Practitioner Credentialing

Thank you for your interest in becoming a participating provider with PacificSource Health Plans. Prior to execution of a new contract or addition to an existing group contract, you will need to complete the credentialing process with PacificSource. Please complete the credentialing application and return to the PacificSource Health Plans Credentialing Department. The following information lists criteria to be verified by our Credentialing team and your rights as an applicant.

PacificSource Health Plans makes every effort to contract with highly qualified practitioners by using clear and standardized credentialing requirements. Before a practitioner can be participating with PacificSource, the practitioner is required to successfully complete the credentialing process, which includes submitting an application supported by qualifying criteria. Credentialing applications are processed within 90 days of receipt of a complete application. Incomplete applications will be returned (to address any missing information), which will delay the credentialing process.

Qualifying Criteria Checklist

Submit a completed application in full, with all necessary attachments and supporting documentation.

Include the attestation page; make sure the information is completed, signed, and dated.*
Explanations for any "yes" answers must be provided.

Include the authorization and release form with the application; make sure the form is signed and dated.*

Provide a current, valid, and unrestricted license to practice for each state in which you will be providing services to PacificSource members.

Provide a copy of all valid DEA certificates or prescribing plan for each state in which you will be providing services to PacificSource members.

Include proof of admitting privileges at a participating hospital, or a written admit plan.

Include the most recent five years of relevant work history with an explanation for any gaps of 60 days or more.

Provide proof of board certification, or completed, verifiable education/training as applicable to your degree. Board certification is required for all MDs, DOs, and DPMs.

Provide evidence of current professional liability insurance coverage with amounts of at least $1,000,000 per occurrence and $3,000,000 aggregate. Please include a copy of the face sheet when returning the application.

* Signatures: Faxed, digital, electronic, scanned, or photocopied signatures are acceptable. Signature stamps are not acceptable unless the practitioner is physically impaired and the disability is documented in the practitioner's file. Signatures cannot be older than 180 days at the time of credentialing approval.

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Other qualifying considerations

The National Practitioner Data Bank (NPDB) will be queried and the received information will be stored with the credentialing file.

A review of Medicare's opt-out list to ensure those listed are not applying for participation in Medicare Advantage plans.

You will be notified if anything is missing. Failing to submit the necessary information by the timeframe communicated by the PacificSource Credentialing Department will disqualify the application from consideration.

Applicant rights

1. The applicant/practitioner has the right to review information submitted to support their credentialing application, e.g., malpractice claims history, state licensing board actions, board certification, etc. The practitioner is not allowed to review references, recommendations, or other peer-review-protected information.
2. PacificSource will notify applicants of any information received that is possibly erroneous, or that substantially deviates from the information provided by the practitioner on the application, curriculum vitae, supplemental documents, or from other sources. Examples might include substantial variations in information on license actions, malpractice claims, or undisclosed board certification decisions. Written notification to the practitioner will occur upon discovery of conflicting information and will include a clear explanation of the conflicting information received. If information is not received within the requested timeframe of the notification, a second request will be sent by certified mail or secured email by the credentialing specialist/coordinator with a new-response timeframe indicated in the letter. Lack of response to the second request may result in closing the initial file, or termination of recredentialing/revalidation and contract participation. The practitioner must provide a complete and written explanation and documentation to support their response to the Credentialing team and/or Chief Medical Officer within the timeframe outlined in the request. Upon receipt of corrected information, Credentialing will date-stamp and initial the corrected documents. Practitioners will be promptly notified via email, telephone, fax, or mail, that their explanation and/or supporting documents have been received.
3. Credentialing will provide updates on status of credentialing/validation processing upon reasonable request, informing the applicant of projected timelines, information pending, or missing and substantial variations in information, but will not share peer-protected information. Credentialing will respond to these requests via email, telephone, fax, or mail.
4. Practitioners will receive notification of these rights at the time of initial credentialing/validation included in the application packet, upon request for a new contract or a request for an application for a practitioner wishing to be added to an existing group contract.
5. PacificSource will take steps to protect the confidentiality of information obtained and generated during the credentialing/validation process.
6. Initial applicants completing the credentialing/validation process are not subject to appeal rights.

