Initial Practitioner Credentialing Application Checklist

Thank you for your interest in Blue Cross of Idaho. Use this checklist to ensure proper completion of the enclosed Idaho Practitioner Application – September 2019.

- Completed Application: Ensure all sections of the application are complete or indicate "Does Not Apply" as appropriate. Please be aware that referencing Curriculum Vitae (CV) is not an acceptable substitute for completing the application.
- Licenses: List all current and expired state professional licenses, including those for Idaho (page 2, Section V)
- DEA Registration: Provide DEA registration information, as applicable (page 2, Section IV)
- Education: Provide education information, complete with start and end dates (pages 2-4, Section VI, VII, VIII)
- Certifications: Provide board and any other applicable certification information (page 4, Section XIV). In addition, nurse practitioners and allied health practitioners must provide copies of professional certifications (i.e., AANP, ANCC, CCNA, CRNA etc.)
- Hospital Affiliations: List current primary admitting facility along with other current or pending hospital affiliations (page 5, Section XVI)
- Work History: Provide complete work history and explain lapses for the previous five years or since earning degree (page 6, Section XVII)
- Liability Insurance: Include copy of current professional liability insurance face sheet showing minimum requirements of $1 million/$3 million in coverage
- Idaho Practitioner Attestation Questions Form: Provide a completed, signed, dated and unaltered copy with written explanation for any "Yes" answers (pages 9 and 10)
- Release of Authorization Form: Provide a completed, signed, dated and unaltered copy (page 11)

Please note: Your application information cannot be more than 180 days old at the time of Blue Cross of Idaho's review. On average, our credentialing process takes 60 to 90 days. Please make sure you provide ample processing time when signing and submitting your application. ***We cannot accept or process incomplete or outdated applications.*** Lack of correct information will delay your ability to contract with Blue Cross of Idaho.

We accept applications by fax at 208-387-6818 or email to ***PR2PI@bcidaho.com***.

For credentialing questions, call 208-286-3447.

(Revised: 9/2019)

3000 E. Pine Avenue, Meridian, ID 83642-5995 • P.O. Box 7408, Boise, ID 83707-1408 • (208) 345-4550 • www.bcidaho.com

Blue Cross of Idaho

Applicant Rights for Credentialing and Recredentialing

- Applicants have the right, upon request, to be informed of the status of their application. Applicants may contact credentialing staff by telephone or in writing to ask about the status of their application.
- Credentialing staff will respond to the applicant's request for information about their application status either by telephone or in writing within 15 calendar days. Blue Cross of Idaho is not required to provide the applicant with information that is peer-review protected. Information reported to the National Practitioner Data Bank (NPDB) is considered confidential and shall not be disclosed. An applicant will be advised that they may complete a self-query to obtain information that is contained in the NPDB.
- Applicants have the right to review the information submitted in support of their credentialing application. This review is at the applicant's request.
- The applicant will be notified in writing of initial credentialing decisions within 60 days of being reviewed.
- Credentialing staff will notify the applicant in writing of any information obtained during the credentialing process that varies significantly from the information provided to Blue Cross of Idaho.
- Should the information provided by the applicant on his or her application vary substantially from the information obtained and/or provided to Blue Cross of Idaho by other individuals or organizations contacted as part of the credentialing and/or recredentialing process, credentialing staff will contact the applicant by fax, mail or email to advise the applicant of the variance and provide the applicant with the opportunity to correct the information if it is incorrect.
- The applicant will submit any corrections in writing within 30 calendar days to the credentialing staff. Any additional documentation will be kept as part of the applicant's credential file.

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Form No. 9-203NI (09-19)

Idaho Practitioner Application

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		Email address
Home mailing address		City	State	ZIP Code
Birth date	Birth place (city, state, country)	Social security number	Citizenship	
Languages spoken by practitioner		Specialty ❑ PCP ❑ Urgent Care ❑ Specialist		Gender ❑ Male ❑ 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

Modification to the wording or format of the Idaho Practitioner Application may invalidate the application.

Form No. 9-203NI (09-19)

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 ❑ PCP ❑ Urgent Care ❑ 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 ❑
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

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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 ❑

Program or course of study | Faculty director

Mailing address | City | State | ZIP code

Dates attended | Phone | Fax

IX. INTERNSHIP/PGYI

Institution — Does Not Apply ❑

Program director

Mailing address | City | State | ZIP code

Start date | Completion date | Phone | Fax

Type of internship | Specialty

Did you successfully complete the program? ❑ Yes ❑ No (If no, please explain on separate sheet.)

