** BettercareMD Standardized Credentialing Application**

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| Section I-Individual Information | | | | |
| TYPE OF PROFESSIONAL | | | | |
| LAST NAME FIRST MIDDLE (JR., SR., ETC.) | | | | |
| MAIDEN NAME YEARS ASSOCIATED (YYYY-YYYY) | | | OTHER NAME YEARS ASSOCIATED (YYYY-YYYY) | |
| HOME MAILING ADDRESS | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | |
| HOME PHONE NUMBER | | SOCIAL SECURITY NUMBER | | ☐ Female ☐Male |
| **CORRESPONDENCE** ADDRESS | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | |
| PHONE NUMBER | FAX NUMBER | | E-MAIL | |
| DATE OF BIRTH (MM/DD/YYYY) | | PLACE OF BIRTH | | CITIZENSHIP |
| IF NOT AMERICAN CITIZEN, VISA NUMBER & STATUS | | | | ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES?  ☐ Yes ☐ No |
| U.S.MILITARY SERVICE/PUBLIC HEALTH  ☐Yes ☐ No | | DATES OF SERVICE (MM/DD/YYYY) TO (MM/DD/YYYY) | | LAST LOCATION |
| BRANCH OF SERVICE | | ARE YOU CURRENTLY ON ACTIVE OR RESERVE MILITARY DUTY?  ☐ Yes ☐ No | | |
| **Education** | | | | |
| **PROFESSIONAL DEGREE** (MEDICAL, DENTAL, CHIROPRACTIC, ETC.)  Issuing Institution**:** | | | | |
| ADDRESS | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | |
| DEGREE | | | ATTENDANCE DATES(MM/YYYY TO MM/YYYY) | |
| *☐ Please**check this box and complete and submit Attachment A if you received other professional degrees.* | | | | |
| **POST-GRADUATE EDUCATION** SPECIALTY  ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment | | | | |
| INSTITUTION | | | | |
| ADDRESS | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | |
| **☐** Program successfully completed | | | ATTENDANCE DATES (MM/YYYY TO MM/YYYY) | |
| PROGRAM DIRECTOR | | | CURRENT PROGRAM DIRECTOR (IF KNOWN) | |
| **POST-GRADUATE EDUCATION** SPECIALTY  ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment | | | | |
| INSTITUTION | | | | |
| ADDRESS | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | |

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| **Education** *- continued* | | | |
| POST-GRADUATE EDUCATION ☐ Program successfully completed | | ATTENDANCE DATES (MM/YYYY TO MM/YYYY) | |
| PROGRAM DIRECTOR | | CURRENT PROGRAM DIRECTOR (IF KNOWN) | |
| ☐ Please *check this box and complete and submit Attachment B if you received additional postgraduate training.* | | | |
| OTHER GRADUATE-LEVEL EDUCATION Issuing Institution: | | | |
| ADDRESS | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | |
| DEGREE | | ATTENDANCE DATES (MM/YYYY TO MM/YYYY) | |
| **Licenses and Certificates** - Please include all license(s) and certifications in all States where you are currently or  have previously been licensed. | | | |
| LICENSE TYPE | LICENSE NUMBER | | STATE OF REGISTRATION |
| ORIGINAL DATE OF ISSUE (MM/DD/YYYY) | EXPIRATION DATE (MM/DD/YYYY) | | DO YOU CURRENTLY PRACTICE IN THIS STATE?  *☐* Yes ☐ No |
| LICENSE TYPE | LICENSE NUMBER | | STATE OF REGISTRATION |
| ORIGINAL DATE OF ISSUE (MM/DD/YYYY) | EXPIRATION DATE (MM/DD/YYYY) | | DO YOU CURRENTLY PRACTICE IN THIS STATE?  ☐ Yes ☐ No |
| LICENSE TYPE | LICENSE NUMBER | | STATE OF REGISTRATION |
| ORIGINAL DATE OF ISSUE (MM/DD/YYYY) | EXPIRATION DATE (MM/DD/YYYY) | | DO YOU CURRENTLY PRACTICE IN THIS STATE?  ☐ Yes ☐ No |
| ☐ DEA Number: | ORIGINAL DATE OF ISSUE (MM/DD/YYYY) | | EXPIRATION DATE (MM/DD/YYYY) |
| ☐ DPS Number: | ORIGINAL DATE OF ISSUE (MM/DD/YYYY) | | EXPIRATION DATE (MM/DD/YYYY) |
| **OTHER CDS** (PLEASE SPECIFY) | NUMBER | | STATE OF REGISTRATION |
| ORIGINAL DATE OF ISSUE (MM/DD/YYYY) | EXPIRATION DATE (MM/DD/YYYY) | | DO YOU CURRENTLY PRACTICE IN THIS STATE?  ☐ Yes ☐ No |
| UPIN | | NATIONAL PROVIDER IDENTIFIER (WHEN AVAILABLE) | |
| ARE YOU A PARTICIPATING MEDICARE PROVIDER?  ☐ Yes ☐ No Medicare Provider Number: | | ARE YOU A PARTICIPATING MEDICAID PROVIDER?  ☐ Yes ☐ No Medicaid Provider Number: | |
| EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES (ECFMG)  ☐ N/A ☐ Yes☐ No ECFMG Number: | | | ECFMG ISSUE DATE (MM/DD/YYYY) |
| **Professional**/**Specialty** **Information** | | | |
| PRIMARY SPECIALTY | BOARD CERTIFIED?  ☐Yes ☐ No Name of Certifying Board: | | |
| INITIAL CERTIFICATION DATE (MM/YYYY) | RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY) | | EXPIRATION DATE, IF APPLICABLE (MM/YYYY) |
| IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.  ☐ I have taken exam, results pending for       Board.  ☐ I have taken Part I and am eligible for Part II of the       Exam.  ☐ I am intending to sit for the Boards on      (date)  ☐ I am not planning to take Boards. | | | |
| DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?  HMO: ☐ Yes ☐ No PPO: ☐ Yes ☐ No POS: ☐ Yes ☐ No | | | |
| SECONDARY SPECIALTY | BOARD CERTIFIED?  ☐ Yes ☐ No Name of Certifying Board: | | |
| INITIAL CERTIFICATION DATE (MM/YYYY) | RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY) | | EXPIRATION DATE, IF APPLICABLE (MM/YYYY) |

