NovaSys Use Only:
Date Mailed________________
Date Received________________
SubProgram________________

NovaSys HEALTH

Return within 10 days of receipt

Effective 1-1-07 only this application will be accepted for MD's or DO's.

(MD's or DO's)

Provider Application

Last Name First Name MI ________ Degree ________ Soc. Sec. Number (*Used for identification only*)

NPI ________________ (National Provider Identifier) Medical License Number________________ DEA Certificate Number________________

Primary Office Location

____
Clinic Name

____
Street Address

____
City, State, Zip

( )____________ ( )____________
Telephone Number Fax Number

____
E-Mail Address

____
Office Manager

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

Secondary Office Location

____
Clinic Name

____
Street Address

____
City, State, Zip

( )____________ ( )____________
Telephone Number Fax Number

____
E-Mail Address

____
Office Manager

Any restrictions? ☐ **Yes** ☐ **No**
If yes, please define:________________

Billing Information: **This information must match locator 33 on the HCFA 1500 Form.** ***Please complete the attached W9 form*.**

________________ ( )____________ ( )____________
Street Address City State Zip Telephone Number Fax Number

Is this a billing service? ☐ **Yes** ☐ **No** What software do you use?________________

Electronic Billing: Do you currently file claims electronically? ☐ Yes ☐ No

If yes, what service bureau/claims clearinghouse do you use?________________

________________ ________________ ________________
Primary Admitting Facility City % of Admits Status

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)

Revised 1-1-04:

Please indicate how you would like to be listed in the NovaSys Provider Directory.

Primary Care Provider: Internal Medicine_____ Family Practice _____ General Practice_____ Pediatrics _____

Specialty Care Provider: Specialty ___________________________ Sub-Specialty _________________________

Call Coverage: ***(Name)*** ***(Specialty)*** ***(Telephone)***

____

____

:

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	☐ Yes	☐ No
________________On-site	________________________	Reference Lab
Radiology	☐ Yes	☐ No
EKG	☐ Yes	☐ No
Audiology	☐ Yes	☐ No
Treadmill	☐ Yes	☐ No
Sigmoidoscopy	☐ Yes	☐ No
Other:	________________________________	

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.

In the past five (5) years, have there been any malpractice claims, or judgements either settled, dismissed, or currently pending involving your professional practice? ☐ Yes ☐ No

If you answered "Yes" to the question above, please supply the following information on Attachment "A." Make copies if more than one page is needed.

- **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**

Health Status Questions: ***You MUST attach a detailed explanation for any question to which you respond "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

Physician Signature:____ **Date:**____________________

Provider Attestation and 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 by the participating PHO and/or network, or be subject to applicable state or federal penalties for perjury.

I grant NovaSys Health, its credentialing delegate, or the entity which has employed NovaSys Health 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, 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 who may be acting as the credentialing agent for other organizations under a delegation arrangement, the right to furnish appropriate 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 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 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, 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 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)

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Rev. 5-15-06 PKF

NovaSys HEALTH

Attachment "A"

Malpractice Claim

(One sheet must be completed for each claim made against you, (in the past five (5) years) regardless of outcome or status; photocopy as needed)

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.

AUTHORIZATION AND RELEASE

I hereby authorize the Arkansas State Medical Board to provide my credentialing information gathered by the Board to NovaSys Health Network, Little Rock (a Credentialing Organization) with whom I am affiliating and seek privileges.

This Authorization shall remain in effect for a period not to exceed two (2) years or until revoked by me in writing.

Typed or Printed Name of Physician: ___________________________________

Licensure Number: ____

Signature of Physician: _____________________________ Date: ____________
(Stamped signature is not acceptable)

*This document does not authorize the Arkansas State Medical Board to release information collected to third parties except as later authorized by the above physician and Arkansas law.

Arkansas State Medical Board

Centralized Credentials Verification Service

Phone: (501) 603-3574 (501) 296-1966

Fax: (501) 296-1806

www.armedicalboard.org

FAX back to CCVS within 10 days of receipt.

DO NOT MAIL

Unless submitted with annual license renewal packet.

DO NOT ALTER THE QUESTIONS ON THIS ATTESTATION FORM!!!

Yes ____ No ____ Do you currently maintain individual or group malpractice insurance coverage? *If NO, list reason*: ____________________________

Policy number (s): __________________________ Coverage amounts: ______________________________________ Expiration date: _______________

Insurance Carrier(s)Name: ____________________________________If Group (List Group Name Policy is under):_________________________________

If you answer YES to any of the following questions, provide an explanation of the circumstances on an attached page.

