



NovaSys Use Only:
Date Mailed _____
Date Received _____
SubProgram _____

Effective 01-01-07 only this application will be accepted for credentialing purposes.

Return within 10 days of receipt

(Allied Health)

Provider Application

_____	_____	_____	_____	_____
Last Name	First Name	MI	Degree	Soc. Sec. Number <i>(Used for identification only)</i>
Date of Birth	____/____/____	Sex ____M ____F	Languages Spoken _____	

NPI (National Provider Identifier)	State License No. (Attach copy)	DEA No. (Attach copy if applicable)
_____	_____	_____
<u>Primary Office Location</u>		<u>Secondary Office Location</u>

Clinic Name

Street Address

City, State, Zip

() _____ () _____
Telephone Number Fax Number

E-Mail Address

County

Office Manager

Clinic Name

Street Address

City, State, Zip

() _____ () _____
Telephone Number Fax Number

E-Mail Address

County

Office Manager

Are you accepting new patients? Yes No

Any restrictions? Yes No
If yes, please define: _____

Please list all health care facilities in which you currently have privileges:

_____ Primary Admitting Facility	_____ City	_____ % of Admits Status
_____ Other Hospital Affiliation	_____ City	_____ % of Admits Status
_____ Other Hospital Affiliation	_____ City	_____ % of Admits Status

Please list any Professional organizations, societies, IPA's or PHO's you are associated with:

_____ Organization Name	_____ Length of Association
_____ Organization Name	_____ Length of Association

This application information must be completed as appropriate to your credentials and specialty and submitted within 10 days from receipt. It is the Policy of NovaSys Health Network that practitioners have the right to review information submitted in support of their credentialing application. (NCQA, CR – 1.5)

Please indicate which participation status you are applying for: Please indicate your specialty and how you would like to be listed in the Provider Directory. If you are Board Certified, you must attach a copy of your Board Certificate.

Primary Care Provider: Internal Medicine _____ Family Practice _____ General Practice _____ Pediatrics _____
Specialty Care Provider: Specialty: _____ Sub-Specialty: _____
Are you Board Certified? Yes ___ No ___
Board Specialty _____
Allied Health Professional: _____
(Please indicate type)
Directory Listing _____
(Indicate how you want to be listed in the directory)

You may submit a detailed Curriculum Vitae in place of this section. (See Note below)

Medical School _____	Address _____	Year Graduated _____
Are you a foreign medical school graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, you must provide a copy of your ECFMG certificate.	
Internship _____	Address _____	Mo/Yr Completed _____ Specialty _____
Residency _____	Address _____	Mo/Yr Completed _____ Specialty _____
Additional Residency _____	Address _____	Mo/Yr Completed _____ Specialty _____
Fellowship _____	Address _____	Mo/Yr Completed _____ Specialty _____
Practice Experience _____	Address _____	From (mo/yr) _____ To (mo/yr) _____
Other Practice Experience _____	Address _____	From (mo/yr) _____ To (mo/yr) _____

NOTE: Please use month/year to identify work and educational periods. Also, please provide an explanation for any gaps of 30 days or more. This includes vacation, studying for ECFMG, studying for boards, time relocating or finding a position, etc. Please provide practice experience from Medical School to present.

Appointment Availability:

Please list time frames for appointments in your practice according to the following: (example: Preventive Care Appointments – Seen within 4-6 Weeks)

Timeliness of Routine Care Appointments _____ Timeliness for Preventive Care Appointments _____

Timeliness of Urgent Care Appointments _____ Timeliness of Emergency Care _____

Access to After Hours Care _____

Telephone Service After Hours: Please list the method for after hours telephone services in your practice: _____

Do you provide the following services in your offices :

Lab Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____ On-site		Reference Lab
Radiology	<input type="checkbox"/> Yes	<input type="checkbox"/> No
EKG	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Audiology	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Treadmill	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sigmoidoscopy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other: _____		

Billing Information: This information must match locator 33 on the HCFA 1500 Form. **Please attach a current W9 form.**

Street Address _____ City _____ State _____ Zip _____ Telephone Number _____ Fax Number _____

Is this a billing service? Yes No Medicare # _____ Medicaid # _____ UPIN # _____

Electronic Billing:

Do you currently file claims electronically? Yes No If yes, what service bureau/claims clearinghouse do you use? _____
What software do you use? _____

Professional Liability Insurance: **(Submit facesheet of current policy)**

Have you ever been denied professional liability insurance or has your coverage ever been cancelled or not renewed. Yes No

If "Yes," please explain _____

Present Carrier's Name _____

Complete Address _____
(No and Street) _____ (City) _____ (State) _____ (Zip) _____

Policy Number _____ Policy Limits _____ Effective Dates (From) _____ (To) _____

Prior Carriers (During past ten (10) years. If insufficient space, provide information on additional paper.)