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| **Professional/Specialty Information** *-continued* | | |
| IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.  ☐ I have taken exam, results pending for      Board.  ☐ I have taken Part I and am eligible for Part II of the       Exam.  ☐ I am intending to sit for the Boards on      (date)  ☐ I am not planning to take Boards. | | |
| DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?  HMO: ☐ Yes ☐ No PPO: ☐ Yes ☐ No POS: ☐ Yes ☐ No | | |
| ADDITIONAL SPECIALTY | BOARD CERTIFIED?  ☐Yes ☐ No Name of Certifying Board: | |
| INITIAL CERTIFICATION DATE (MM/YYYY) | RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY) | EXPIRATION DATE, IF APPLICABLE (MM/YYYY) |
| IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.  ☐ I have taken exam, results pending for       Board.  ☐ I have taken Part I and am eligible for Part II of the       Exam.  ☐ I am intending to sit for the Boards on       (date)  ☐ I am not planning to take Boards. | | |
| DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?  HMO: ☐ Yes ☐ No PPO: ☐ Yes ☐ No POS: ☐ Yes ☐ No | | |
| PLEASE LIST OTHER AREAS OF PROFESSIONAL PRACTICE INTEREST OR FOCUS (HIV/AIDS, ETC.) | | |
| **Work History** *- Please provide a chronological work history. You may submit a Curriculum Vitae as*  *a supplement. Please explain all gaps in employment that lasted more than six months.* | | |
| CURRENT PRACTICE/EMPLOYER NAME | | START DATE/END DATE (MM/YYYY TO MM/YYYY) |
| ADDRESS | | |
| CITY STATE/COUNTRY POSTAL CODE | | |
| PREVIOUS PRACTICE/EMPLOYER NAME | | START DATE/END DATE (MM/YYYY TO MM/YYYY) |
| ADDRESS | | |
| CITY STATE/COUNTRY POSTAL CODE | | |
| REASON FOR DISCONTINUANCE | | |
| PREVIOUS PRACTICE/EMPLOYER NAME | | START DATE/END DATE (MM/YYYY TO MM/YYYY) |
| ADDRESS | | |
| CITY STATE/COUNTRY POSTAL CODE | | |
| REASON FOR DISCONTINUANCE | | |
| PREVIOUS PRACTICE/EMPLOYER NAME | | START DATE/END DATE (MM/YYYY TO MM/YYYY) |
| ADDRESS | | |
| CITY STATE/COUNTRY POSTAL CODE | | |
| REASON FOR DISCONTINUANCE | | |
| PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS GREATER THAN SIX MONTHS (MM/YYYY TO MM/YYYY) IN WORK HISTORY.  Gap Dates:             Explanation:        Gap Dates:             Explanation: | | |

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| **Work History** *– continued* | | | | |
| Gap Dates:             Explanation: | | | | |
| Gap Dates:             Explanation: | | | | |
| *☐ Please check this box and complete and submit Attachment C if you have additional work history* | | | | |
| **Hospital Affiliations*-****Please include all hospitals where you currently have or have previously had privileges.* | | | | |
| DO YOU HAVE HOSPITAL PRIVILEGES?  ☐ Yes *☐* No | IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHAT ADMITTING ARRANGEMENTS DO YOU HAVE? | | | |
| PRIMARY HOSPITAL WHERE YOU HAVE ADMITTING PRIVILEGES | | | | START DATE (MM/YYYY) |
| ADDRESS | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | |
| PHONE NUMBER | FAX | E-MAIL | | |
| FULL UNRESTRICTED PRIVILEGES?  ☐ Yes *☐* No | TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) | | | ARE PRIVILEGES TEMPORARY?  ☐ Yes *☐* No |
| OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO PRIMARY HOSPITAL? | | | | |
| OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES | | | | START DATE (MM/YYYY) |
| ADDRESS | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | |
| PHONE NUMBER | FAX | E-MAIL | | |
| FULL UNRESTRICTED PRIVILEGES?  ☐ Yes *☐* No | TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) | | | ARE PRIVILEGES TEMPORARY?  ☐ Yes *☐* No |
| OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL? | | | | |
| *☐ Please check this box and complete and submit Attachment D if you have additional current hospital affiliations.* | | | | |
| PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES | | | | AFFILIATION DATES (MM/YYYY TO MM/YYYY) |
| ADDRESS | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | |
| FULL UNRESTRICTED PRIVILEGES?  ☐ Yes *☐* No | TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) | | | WERE PRIVILEGES TEMPORARY?  ☐ Yes *☐* No |
| REASON FOR DISCONTINUANCE | | | | |
| *☐ Please check this box and complete and submit Attachment E if you have additional previous hospital affiliations.* | | | | |
| **References**-*Please provide three peer references from the same field and/or specialty who are not partners in your own group practice and are not relatives. All peer references should have firsthand knowledge of your abilities.*  *.* | | | | |
| 1. NAME/TITLE | | | PHONE NUMBER | |
| ADDRESS | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | |

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| **References-** *continued* | | | | | |
| **2** NAME/TITLE | | | | PHONE NUMBER | |
| ADDRESS | | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | | |
| **3** NAME/TITLE | | | | PHONE NUMBER | |
| ADDRESS | | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | | |
| **Professional Liability Insurance Coverage** | | | | | |
| SELF-INSURED?  ☐ Yes ☐ No | NAME OF CURRENT MALPRACTICE INSURANCE CARRIER OR SELF-INSURED ENTITY | | | | |
| ADDRESS | | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | | |
| PHONE NUMBER | | POLICY NUMBER | EFFECTIVE DATE (MM/DD/YYYY) | | EXPIRATION DATE (MM/DD/YYYY) |
| AMOUNT OF COVERAGE PER OCCURRENCE | | AMOUNT OF COVERAGE AGGREGATE | TYPE OF COVERAGE  ☐ Individual ☐ Shared | | LENGTH OF TIME WITH CARRIER |
| NAME OF PREVIOUS MALPRACTICE INSURANCE CARRIER IF WITH CURRENT CARRIER LESS THAN 5 YEARS | | | | | |
| ADDRESS | | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | | |
| PHONE NUMBER | | POLICY NUMBER | EFFECTIVE DATE (MM/DD/YYYY) | | EXPIRATION DATE (MM/DD/YYYY) |
| AMOUNT OF COVERAGE PER OCCURRENCE | | AMOUNT OF COVERAGE AGGREGATE | TYPE OF COVERAGE  ☐ Individual ☐ Shared | | LENGTH OF TIME WITH CARRIER |
| **Call Coverage** | | | | | |
| ☐ See attached list of hospital staff within my department I utilize for call coverage. | | | | | |
| PLEASE LIST NAMES OF COLLEAGUE(S) PROVIDING REGULAR COVERAGE AND HIS OR HER SPECIALTIES.  Name:       Specialty: | | | | | |
| Name:       Specialty: | | | | | |
| Name:       Specialty: | | | | | |
| Name:       Specialty: | | | | | |
| Name:       Specialty: | | | | | |
| PLEASE LIST FULL NAMES OF ALL PARTNERS IN YOUR PRACTICE. ☐ CHECK THIS BOX AND ATTACH LIST FOR LARGE GROUP.  Name:       Name: | | | | | |
| Name:       Name: | | | | | |
| Name:       Name: | | | | | |
| Name:       Name: | | | | | |

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| **Practice LocationInformation** *– Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.* | | | | | PRACTICE LOCATION    of |
| TYPE OF SERVICE PROVIDED  ☐ Solo Primary Care ☐ Solo Specialty Care ☐ Group Primary Care **☐** Group Single Specialty **☐** Group Multi-Specialty | | | | | |
| GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY | | | GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9 | | |
| **PRACTICE LOCATION ADDRESS**  **☐ Primary** | | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | | |
| PHONE NUMBER | FAX NUMBER | | E-MAIL | | |
| BACK OFFICE PHONE NUMBER | | SITE-SPECIFIC MEDICAID NUMBER | | TAX ID NUMBER | |
| GROUP NUMBER CORRESPONDING TO TAX ID NUMBER | | GROUP NAME CORRESPONDING TO TAX ID NUMBER | | | |
| ARE YOU CURRENTLY PRACTICING AT THIS LOCATION?  ☐ Yes ☐ No | | IF NO, EXPECTED START DATE? (MM/DD/YYYY) | | DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? ☐ Yes ☐ No | |
| OFFICE MANAGER OR STAFF CONTACT | | | PHONE NUMBER | | FAX NUMBER |
| **CREDENTIALING CONTACT** | | | | | |
| ADDRESS | | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | | |
| PHONE NUMBER | FAX NUMBER | | E-MAIL | | |
| **BILLING COMPANY’S NAME** (IF APPLICABLE) | | | | BILLING REPRESENTATIVE | |
| ADDRESS | | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | | |
| PHONE NUMBER | FAX NUMBER | | E-MAIL | | |
| DEPARTMENT NAME IF HOSPITAL-BASED | | CHECK PAYABLE TO | | CAN YOU BILL ELECTRONICALLY?  ☐ Yes ☐ No | |
| HOURS PATIENTS ARE SEEN  Monday ☐ No Office Hours Morning:       Afternoon:       Evening:        Tuesday ☐ No Office Hours Morning:       Afternoon:       Evening:  Wednesday ☐ No Office Hours Morning:       Afternoon:       Evening:  Thursday ☐ No Office Hours Morning:       Afternoon:       Evening:  Friday ☐ No Office Hours Morning:       Afternoon:       Evening:  Saturday ☐ No Office Hours Morning:       Afternoon:       Evening:  Sunday ☐ No Office Hours Morning:       Afternoon:       Evening: | | | | | |
| DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?  ☐ Answering Service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions ☐ None | | | | | |
| THIS PRACTICE LOCATION ACCEPTS  ☐ all new patients ☐ existing patients with change of payor ☐ new patients with referral ☐ new Medicare patients ☐ new Medicaid patients | | | | | |
| IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION. | | | | | |
| PRACTICE LIMITATIONS  ☐ Male only ☐ Female only Age:       ☐ Other: | | | | | |
| DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?  **☐** Yes ☐ No If yes, provide the following information for each staff member: | | | | | |
| NAME PROFESSIONAL DESIGNATION STATE & LICENSE NO. | | | | | |
| NAME PROFESSIONAL DESIGNATION STATE & LICENSE NO. | | | | | |