X. RESIDENCIES

Institution — Does Not Apply ❑

Program director

Mailing address | City | State | ZIP code

Start date | Completion date | Phone | Fax

Type of residency | Specialty

Did you successfully complete the program? ❑ Yes ❑ No (If no, please explain on separate sheet.)

Institution — Does Not Apply ❑

Program director

Mailing address | City | State | ZIP code

Start date | Completion date | Phone | Fax

Type of residency | Specialty

Did you successfully complete the program? ❑ Yes ❑ No (If no, please explain on separate sheet.)

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XI. FELLOWSHIPS

Institution — Does Not Apply ❑

Program director

Mailing address	City	State	ZIP code

Start date	Completion date	Phone	Fax

Course of study

Did you successfully complete the program? ❑ Yes ❑ No (If no, please explain on separate sheet.)

Institution — Does Not Apply ❑

Program director

Mailing address	City	State	ZIP code

Start date	Completion date	Phone	Fax

Course of study

Did you successfully complete the program? ❑ Yes ❑ No (If no, please explain on separate sheet.)

XII. PRECEPTORSHIP

Institution — Does Not Apply ❑

Department chairman

Mailing address	City	State	ZIP code

Start date	Completion date	Phone	Fax

Training

XIII. FACULTY APPOINTMENT

Institution — Does Not Apply ❑

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 ❑

❑ **Yes** If yes, please complete below

❑ **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? ❑ Yes ❑ No

If so, list certification and date.

If you participate in a specialty which does not have board certification, please indicate specialty.

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XV. OTHER CERTIFICATIONS

ACLS, BLS, ATLS, PALS, NRP, NALS (i.e., Fluoroscopy, Radiography, etc. – Attach certificate if applicable)		Does Not Apply ❑
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 ❑

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? ❑ Yes ❑ 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? ❑ Yes ❑ 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? ❑ Yes ❑ 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	

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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.

For those with admitting privileges, please list the physicians who provide call coverage for you.

Does Not Apply ❑

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				

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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)

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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 ❑

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? $

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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	❑ Yes	❑ No
	b.	Other professional registration or certification in any jurisdiction	❑ Yes	❑ No
	c.	Specialty or subspecialty board certification	❑ Yes	❑ No
	d.	Membership on any hospital medical staff	❑ Yes	❑ No
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	❑ Yes	❑ No
	f.	Medicare, Medicaid, FDA, governmental, national or international regulatory agency or any public program	❑ Yes	❑ No
	g.	Professional society membership or fellowship	❑ Yes	❑ No
	h.	Participation/membership in an HMO, PPO, IPA, PHO or other entity	❑ Yes	❑ No
	i.	Academic Appointment	❑ Yes	❑ No
	j.	Authority to prescribe controlled substances (DEA or other authority)	❑ Yes	❑ 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?		❑ Yes	❑ No
③	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		❑ Yes	❑ No
④	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		❑ Yes	❑ 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?		❑ Yes	❑ No
	a.	Do you have notice of any such anticipated charges?	❑ Yes	❑ No
	b.	Are you currently under governmental investigation?	❑ Yes	❑ No
C.	**AFFIRMATION OF ABILITIES**			
①	Do you presently use any drugs illegally?		❑ Yes	❑ 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. If the answer to this question is yes, 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.		❑ Yes	❑ 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?		❑ Yes	❑ 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?		❑ Yes	❑ 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?		❑ Yes	❑ No
③	Are there any such claims being asserted against you now?		❑ Yes	❑ 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)?		❑ Yes	❑ No
⑤	Are any of the privileges that you are requesting not covered by your current malpractice coverage?		❑ Yes	❑ No
E.	**Attestation**			

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.

Typed or printed name	Signature	Date
_____	_____	_____

Modification to the wording or format of the Idaho Practitioner Application may invalidate the application.

XXII. ATTESTATION	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

_____

_____

_____

_____

_____

_____

Modification to the wording or format of the Idaho Practitioner Application may invalidate the application.

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: _____ Date: _____

Stamped signature is not acceptable

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