Prior Carrier's Name _____

Complete Address _____
(No and Street) _____ (City) _____ (State) _____ (Zip) _____

Policy Number _____ Policy Limits _____ Effective Dates (From) _____ (To) _____

Prior Carrier's Name _____

Complete Address _____
(No and Street) _____ (City) _____ (State) _____ (Zip) _____

Policy Number _____ Policy Limits _____ Effective Dates (From) _____ (To) _____

Malpractice Claims History

All information is held in strict confidence and will be used for credentialing and recredentialing purposes only. Failure to supply sufficient details may delay approval of your application or prevent its approval.

During the past five (5) years have there been or are there currently pending any malpractice claims, suits, judgements, settlements or arbitration proceedings involving your professional practice? Yes No

If you answered "Yes" to the question above, please supply the following information on Attachment "A"

- Name of Insurance Carrier
- Date of Incident
- Date Suit or Claim was Filed
- Your Involvement in Patient's Care
- Nature and Substance of Claim
- Describe any other Details Pertinent to the Case
- Identify other Parties Named in the Suit
- Current Status of Case
- Total Amount of Settlement/Judgement
- Amount Paid on your Behalf

Physician Signature: _____ **Date:** _____

Confidential Information: You MUST attach a detailed explanation for any question to which you respond "Yes".

1. Have you ever been convicted of a crime or do you have any felony or misdemeanor charges pending (other than traffic offenses). Yes No
2. Have you ever had any of the following items involuntarily denied, revoked, suspended, not renewed, placed under probation, subjected to disciplinary action or otherwise limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items?
 - A. State License Yes No
 - B. DEA registration or other applicable narcotic registration Yes No
 - C. Hospital or other health care facility staff membership or privileges Yes No
 - D. Professional ethics committee Yes No
 - E. Professional organization membership Yes No
 - F. Medicare, Medicaid, or other local, state, and/or federal government program participation. Yes No
 - G. HMO, PPO, or other prepaid health plan participation Yes No
 - H. Regulatory agency (CLIA, OSHA, etc.) Yes No
 - I. Professional Training School or Program Yes No
3. Have you ever been subject of any reports to a state or federal data bank? Yes No
4. Do you or a member of your family own or have an investment in; a testing center, hospital, surgical center, or other business dealing with the provision of ancillary health services, equipment or supplies? If "Yes", please provide the following information. Attach an additional page, if needed.

Name of Organization	Tax ID Number	Street Address	City	State	Zip
Type of Organization	Size of Organization	% of Business Owned/Invested		Nature of Business Interest	

Health Status Questions: You MUST Give an explanation for any questions marked "Yes".

1. Are you currently under the care of a physician for a continuing health problem? Yes No
2. Have you been hospitalized or received any other institutional care for a health problem in the last five (5) years? Yes No
3. Do you have **at the present time** a chemical dependency/substance abuse problem, treated or untreated, which in any way impairs your ability to practice to the fullest extent of your licensure and qualifications or in any way poses a risk of harm to your patients? Yes No
4. Have you **in the past** had a chemical dependency/substance abuse problem, treated or untreated, which in any way impaired your ability to practice to the fullest extent of your licensure and qualifications or in any way posed a risk or harm to your patients? Yes No
5. Are you currently taking any medications that may affect either your clinical judgement or motor skills? Yes No
6. Do you have **at the present time** any physical or mental health condition, treated or untreated, which in any way impairs your ability to practice to the fullest extent of your licensure and qualifications, with or without reasonable accommodations according to accepted standards of professional performance and without posing a direct threat to patients? Yes No
7. Have you **in the past** had any physical or mental health condition, treated or untreated, which in any way impaired your ability to practice to the fullest extent of your licensure and qualifications, with or without reasonable accommodations according to accepted standards of professional performance and without posing a direct threat to patients? Yes No

Call Coverage: Please list those Physicians who cover for you after hours and when you are out of town. It is imperative that you have seven (7) day a week, twenty-four (24) hour coverage.

Please List name, address, and phone number of covering physicians:

1.

(Physician)	(Specialty)	(Address)	(Telephone Number)
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2.

(Physician)	(Specialty)	(Address)	(Telephone Number)
-------------	-------------	-----------	--------------------
3.

(Physician)	(Specialty)	(Address)	(Telephone Number)
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Provider Attestation, and Obtain/Release Authorization

I hereby affirm and attest that all statements, answers, and information contained in this application are true to the best of my knowledge, information, and belief. I understand that falsification, misrepresentation, or omission of any fact(s) requested would be sufficient cause for denial of this application and/or subsequent termination of any participating privileges granted upon the basis of this application.

I hereby affirm and attest that no changes to the wording of this application have been made by me or are known to me. I also agree that if any changes are found, I will complete a new application.

I understand that the information contained in this application will be used to evaluate my credentials according to the quality assessment standards of NovaSys Health Network. As part of this evaluation process and for the purpose of verifying any information provided on or relative to this application, I grant NovaSys Health Network, its credentialing delegate, or the entity which has employed NovaSys Health Network to assist in its credentialing process, permission to contact any individual, institution, agency, or other entity identified on or relative to this application.

