

Follow these instructions to use the Idaho Practitioner Application (IPA):

- Complete the application in its entirety using black or blue ink. Keep an unsigned and undated copy of the application on file for future requests. When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate. Please sign and date pages 9 , 10 and 11. Document any "YES" responses on the Attestation Question page.
- Inquire with the organization prior to submitting this application to any healthcare-related organization, as you may need authorization (through a pre-application process) before the application is accepted. Identify the healthcare related organization(s) to which this application is being submitted in the space provided below.
- Attach copies of requested documents each time the application is submitted.
- If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- Check the provided box at the top of the section if a section does not apply to you.
- Expect addendums from the requesting organizations for information not included on the IPA.

This application is submitted to

I. INSTRUCTIONS

This form should be **typed or legibly printed in black or blue ink**. If more space is needed than provided, attach additional sheets and reference the question being answered.

Please do not use abbreviations. **Current copies of the following documents must be submitted with this application**

(all are required for MDs, DOs; as applicable for other health practitioners). If not available, indicate why.

- State Professional License(s)
- DEA Certificate w/ Idaho address
- ECFMG (if applicable)
- ISBP Certificate
- Passport photo (for hospitals only)
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

**** All sections must be completed in their entirety.****

II. PRACTITIONER INFORMATION

Last name (include suffix; Jr., Sr., III)		First (do not abbreviate)		Middle (do not abbreviate)	
Other name(s) under which you have been known by reference, licensing and or educational institutions?				Degree(s)	
Home telephone number		Pager number		Cell number	
Home mailing address		City		State	
Birth date		Birth place (city, state, country)		ZIP Code	
Social security number		Citizenship			
Languages spoken by practitioner		Specialty <input type="checkbox"/> PCP <input type="checkbox"/> Urgent Care <input type="checkbox"/> Specialist		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
NPI		Medicare UPIN		Medicare number (ID)	
Medicaid number(s)		Other professional interests in practice, research, etc.		Specialty	
				Subspecialties	

III. PRACTICE INFORMATION

Effective Date at Primary Practice location _____			
Name of practice, affiliation or clinic name			Department name (if hospital based)
Primary office street address		City	State
ZIP Code			
Patient appointment telephone number		Fax number	Name affiliated with tax ID number
Federal tax ID number			
Mailing address (if different from above)		City	State
ZIP Code			

III. PRACTICE INFORMATION (CONTINUED)	Billing address (if different from above)		City	State	ZIP Code
	Office manager / Administrator name		Administration telephone number	Fax number	E-mail address
	Credentialing contact (if different from above)		Credentialing telephone number	Fax number	E-mail address
	Effective Date at Secondary Practice location _____				
	Secondary office street address		City	State	ZIP Code
	Patient appointment telephone number		Fax number	Name affiliated with tax ID number	Federal tax ID number
	Mailing address (if different from above)		City	State	ZIP Code
	Billing address (if different from above)		City	State	ZIP Code
	Office manager / Administrator name		Administration telephone number	Fax number	E-mail address
	Credentialing contact (if different from above)		Credentialing telephone number	Fax number	E-mail address
List other office locations with above information on a separate sheet.					

IV. PROFESSIONAL LICENSURE	Effective Date at Primary Practice location _____			Status <input type="checkbox"/> PCP <input type="checkbox"/> Urgent Care <input type="checkbox"/> Specialist	
	Issue date	Expiration date	Name of sponsor if required by licensure, (i.e. Physician's Assistant).		
	Drug Enforcement Administration (DEA) registration number		Issue date	Expiration date	
	State controlled substance certificate number		Issue date	Expiration date	
	ECFMG number (applicable to foreign medical graduates)			Date issued	

V. ALL OTHER PROFESSIONAL LICENSES	State	License/registration/certificate number		Date Issued
	Expiration date	Year relinquished	Reason	
	State	License/registration/certificate number		Date Issued
	Expiration date	Year relinquished	Reason	
	State	License/registration/certificate number		Date Issued
	Expiration date	Year relinquished	Reason	

VI. UNDER-GRADUATE EDUCATION	Name of college or university				Does Not Apply <input type="checkbox"/>
	Degree received			Graduation date	
	Mailing address	City	State	ZIP code	
	Name of college or university				
	Degree received			Graduation date	
	Mailing address	City	State	ZIP code	