1. Yes ____ No ____ *Since your last attestation*, have your privileges or medical staff membership at any hospital or other healthcare organization been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending?* *If YES, briefly explain on attached page.*

2. Yes ____ No ____ *Since your last attestation*, have you been charged or convicted of (including a plea of guilty or *nolo contendere*) a felony? (NOTE: Applicants must answer affirmatively if records, charges, or convictions have been pardoned, expunged, plead down, released or sealed.)* *If YES, briefly explain on attached page or attach copies of your documents.*

3. Yes ____ No ____ *Since your last attestation,* has your license or certificate to practice medicine or Drug Enforcement Administration registration in any jurisdiction (state or country) been challenged, denied, reduced, limited, suspended, revoked, placed on probation, not renewed, voluntarily or involuntarily relinquished, or is any such action pending?* *If YES, briefly explain on attached page.*

4. Yes ____ No ____ *Since your last attestation*, have you been or are you presently being treated for alcoholism or substance abuse? If Yes, was this voluntary or the result of a Medical Board action?* *If YES, briefly explain on attached page.*

5. Yes ____ No ____ *Since your last attestation*, have you been advised or required by the Arkansas State Medical Board or any other licensing, privileging or credentialing body to seek treatment for a physical or mental health condition?* *If YES, briefly explain on attached page.*

6. Yes ____ No ____ *Since your last attestation,* do you currently, or have you had since your last renewal, any physical or mental health condition, including alcohol or drug dependency, which, with or without accommodation, affects or is reasonably likely to affect your ability to practice medicine or to perform professional or medical staff duties appropriately?* *If YES, briefly explain on attached page.*

7. Yes ____ No ____ *Since your last attestation*, are you presently involved in the use of any illegal substance?* *If YES, briefly explain on attached page.*

8. Yes ____ No ____ *Since your last attestation*, have any malpractice claims or professional liability lawsuits been filed against you?* *If YES, briefly explain on attached page.* **CLAIM DATE ____/____/____ CLAIMANT'S INITIALS ____________________. ASMB Requirement (Medical Practices Act 17-95-103)**

9. Yes ____ No ____ *Since your last attestation,* have any malpractice judgments been entered against you, or settlements been agreed to, in professional liability lawsuits or malpractice claims?* *If YES, briefly explain on attached page or attach documents.*

   CLAIM DATE _____/_____/_____ CLAIMANT'S INITIALS ___________________.

10. Yes ____ No ____ Have you participated in continuing medical education related to your area of practice **since your last AR license renewal**?*

    If NO, list reason:____

11. How many CME credits have you acquired since your last AR license renewal? _______How many relate to your practice specialty? ________.

ATTESTATION – ALL QUESTIONS MUST BE ANSWERED (if not applicable, put N/A in blank)

I affirm that all information contained in the original application or most recent update is true, correct, current, and complete in all respects to the best of my ability. I accept the responsibility to keep the Arkansas State Medical Board advised of any change or appropriate addition to any information contained in this form between now and the time such information is updated by subsequent renewals or updates.

____

Licensee's Signature (Required) ***(No Rubber Stamps)*** **Date Signed (Month/Day/Year - Required)**

____ ______________________________

Licensee's Printed/Typed Name (Required) **AR License Number (Required)**

*JCAHO; NCQA application/attestation intent – 2006 Standards

Form **W-9**
(Rev. December 1996)
Department of the Treasury
Internal Revenue Service

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: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ____________

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)

List account number(s) here (optional)

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: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number

OR

Employer identification number

Part II For Payees exempt From Backup Withholding (See the instructions on page 2)

►

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 ►**

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.

Use Form W-9 to give your correct TIN to the person requestg it (the requester) and when applicable, to:

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.

Note: *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.*

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, 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.

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:

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
5. You do not certify your TIN when required. See the Part III instructions o page 2 for details.

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.**

Penalties

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 willf neglect.

Civil Penalty for False Information With Respect to Withholding – If you make a false statement with no reasonable basis that results ir no backup withholding, you are subject to a $500 penalty.

Criminal Penalty for Falsifying Information– Willfully falsifying certification or affirmations may subject you to criminal penalties including fines and/or imprisonment.

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.