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| **Practice Location Information** - continued | | |
| NAME PROFESSIONAL DESIGNATION STATE & LICENSE NO. | | |
| NAME PROFESSIONAL DESIGNATION STATE & LICENSE NO. | | |
| NAME PROFESSIONAL DESIGNATION STATE & LICENSE NO. | | |
| NAME PROFESSIONAL DESIGNATION STATE & LICENSE NO. | | |
| NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS | NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL | |
| ARE INTERPRETERS AVAILABLE?  ☐ Yes ☐ No If yes, please specify languages: | | |
| DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?  ☐ Yes ☐ No | WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?  ☐ Building ☐Parking ☐ Restroom ☐ Other: | |
| DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?  ☐Text Telephony-TTY ☐ American Sign Language-ASL ☐ Mental/Physical Impairment Services ☐ 0ther: | | |
| IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?  ☐Bus ☐ Regional Train ☐Other: | | |
| DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?  ☐Yes ☐ No | DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?  ☐Yes ☐ No | |
| WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)  Basic Life Support ☐ Staff ☐ Provider Exp:       Advanced Life Support in OB ☐ Staff ☐ Provider Exp:       Advanced Trauma Life Support ☐ Staff ☐ Provider Exp:       Cardio-Pulmonary Resuscitation ☐ Staff ☐ Provider Exp:       Advanced Cardiac Life Support ☐ Staff ☐ Provider Exp:       Pediatric Advanced Life Support ☐ Staff ☐ Provider Exp:       Neonatal Advanced Life Support ☐ Staff ☐ Provider Exp:       Other (please specify)       ☐Staff ☐ Provider Exp: | | |
| DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No  ☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE): | | |
| DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No  ☐ X-ray; please list all certifications: | | |
| OTHER SERVICES ☐ Radiology Services ☐ EKG ☐ Care of Minor Lacerations ☐ Pulmonary Function Tests  ☐ Allergy Injections ☐ Allergy Skin Tests ☐ Routine Office Gynecology ☐ Drawing Blood  ☐ Age Appropriate Immunizations ☐ Flexible Sigmoidoscopy ☐ Tympanometry/Audiometry Tests ☐ Asthma Treatments  ☐ Osteopathic Manipulations ☐ IV Hydration /Treatments ☐ Cardiac Stress Tests ☐ Physical Therapies  ☐ Other: | | |
| PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES) | | |
| IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?  ☐ Yes ☐ No Please specify the classes or categories: | | WHO ADMINISTERS IT? |
| ☐ Please *check this box and complete and submit Attachment F if you have other practice locations.* | | |

**Section II-Disclosure Questions -** Please*provide* an explanation for any question answered yes-except 16-on page 10.

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| **Licensure** | | |
| **1** | Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board? |  |
|  |  | ☐ Yes ☐ No |
| **2** | Have you ever received a reprimand or been fined by any state licensing board? |  |
|  |  | ☐ Yes ☐ No |
|  | | |
| **Hospital Privileges and Other Affiliations** | | |
| **3** | Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? |  |
|  |  | ☐ Yes ☐ No |
|  |  |  |
| **4** | Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? |  |
|  |  | ☐ Yes ☐ No |
| **5** | Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? |  |
|  |  | ☐ Yes ☐ No |
| **Education, Training and Board Certification** | |  |
| **6** | Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? |  |
|  |  | ☐ Yes ☐ No |
| **7** | Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? |  |
|  |  | ☐ Yes ☐ No |
| **8** | Have any of your board certifications or eligibility ever been revoked? |  |
|  |  | ☐ Yes ☐ No |
| **9** | Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? |  |
|  |  | ☐ Yes ☐ No |
|  | |  |
| **DEA or DPS** | |  |
| **10** | Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished? |  |
|  | | ☐ Yes ☐ No |
|  | |  |
| **Medicare, Medicaid or other Governmental Program Participation** | |  |
| **11** | Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs? |  |
|  |  | ☐ Yes ☐ No |
|  | |  |
| **Other Sanctions or Investigations** | |  |
| **12** | Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program? |  |
|  |  | ☐ Yes ☐ No |
|  |  |  |