VII. MEDICAL/PROFESSIONAL EDUCATION	Medical/Professional school					
	Start date		Graduation date		Degree received	
	Mailing address		City		State	
			ZIP code			
			Phone		Fax	
Medical/Professional School						
Start date		Graduation date		Degree received		
Mailing address		City		State		
		ZIP code				
		Phone		Fax		

VIII. GRADUATE EDUCATION	Institution Does Not Apply <input type="checkbox"/>				
	Program or course of study			Faculty director	
	Mailing address		City	State	ZIP code
	Dates attended		Phone	Fax	

IX. INTERNSHIP/PGYI	Institution Does Not Apply <input type="checkbox"/>				
	Program director				
	Mailing address		City	State	ZIP code
	Start date	Completion date	Phone	Fax	
	Type of internship		Specialty		
	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please explain on separate sheet.)				

X. RESIDENCIES	Institution Does Not Apply <input type="checkbox"/>				
	Program director				
	Mailing address		City	State	ZIP code
	Start date	Completion date	Phone	Fax	
	Type of residency		Specialty		
	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please explain on separate sheet.)				
	Institution Does Not Apply <input type="checkbox"/>				
	Program director				
	Mailing address		City	State	ZIP code
	Start date	Completion date	Phone	Fax	
Type of residency		Specialty			
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please explain on separate sheet.)					

XI. FELLOWSHIPS	Institution					Does Not Apply <input type="checkbox"/>	
	Program director						
	Mailing address			City	State		ZIP code
	Start date	Completion date	Phone		Fax		
	Course of study						
	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please explain on separate sheet.)						
	Institution					Does Not Apply <input type="checkbox"/>	
	Program director						
	Mailing address			City	State		ZIP code
	Start date	Completion date	Phone		Fax		
Course of study							
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please explain on separate sheet.)							

XII. PRECEPTORSHIP	Institution					Does Not Apply <input type="checkbox"/>	
	Department chairman						
	Mailing address			City	State		ZIP code
	Start date	Completion date	Phone		Fax		
	Training						

XIII. FACULTY APPOINTMENT	Institution					Does Not Apply <input type="checkbox"/>	
	Department chairman						
	Mailing address			City	State		ZIP code
	Start date	Completion date	Phone		Fax		
	Position						

XIV. BOARD CERTIFICATION	Are you board or otherwise professionally certified? Does Not Apply <input type="checkbox"/>					
	<input type="checkbox"/> Yes If yes, please complete below			<input type="checkbox"/> No If no, describe your intent for certification, if any, and dates of testing for Certification on separate sheet.		
	Issuing Board/Entity	State issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)
	Have you applied for certification other than those indicated above? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	If so, list certification and date.					
If you participate in a specialty which does not have board certification, please indicate specialty.						

XV. OTHER CERTIFICATIONS	ACLS, BLS, ATLS, PALS, NRP, NALS (i.e., Fluoroscopy, Radiography, etc. – Attach certificate if applicable)				Does Not Apply <input type="checkbox"/>
	Type			Number	Expiration Date
	Type			Number	Expiration Date
	Type			Number	Expiration Date
	Type			Number	Expiration Date

XVI. HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS	Does Not Apply <input type="checkbox"/>				
	Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you (A) have current affiliations, (B) applications in process, (C) have had previous affiliations or, if no current affiliation, (D) have a current coverage plan. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.				

A. CURRENT AFFILIATIONS	Name of primary facility (Do you have admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No)				
	Department		Department / Clinical Chair		Status (active, provisional, courtesy, temporary, etc.)
	Mailing address		City	State	ZIP code
	Phone number		Fax number		Appointment date
	Name of secondary facility (Do you have admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No)				
	Department		Department / Clinical Chair		Status (active, provisional, courtesy, temporary, etc.)
	Mailing address		City	State	ZIP code
	Phone number		Fax number		Appointment date
	Name of other facility (Do you have admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No)				
	Department		Department / Clinical Chair		Status (active, provisional, courtesy, temporary, etc.)
	Mailing address		City	State	ZIP code
	Phone number		Fax number		Appointment date

