settlements, arbitration proceedings, or complaints filed involving your professional practice?	Yes	No
14	In the past 10 years, have any judgments been made against you or settlements paid by or for you in any professional liability claim?	Yes	No
15	In the past 10 years, have you been denied liability insurance, in whole or in part, or has your policy ever been canceled, involuntarily restricted, denied renewal, or rated up because of the nature of volume of claims against you?	Yes	No
16	In the past 5 years, has your DEA license or narcotics registration been suspended or revoked?	Yes	No

PROFESSIONAL LIABILITY CLAIMS HISTORY DETAIL/EXPLANATION

Please complete this form for every professional liability case filed against you in the last 10 years, whether currently open, settled, dismissed or judgments rendered. Please answer the following questions for EACH claim. Duplicate this page as necessary.

Patient name:	Plaintiff name (if other than patient):		
Your involvement in the case (Attending, consulting):	Date of occurrence (month/day/year):		
Your status in the case (Primary or co-defendant):	Date claim was filed (month/day/year):		
Professional liability insurance carrier involved:			
Additional defendants:			
Describe the allegation and alleged injury to the patient:			
Provide explanation or information of the events leading to the allegation:			
Claimant/Plaintiff filed suit in court? ❒ Yes ❒ No	Court Case #:	State:	County/Parish:
Federal Court (US District Court) Case Number:	District:		
Present status of claim: ❒ Open ❒ Closed			
If closed, indicate the method of resolution: ❒ Dismissed Date: _____ ❒ Settled (with prejudice) Date: _____ ❒ Settled (without prejudice) Date: _____ ❒ Judgment for defendant(s) Date: _____ ❒ Judgment for plaintiff(s) Date: _____	Amount paid on your behalf (if any):		

CERTIFICATION/ATTESTATION AND CONSENT TO THE INSPECTION OF RECORDS AND DOCUMENTS RELEASE OF INFORMATION AND LIABILITY

I certify and attest to the fact that all the information submitted by me in this application is true and accurate to the best of my knowledge and belief.

I authorize TriWest Healthcare Alliance, its professional staff and legal representatives for the purpose of evaluating my professional competence, character, criminal history and ethical conduct, to contact and consult with administrators and members of the professional staff of any treatment facility, institution, professional society, school, employer, law enforcement agency, or practice with which I have been associated. In addition, I consent to the inspection by TriWest Healthcare Alliance, its professional staff and legal representatives of all records and documents, including health records at other treatment facilities that may be material for evaluation of my professional qualifications. I also release from liability all individuals or organizations for their acts performed in good faith and without malice who honestly initiate and respond to the inquiries authorized for use by TriWest Healthcare Alliance. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

_____ _____

Practitioner Signature Date

PLEASE ATTACH
DEPARTMENT OF THE TREASURY INTERNAL REVENUE SERVICE
FORM W-9