**Section II - Disclosure Questions** ***-*** *continued*

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| **Other Sanctions or Investigations** | |  |
| **13** | To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? |  |
|  |  | ☐ Yes ☐ No |
| **14** | Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? |  |
|  |  | ☐ Yes ☐ No |
| **15** | Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency? |  |
|  |  | ☐ Yes ☐ No |
|  |  |  |
| **Malpractice Claims History** | |  |
| **16** | Have you had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated? |  |
|  |  | ☐ Yes ☐ No |
|  | ☐ *If yes, please check this box and complete and submit Attachment G.* |  |
|  |  |  |
| **Criminal** | |  |
| **17** | Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional |  |
|  |  | ☐ Yes ☐ No |
| **18** | Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense? |  |
|  |  | ☐ Yes ☐ No |
| **19** | Have you been court-martialed for actions related to your duties as a medical professional? |  |
|  |  | ☐ Yes ☐ No |
|  |  |  |
| **Ability to Perform Job** | |  |
| **20** | Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.) |  |
|  |  | ☐ Yes ☐ No |
| **21** | Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? |  |
|  |  | ☐ Yes ☐ No |
| **Ability to Perform Job** | |  |
| **22** | Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients? |  |
|  |  | ☐ Yes ☐ No |
| **23** | Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation? |  |
|  |  | ☐ Yes ☐ No |
|  |  |  |
| *Please use this space to explain yes answers to any question except #16.* | |  |

**Section II - Disclosure Questions***-continued*

*Please use the space below to explain yes answers to any question except 16.*

|  |  |
| --- | --- |
| QUESTION NUMBER | PLEASE EXPLAIN |
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APPLICANT’S INITIALS AND DATE (MM⁄DD⁄YYYY)

SIGNATURE

NAME (PLEASE PRINT OR TYPE)

Last 4 digits of SSN or NPI (PLEASE PRINT OR TYPE)

DATE (MM⁄DD⁄YYYY)

**Required Attachments or Supplemental Information**–Please attach hard copy or scanned documents of the following:

☐ Copy of DEA or state DPS Controlled Substances Registration Certificate

☐ Copy of other Controlled Dangerous Substances Registration Certificate(s)

☐ Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and applicant’s name

☐ Copies of IRS W-9s for verification of each tax identification number used

☐ Copy of workers compensation certificate of coverage, if applicable

☐ Copy of CLIA certifications, if applicable

☐ Copies of radiology certifications, if applicable

☐ Copy of DD214, record of military service, if applicable

BetterCareMD Standardized Credentialing ApplicationAttachment A – Other Professional Degrees

|  |  |
| --- | --- |
| **OTHER PROFESSIONAL DEGREE**  Issuing Institution**:** | |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| DEGREE | ATTENDANCE DATES(MM/YYYY TO MM/YYYY) |
| **OTHER PROFESSIONAL DEGREE**  Issuing Institution**:** | |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| DEGREE | ATTENDANCE DATES(MM/YYYY TO MM/YYYY) |
| **OTHER PROFESSIONAL DEGREE**  Issuing Institution**:** | |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| DEGREE | ATTENDANCE DATES(MM/YYYY TO MM/YYYY) |
| **OTHER PROFESSIONAL DEGREE**  Issuing Institution**:** | |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| DEGREE | ATTENDANCE DATES(MM/YYYY TO MM/YYYY) |
| **OTHER PROFESSIONAL DEGREE**  Issuing Institution**:** | |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| DEGREE | ATTENDANCE DATES(MM/YYYY TO MM/YYYY) |
| **OTHER PROFESSIONAL DEGREE**  Issuing Institution**:** | |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| DEGREE | ATTENDANCE DATES(MM/YYYY TO MM/YYYY) |
| **OTHER PROFESSIONAL DEGREE**  Issuing Institution**:** | |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| DEGREE | ATTENDANCE DATES(MM/YYYY TO MM/YYYY) |