B. APPLICATIONS IN PROCESS	Hospital/Institution				
	Mailing address		City	State	ZIP code
	Phone number		Fax number		Date application submitted
	Hospital/Institution				
	Mailing address		City	State	ZIP code
	Phone number		Fax number		Date application submitted

A. CURRENT AFFILIATIONS	Name of facility				
	Department		Department / Clinical Chair		
	Mailing address		City	State	ZIP code
	Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)		
	Reason for leaving			Appointment date (from– to)	
	Name of facility				
	Department		Department / Clinical Chair		
	Mailing address		City	State	ZIP code
	Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)		
	Reason for leaving			Appointment date (from– to)	
	Name of facility				
	Department		Department / Clinical Chair		
Mailing address		City	State	ZIP code	
Phone number		Fax number	Previous status (active, provisional, courtesy, temporary, etc.)		
Reason for leaving			Appointment date (from– to)		

D. INPATIENT COVERAGE - ON-CALL PLAN	For those without admitting privileges, please attach signed letter of agreement from the physician or group representative that admits and manages the inpatient care for your patients.		Does Not Apply <input type="checkbox"/>	
	For those with admitting privileges, please list the physicians who provide call coverage for you.			
	Name of admitting physician/practice/clinic/group		Hospital where privileged	

XVII. WORK HISTORY	Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient.				
	Name of current practice/employer				
	Contact name	Phone number	Fax number	From	To
	Mailing address	City	State	ZIP code	
	Reason for leaving				
	Name of current practice/employer				
	Contact name	Phone number	Fax number	From	To
	Mailing address	City	State	ZIP code	
Reason for leaving					

XVII. WORK HISTORY (CONTINUED)	Name of current practice/employer				
	Contact name	Phone number	Fax number	From	To
	Mailing address	City	State	ZIP code	
	Reason for leaving				
	Please account for all gaps in time between date of medical / professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable.				
	Activity / Name			From	To

XVIII. PROFESSIONAL AFFILIATIONS	Please List Membership In All Professional Societies Complete Name of Society		Date Joined	Current Member	
				Yes	No

XIX. PEER REFERENCES	List three professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. One reference must be from same discipline.				
	Name of reference			Title and specialty	
	Mailing address	City	State	ZIP code	
	E-mail address	Telephone number	Fax number	Cell phone number (optional)	
	Name of reference			Title and specialty	
	Mailing address	City	State	ZIP code	
	E-mail address	Telephone number	Fax number	Cell phone number (optional)	
	Name of reference			Title and specialty	
	Mailing address	City	State	ZIP code	
	E-mail address	Telephone number	Fax number	Cell phone number (optional)	

XX. PROFESSIONAL LIABILITY	Current insurance carrier			Policy number	
	Mailing address		City	State	ZIP code
	Phone number	Fax number		Origination (retroactive) date	
	Per claim amount	Aggregate amount		Effective date	Expiration date
	Please list ALL professional liability carriers within the past ten years				
	Name of carrier			Policy number	
	Mailing address		City	State	ZIP code
	Phone number	Fax number		From	To
	Name of carrier			Policy number	
	Mailing address		City	State	ZIP code
	Phone number	Fax number		From	To
	Name of carrier			Policy number	
	Mailing address		City	State	ZIP code
Phone number	Fax number		From	To	

XXI. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL	Practitioner name (print or type)		Does Not Apply <input type="checkbox"/>
	Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected health information (PHI). Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.		
	Date and clinical details of the incident, with preceding events		
	Date	Details	
	Your role and specific responsibility in the incident		
	Subsequent events, including patient's clinical outcome		
	Date suit or claim was filed		
	Name and Address of Insurance Carrier that handled the claim		
	Your status in the legal action (primary defendant, co-defendant, other)		
	Current status of suit or other action		
Date of settlement, judgment, or dismissal			
If case was settled out-of-court, or with a judgment, settlement amount attributed to you? \$			

IDAHO PRACTITIONER ATTESTATION QUESTIONS - *To be completed by the practitioner*

Please circle your answer to **EACH** of the following questions. If you circle "Yes", provide details as specified on a separate sheet.
If you attach additional sheets, sign and date each sheet.