I also grant permission for NovaSys Health Network, or its credentialing agent to perform an on-site review of my practice location(s). I understand that this application process will not be considered complete without an on-site review for all primary care providers.

I also grant permission for NovaSys Health Network who may be acting as the credentialing agent for other organizations under a delegation arrangement, the right to furnish any information in regards to my credentialing process to use in the organizations final decision of appointment.

In the event that I subsequently receive notice of participating status, I authorize NovaSys Health Network to use this information, excluding the Licenses and DEA Certificates, Professional Liability Insurance, Confidential Information, and the Confidential Health Status sections to answer any questions that covered persons may have about my practice. I further agree that if I receive notice of participating status, I will assume the duty of informing NovaSys Health Network in a timely manner of subsequent changes in any of the information provided on or relative to this application.

I hereby release, indemnify, and agree to hold harmless NovaSys Health Network, its agents, representatives, and employees, and any person or entity who or which provides information described above.

I understand that I will be notified via certified mail if information submitted for Credentialing purposes from outside sources, such as the NPDB, varies substantially from information that I have provided. The credentialing agency is not obligated to reveal the source of information if the information is not obtained to meet the requirements of the credentialing verification requirements or if law prohibits disclosure. (NCQA, CR – 1.6 & 1.7)

It is the Policy of NovaSys HEALTH NETWORK that Practitioners have the right to review information submitted in support of their credentialing application. (NCQA, CR –1.5)

I understand that this application is effective for 180 days from the date of signature. I also understand that if this application exceeds the maximum allowed time set by NCQA before the credentialing decision has been determined, a new application will be requested.

(Print or type name)

(Signature)

_____/_____/_____
(Date)



Malpractice

Carrier Name _____

Date of Incident _____

Date Filed _____

Your Status in the Case? Primary Defendant _____ Co-Defendant _____ Other _____

Nature and Substance of Claim _____

Your Involvement in Patient's Care _____

Describe Any Other Details Pertinent to the Case _____

Identify Other Parties Named in the Suit: _____

Current Status of Case Dropped _____ Pending _____ Found for Defendant _____
Dismissed _____ Settled Out of Court _____ Found for Plaintiff _____

If Pending, when was the last contact with the Plaintiff's attorney? _____

What is the likely outcome of the case? _____

If damages were paid, what was the amount: Total paid by all parties _____
Amount Paid on Your Behalf _____

Date Suite was Resolved _____

Name _____
(Print or type)

Signature _____

Date _____

Your application will not be processed if you have had a claim and this form is incomplete or not attached to the application.

Request for Taxpayer Identification Number and Certification

Give form to the
Requester. Do NOT
send to the IRS.

Name (if a joint account or you changed your name, see Specific Instructions of page 2.)	
Business Name, if different from above. (See Specific Instructions on page 2.)	
Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other <input type="checkbox"/>	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, State, and ZIP code	
Part I Taxpayer Identification Number (TIN)	
Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, if you are a resident alien OR a sole proprietor, see the instructions on page 2. For other entities, it is your employer identification number, see How to Get a TIN on page 2. Note: <i>If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.</i>	List account number(s) here (optional)
	Social security number OR Employer identification number
Part III Certification	

Under the penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions – You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See instructions on page 2.)

Sign Here	Signature ▶	Date ▶
<p>Purpose of Form – A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.</p> <p>Use Form W-9 to give your correct TIN to the person request it (the requester) and when applicable, to:</p> <ol style="list-style-type: none"> 1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued), 2. Certify you are not subject to backup withholding, or 3. Claim exemption from backup withholding if you are an exempt payee. <p>Note: <i>If a requester gives you a form other than a W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.</i></p> <p>What is Backup Withholding? – Persons making certain payment to you must withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends,</p>	<p>broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.</p> <p>If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. Payments you receive will be subject to backup withholding if:</p> <ol style="list-style-type: none"> 1. You do not furnish your TIN to the requester, or 2. The IRS tells the requester that you furnished an incorrect TIN, or 3. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or 4. You do not certify to the requester that you are not subject to backup withholding under 3 above (for reportable interest and dividend accounts opened after 1983 only), or 	<ol style="list-style-type: none"> 5. You do not certify your TIN when required. See the Part III instructions on page 2 for details. <p>Certain payees and payments are exempt from backup withholding. See the Part II instructions and the separate Instruction for the Requester of Form W-9.</p> <p>Penalties</p> <p>Failure to Furnish TIN – If you fail to furnish you correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.</p> <p>Civil Penalty for False Information With Respect to Withholding – If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.</p> <p>Criminal Penalty for Falsifying Information – Willfully falsifying certification or affirmations may subject you to criminal penalties including fines and/or imprisonment.</p> <p>Misuse of TINs – If the requester discloses or uses TINs in violation of Federal law, the request may be subject to civil and criminal penalties.</p>