BetterCareMD Standardized Credentialing ApplicationAttachment B – Other Post Graduate Education

|  |  |
| --- | --- |
| **OTHER POST-GRADUATE EDUCATION** SPECIALTY  ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment | |
| INSTITUTION | |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| **☐** Program successfully completed | ATTENDANCE DATES (MM/YYYY TO MM/YYYY) |
| PROGRAM DIRECTOR | CURRENT PROGRAM DIRECTOR (IF KNOWN) |
| **OTHER POST-GRADUATE EDUCATION** SPECIALTY  ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment | |
| INSTITUTION | |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| **☐** Program successfully completed | ATTENDANCE DATES (MM/YYYY TO MM/YYYY) |
| PROGRAM DIRECTOR | CURRENT PROGRAM DIRECTOR (IF KNOWN) |
| **OTHER POST-GRADUATE EDUCATION** SPECIALTY  ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment | |
| INSTITUTION | |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| **☐** Program successfully completed | ATTENDANCE DATES (MM/YYYY TO MM/YYYY) |
| PROGRAM DIRECTOR | CURRENT PROGRAM DIRECTOR (IF KNOWN) |
| **OTHER POST-GRADUATE EDUCATION** SPECIALTY  ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment | |
| INSTITUTION | |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| **☐** Program successfully completed | ATTENDANCE DATES (MM/YYYY TO MM/YYYY) |
| PROGRAM DIRECTOR | CURRENT PROGRAM DIRECTOR (IF KNOWN) |
| **OTHER POST-GRADUATE EDUCATION** SPECIALTY  ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment | |
| INSTITUTION | |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| **☐** Program successfully completed | ATTENDANCE DATES (MM/YYYY TO MM/YYYY) |
| PROGRAM DIRECTOR | CURRENT PROGRAM DIRECTOR (IF KNOWN) |

BetterCareMD Standardized Credentialing ApplicationAttachment C – Other Work History

|  |  |
| --- | --- |
| PREVIOUS PRACTICE/EMPLOYER NAME | START DATE/END DATE (MM/YYYY TO MM/YYYY) |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| REASON FOR DISCONTINUANCE | |
| PREVIOUS PRACTICE/EMPLOYER NAME | START DATE/END DATE (MM/YYYY TO MM/YYYY) |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| REASON FOR DISCONTINUANCE | |
| PREVIOUS PRACTICE/EMPLOYER NAME | START DATE/END DATE (MM/YYYY TO MM/YYYY) |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| REASON FOR DISCONTINUANCE | |
| PREVIOUS PRACTICE/EMPLOYER NAME | START DATE/END DATE (MM/YYYY TO MM/YYYY) |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| REASON FOR DISCONTINUANCE | |
| PREVIOUS PRACTICE/EMPLOYER NAME | START DATE/END DATE (MM/YYYY TO MM/YYYY) |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| REASON FOR DISCONTINUANCE | |
| PREVIOUS PRACTICE/EMPLOYER NAME | START DATE/END DATE (MM/YYYY TO MM/YYYY) |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| REASON FOR DISCONTINUANCE | |
| PREVIOUS PRACTICE/EMPLOYER NAME | START DATE/END DATE (MM/YYYY TO MM/YYYY) |
| ADDRESS | |
| CITY STATE/COUNTRY POSTAL CODE | |
| REASON FOR DISCONTINUANCE | |

BetterCareMD Standardized Credentialing ApplicationAttachment D – Other Current Hospital Affiliations

|  |  |  |  |
| --- | --- | --- | --- |
| OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES | | | START DATE (MM/YYYY) |
| ADDRESS | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | |
| PHONE NUMBER | FAX | E-MAIL | |
| FULL UNRESTRICTED PRIVILEGES?  *☐ Yes ☐* No | TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) | | ARE PRIVILEGES TEMPORARY?  *☐ Yes ☐* No |
| OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL? | | | |
| OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES | | | START DATE (MM/YYYY) |
| ADDRESS | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | |
| PHONE NUMBER | FAX | E-MAIL | |
| FULL UNRESTRICTED PRIVILEGES?  *☐ Yes ☐* No | TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) | | ARE PRIVILEGES TEMPORARY?  *☐ Yes ☐* No |
| OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL? | | | |
| OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES | | | START DATE (MM/YYYY) |
| ADDRESS | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | |
| PHONE NUMBER | FAX | E-MAIL | |
| FULL UNRESTRICTED PRIVILEGES?  *☐ Yes ☐* No | TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) | | ARE PRIVILEGES TEMPORARY?  *☐ Yes ☐* No |
| OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL? | | | |
| OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES | | | START DATE (MM/YYYY) |
| ADDRESS | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | |
| PHONE NUMBER | FAX | E-MAIL | |
| FULL UNRESTRICTED PRIVILEGES?  *☐ Yes ☐* No | TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) | | ARE PRIVILEGES TEMPORARY?  *☐ Yes ☐* No |
| OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL? | | | |
| OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES | | | START DATE (MM/YYYY) |
| ADDRESS | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | |
| PHONE NUMBER | FAX | E-MAIL | |
| FULL UNRESTRICTED PRIVILEGES?  *☐ Yes ☐* No | TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) | | ARE PRIVILEGES TEMPORARY?  *☐ Yes ☐* No |
| OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL? | | | |

