

## 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 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.**

CAQH Identification #

## CREDENTIALING APPLICATION

### PERSONAL DATA

PROVIDER'S NAME (Last Name, First Name, MI, Degree)		MAIDEN NAME (If Applicable)	SOCIAL SECURITY NUMBER	
DATE OF BIRTH	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	PLACE OF BIRTH (City, State, Country)	FOREIGN LANGUAGES: <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write	
Individual NPI #:	Medicare UPIN:	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	If you are not a U.S. Citizen, are you lawfully authorized to work in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eligible	If eligible, date exam taken:		
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eligible	If eligible, date exam taken:		
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> 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: Y/N	

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: <input type="checkbox"/> Solo <input type="checkbox"/> Group/Partnership <input type="checkbox"/> 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 E MAIL ADDRESS	
FOREIGN LANGUAGE(S) IN OFFICE: <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write		ARE YOU CURRENTLY ACCEPTING NEW PATIENTS: <input type="checkbox"/> YES <input type="checkbox"/> 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: ____ / ____		<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship
		From: ____ / ____ To: ____ / ____		<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship
		From: ____ / ____ To: ____ / ____		<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship
		From: ____ / ____ To: ____ / ____		<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship
		From: ____ / ____ To: ____ / ____		<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> 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? (Circle one)	Which Service Branch applies? (Check one)
Active Reserve Active National Guard Retired Reserve Retired Regular Retired National Guard	US Army                      US Navy Army National Guard      US Coast Guard US Air Force                  US Marine Corps Air National Guard          Commissioned Corps 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Court Case #	State	County/Parish
Federal Court (US District Court) Case Number		District		
Present status of claim <input type="checkbox"/> Open <input type="checkbox"/> Closed				
If closed, indicate the method of resolution:			Amount paid on your behalf (if any)	
<input type="checkbox"/> Dismissed <input type="checkbox"/> Settled (with prejudice) <input type="checkbox"/> Settled (without prejudice) <input type="checkbox"/> Judgment for defendant(s) <input type="checkbox"/> Judgment for plaintiff(s)			Date: Date: Date: Date: Date:	

**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