A.	PROFESSIONAL SANCTIONS		
①	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?		
	a.	License to practice any profession in any jurisdiction	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b.	Other professional registration or certification in any jurisdiction	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c.	Specialty or subspecialty board certification	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d.	Membership on any hospital medical staff	<input type="checkbox"/> Yes <input type="checkbox"/> No
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
	f.	Medicare, Medicaid, FDA, governmental, national or international regulatory agency or any public program	<input type="checkbox"/> Yes <input type="checkbox"/> No
	g.	Professional society membership or fellowship	<input type="checkbox"/> Yes <input type="checkbox"/> No
	h.	Participation/membership in an HMO, PPO, IPA, PHO or other entity	<input type="checkbox"/> Yes <input type="checkbox"/> No
	i.	Academic Appointment	<input type="checkbox"/> Yes <input type="checkbox"/> No
j.	Authority to prescribe controlled substances (DEA or other authority)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
②	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		<input type="checkbox"/> Yes <input type="checkbox"/> No
③	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		<input type="checkbox"/> Yes <input type="checkbox"/> No
④	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		<input type="checkbox"/> Yes <input type="checkbox"/> No
B.	CRIMINAL HISTORY		
①	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	a.	Do you have notice of any such anticipated charges?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b.	Are you currently under governmental investigation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C.	AFFIRMATION OF ABILITIES		
①	Do you presently use any drugs illegally?		<input type="checkbox"/> Yes <input type="checkbox"/> No
②	Do you have, or have you ever had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or could affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. <u>If the answer to this question is yes</u> , please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		<input type="checkbox"/> Yes <input type="checkbox"/> No
③	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		<input type="checkbox"/> Yes <input type="checkbox"/> No
D.	LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section, please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)		
①	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		<input type="checkbox"/> Yes <input type="checkbox"/> No
②	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?		<input type="checkbox"/> Yes <input type="checkbox"/> No
③	Are there any such claims being asserted against you now?		<input type="checkbox"/> Yes <input type="checkbox"/> No
④	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
⑤	Are any of the privileges that you are requesting not covered by your current malpractice coverage?		<input type="checkbox"/> Yes <input type="checkbox"/> No
E.	Attestation		
<p>I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 30%; border-bottom: 1px solid black; text-align: center;"> Typed or printed name </div> <div style="width: 30%; border-bottom: 1px solid black; text-align: center;"> Signature </div> <div style="width: 30%; border-bottom: 1px solid black; text-align: center;"> Date </div> </div>			

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Printed Name Here _____

Signature _____

Date _____

Review dates and initials

Authorization for Release of Information

By submitting this Authorization for Release of Information form in conjunction with the Idaho Practitioner Application or Blue Cross of Idaho recredentialing application, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for participating status with Blue Cross of Idaho for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications in a timely manner. I understand that the application will not be processed until Blue Cross of Idaho deems the application complete.
2. I further understand and acknowledge that Blue Cross of Idaho or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of Blue Cross of Idaho as part of the verification and credentialing process.
3. I authorize all individuals, institutions and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to Blue Cross of Idaho, their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with providing information, investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of Blue Cross of Idaho or its respective agent(s) who act in good faith and without malice in connection with the investigation of this application.
6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have participating status at Blue Cross of Idaho, unless revoked by me in writing.
7. I acknowledge that I have been informed of, and hereby agree to abide by Blue Cross of Idaho rules, regulations, contractual agreements, and policies.
8. I acknowledge that I am responsible for notifying Blue Cross of Idaho of any changes/challenges to licensure, DEA, malpractice claims, criminal convictions, hospital privileges or other disciplinary actions.
9. I attest to the accuracy, currency and completeness of the information provided. I understand and agree that any misstatements in or omissions from the application and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of participation agreement.
10. I agree to exhaust all available procedures and remedies as outlined in the, rules, regulations, and policies, and/or contractual agreement of Blue Cross of Idaho before initiating judicial actions.
11. I understand that completion and submission of the Authorization for Release does not automatically grant me participating status with Blue Cross of Idaho.
12. I further acknowledge that I have read and understand the foregoing Authorization for Release of Information. A photocopy of this Authorization for Release of Information shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

Print Name: _____

Signature: _____

Stamped signature is not acceptable

Date: _____

Modification to the wording or formation of the Authorization for Release of Information may invalidate an application.