BetterCareMD Standardized Credentialing Application Attachment E – Other Previous Hospital Affiliations

|  |  |  |
| --- | --- | --- |
| PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES | | AFFILIATION DATES (MM/YYYY TO MM/YYYY) |
| ADDRESS | | |
| CITY STATE/COUNTRY POSTAL CODE | | |
| FULL UNRESTRICTED PRIVILEGES?  *☐ Yes ☐* No | TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) | WERE PRIVILEGES TEMPORARY?  *☐ Yes ☐* No |
| REASON FOR DISCONTINUANCE | | |
| PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES | | AFFILIATION DATES (MM/YYYY TO MM/YYYY) |
| ADDRESS | | |
| CITY STATE/COUNTRY POSTAL CODE | | |
| FULL UNRESTRICTED PRIVILEGES?  *☐ Yes ☐* No | TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) | WERE PRIVILEGES TEMPORARY?  *☐ Yes ☐* No |
| REASON FOR DISCONTINUANCE | | |
| PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES | | AFFILIATION DATES (MM/YYYY TO MM/YYYY) |
| ADDRESS | | |
| CITY STATE/COUNTRY POSTAL CODE | | |
| FULL UNRESTRICTED PRIVILEGES?  *☐ Yes ☐* No | TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) | WERE PRIVILEGES TEMPORARY?  *☐ Yes ☐* No |
| REASON FOR DISCONTINUANCE | | |
| PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES | | AFFILIATION DATES (MM/YYYY TO MM/YYYY) |
| ADDRESS | | |
| CITY STATE/COUNTRY POSTAL CODE | | |
| FULL UNRESTRICTED PRIVILEGES?  *☐ Yes ☐* No | TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) | WERE PRIVILEGES TEMPORARY?  *☐ Yes ☐* No |
| REASON FOR DISCONTINUANCE | | |
| PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES | | AFFILIATION DATES (MM/YYYY TO MM/YYYY) |
| ADDRESS | | |
| CITY STATE/COUNTRY POSTAL CODE | | |
| FULL UNRESTRICTED PRIVILEGES?  *☐ Yes ☐* No | TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) | WERE PRIVILEGES TEMPORARY?  *☐ Yes ☐* No |
| REASON FOR DISCONTINUANCE | | |
| PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES | | AFFILIATION DATES (MM/YYYY TO MM/YYYY) |
| ADDRESS | | |
| CITY STATE/COUNTRY POSTAL CODE | | |
| FULL UNRESTRICTED PRIVILEGES?  *☐ Yes ☐* No | TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) | WERE PRIVILEGES TEMPORARY?  *☐ Yes ☐* No |
| REASON FOR DISCONTINUANCE | | |

BetterCareMD Standardized Credentialing ApplicationAttachment F – Other Practice Locations

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Practice LocationInformation** *- Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.* | | | | | PRACTICE LOCATION  of |
| TYPE OF SERVICE PROVIDED  ☐ Solo Primary Care ☐ Solo Specialty Care ☐ Group Primary Care **☐** Group Single Specialty **☐** Group Multi-Specialty | | | | | |
| GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY | | | GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9 | | |
| **PRACTICE LOCATION ADDRESS**  **☐ Primary** | | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | | |
| PHONE NUMBER | FAX NUMBER | | E-MAIL | | |
| BACK OFFICE PHONE NUMBER | | SITE-SPECIFIC MEDICAID NUMBER | | TAX ID NUMBER | |
| GROUP NUMBER CORRESPONDING TO TAX ID NUMBER | | GROUP NAME CORRESPONDING TO TAX ID NUMBER | | | |
| ARE YOU CURRENTLY PRACTICING AT THIS LOCATION?  ☐ Yes ☐ No | | IF NO, EXPECTED START DATE? (MM/DD/YYYY) | | DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? ☐ Yes ☐ No | |
| OFFICE MANAGER OR STAFF CONTACT | | | PHONE NUMBER | | FAX NUMBER |
| **CREDENTIALING CONTACT** | | | | | |
| ADDRESS | | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | | |
| PHONE NUMBER | FAX NUMBER | | E-MAIL | | |
| **BILLING COMPANY'S NAME** (IF APPLICABLE) | | | | BILLING REPRESENTATIVE | |
| ADDRESS | | | | | |
| CITY STATE/COUNTRY POSTAL CODE | | | | | |
| PHONE NUMBER | FAX NUMBER | | E-MAIL | | |
| DEPARTMENT NAME IF HOSPITAL-BASED | | CHECK PAYABLE TO | | CAN YOU BILL ELECTRONICALLY?  ☐ Yes ☐ No | |
| HOURS PATIENTS ARE SEEN  Monday ☐ No Office Hours Morning:       Afternoon:       Evening:  Tuesday ☐ No Office Hours Morning:       Afternoon:       Evening:  Wednesday ☐ No Office Hours Morning:       Afternoon:       Evening:  Thursday ☐ No Office Hours Morning:       Afternoon:       Evening:  Friday ☐ No Office Hours Morning:       Afternoon:       Evening:  Saturday ☐ No Office Hours Morning:       Afternoon:       Evening:  Sunday ☐ No Office Hours Morning:       Afternoon:       Evening: | | | | | |
| DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?  ☐ Answering Service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions ☐ None | | | | | |
| THIS PRACTICE LOCATION ACCEPTS  ☐ all new patients ☐ existing patients with change of payor ☐ new patients with referral ☐ new Medicare patients ☐ new Medicaid patients | | | | | |
| IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION. | | | | | |
| PRACTICE LIMITATIONS  ☐ Male only ☐ Female only Age:       ☐ Other: | | | | | |
| DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?  **☐** Yes ☐ No If yes, provide the following information for each staff member: | | | | | |
| NAME PROFESSIONAL DESIGNATION STATE & LICENSE NO. | | | | | |
| NAME PROFESSIONAL DESIGNATION STATE & LICENSE NO. | | | | | |

Attachment F (continued)

|  |  |  |
| --- | --- | --- |
| **Practice Location Information** - continued | | |
| NAME PROFESSIONAL DESIGNATION STATE & LICENSE NO. | | |
| NAME PROFESSIONAL DESIGNATION STATE & LICENSE NO. | | |
| NAME PROFESSIONAL DESIGNATION STATE & LICENSE NO. | | |
| NAME PROFESSIONAL DESIGNATION STATE & LICENSE NO. | | |
| NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS | NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL | |
| ARE INTERPRETERS AVAILABLE?  ☐ Yes ☐ No If yes, please specify languages: | | |
| DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?  ☐ Yes ☐ No | WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?  ☐ Building ☐Parking ☐ Restroom ☐ Other: | |
| DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?  ☐Text Telephony-TTY ☐ American Sign Language-ASL ☐ Mental/Physical Impairment Services ☐ 0ther: | | |
| IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?  ☐Bus ☐ Regional Train ☐Other: | | |
| DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?  ☐Yes ☐ No | DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?  ☐Yes ☐ No | |
| WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)  Basic Life Support ☐ Staff ☐ Provider Exp:       Advanced Life Support in OB ☐ Staff ☐ Provider Exp:  Advanced Trauma Life Support ☐ Staff ☐ Provider Exp:       Cardio-Pulmonary Resuscitation ☐ Staff ☐ Provider Exp:  Advanced Cardiac Life Support ☐ Staff ☐ Provider Exp:       Pediatric Advanced Life Support ☐ Staff ☐ Provider Exp:  Neonatal Advanced Life Support ☐ Staff ☐ Provider Exp:       Other (please specify)       ☐Staff ☐ Provider Exp: | | |
| DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No  ☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE): | | |
| DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No  ☐ X-ray; please list all certifications: | | |
| OTHER SERVICES ☐ Radiology Services ☐ EKG ☐ Care of Minor Lacerations ☐ Pulmonary Function Tests  ☐ Allergy Injections ☐ Allergy Skin Tests ☐ Routine Office Gynecology ☐ Drawing Blood  ☐ Age Appropriate Immunizations ☐ Flexible Sigmoidoscopy ☐ Tympanometry/Audiometry Tests ☐ Asthma Treatments  ☐ Osteopathic Manipulations ☐ IV Hydration /Treatments ☐ Cardiac Stress Tests ☐ Physical Therapies  ☐ Other: | | |
| PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES) | | |
| IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?  ☐ Yes ☐ No Please specify the classes or categories: | | WHO ADMINISTERS IT? |
| ☐ Please *check this box and complete and submit Attachment F if you have other practice locations.* | | |

BetterCareMD Standardized Credentialing ApplicationAttachment G – Malpractice Claims History

|  |  |  |
| --- | --- | --- |
| **INCIDENT** DATE (MM/DD/YYYY) | DATE CLAIM WAS FILED (MM/DD/YYYY) | CLAIM/CASE STATUS |
| PROFESSIONAL LIABILITY CARRIER INVOLVED | | |
| ADDRESS | | |
| CITY STATE/COUNTRY POSTAL CODE | | |
| PHONE NUMBER | POLICY NUMBER | AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID  **$**      **$** |
| METHOD OF RESOLUTION  ☐ Dismissed | ☐ Settled (with prejudice) | ☐ Settled (without prejudice) |
| ☐ Judgment for Defendant(s) | ☐ Judgment for Plaintiff(s) | ☐ Mediation or Arbitration |
| DESCRIPTION OF ALLEGATIONS | | |
|  | | |
|  | | |
| WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT? | NUMBER OF OTHER CO-DEFENDANTS | YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.) |
| DESCRIPTION OF ALLEGED INJURY TO THE PATIENT | | |
| TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?  ☐ Yes ☐ No | | |
| **INCIDENT** DATE (MM/DD/YYYY) | DATE CLAIM WAS FILED (MM/DD/YYYY) | CLAIM/CASE STATUS |
| PROFESSIONAL LIABILITY CARRIER INVOLVED | | |
| ADDRESS | | |
| CITY STATE/COUNTRY POSTAL CODE | | |
| PHONE NUMBER | POLICY NUMBER | AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID  **$**      **$** |
| METHOD OF RESOLUTION  ☐ Dismissed | ☐ Settled (with prejudice) | ☐ Settled (without prejudice) |
| ☐ Judgment for Defendant(s) | ☐ Judgment for Plaintiff(s) | ☐ Mediation or Arbitration |
| DESCRIPTION OF ALLEGATIONS | | |
|  | | |
|  | | |
| WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT? | NUMBER OF OTHER CO-DEFENDANTS | YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.) |
| DESCRIPTION OF ALLEGED INJURY TO THE PATIENT | | |
| TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?  ☐ Yes ☐ No | | |