Questions?

For more information about credentialing or validation, please contact the Credentialing team at **541-225-3747,** TTY: 711. We accept all relay calls. Or email Credentialing@PacificSource.com.

Provider information

Type of provider: PCP Urgent Care Specialist

Last name (include suffix: Jr., Sr., III) ______________________ First ____________ Middle ______

Other name(s) under which you have been known by reference, licensing, and/or educational institutions:

______________________ Degree(s) ____________ Gender: Male Female X

Home phone number ____________ Pager number ____________ Cell number ____________

Home mailing address ______________________ City ____________ State _____ Zip ________

Birth date ____________ Birth place (city, state, country) ______________________

Social Security number ____________ Email address ______________________

Race/ethnicity (optional) ____________ Languages spoken by provider ______________________

Individual NPI number ____________ Individual Medicare number ______________________

Individual Medicaid number(s) ______________________

Specialty at the primary practice location ______________________ Subspecialties ____________

Taxonomy (10-digit code identifying specialty or subspecialty) ______________________

Primary practice information

Effective date at primary practice location ____________ Do you offer telehealth? Yes No

Name of practice/affiliation/clinic name ______________________

Office street address ______________________ City ____________ State _____ Zip ________

Patient appointment phone number ____________ Fax number ____________

Name affiliated with tax ID number ____________ Federal tax ID number ____________

Billing address (if different from above)

Street address ______________________ City ____________ State _____ Zip ________

Credentialing address (if different from above)

Street address ______________________ City ____________ State _____ Zip ________

Office manager/admin name ____________ Admin phone number ____________

Admin email address ____________ Admin fax number ____________

Credentialing contact (if different from above) ____________ Credentialing phone number ____________

Credentialing email address ____________ Credentialing fax number ____________

Secondary practice information

Effective date at secondary practice location (MM/YY) ______________ Do you offer telehealth? Yes No

Name of practice/affiliation/clinic name ____

Department name ____

Office street address ______________________ City ____________ State _____ Zip ________

Patient appointment phone number ____________________ Fax number ____________________

Name affiliated with tax ID number ____________________ Federal tax ID number ________________

Billing address (if different from above)

Street address ______________________ City ____________ State _____ Zip ________

Credentialing address (if different from above)

Street address ______________________ City ____________ State _____ Zip ________

Office manager/admin name ______________________ Admin phone number ________________

Admin email address ______________________ Admin fax number ________________

Credentialing contact (if different from above) ____________ Credentialing phone number ____________

Credentialing email address ______________________ Credentialing fax number ____________

List other office locations with above information on a separate sheet.

Professional licensure

State professional license/registration/certificate number ______________________________________

Issue date (MM/YY) ____________ Expiration date (MM/YY) ____________ Status: Active Temporary

Name of supervisor if required (e.g., Physician's Assistant) ______________________________

DEA registration number ____________________ Issue date (MM/YY) ______ Exp. date (MM/YY) ______

State controlled substance certificate number ________ Issue date (MM/YY) ______ Exp. date (MM/YY) ______

All other professional licenses

State ______ License/registration/certificate number ________________ Date issued (MM/YY) ________

Expiration date (MM/YY) _______ Year relinquished ________ Reason ______________________

State ______ License/registration/certificate number ________________ Date issued (MM/YY) ________

Expiration date (MM/YY) _______ Year relinquished ________ Reason ______________________

State ______ License/registration/certificate number ________________ Date issued (MM/YY) ________

Expiration date (MM/YY) _______ Year relinquished ________ Reason ______________________

Medical/professional education

Medical/professional school ______________________ Phone ____________ Fax ____________

Start date (MM/YY) ________ Graduation date (MM/YY) ________ Degree received ______________

Mailing address ______________________ City ____________ State _____ Zip ________

Medical/professional school ______________________ Phone ____________ Fax ____________

Start date (MM/YY) ________ Graduation date (MM/YY) ________ Degree received ______________

Mailing address ______________________ City ____________ State _____ Zip ________

Graduate education

Institution ______________________________________ Does not apply

Program or course of study ______________________________________

Mailing address ______________________ City ____________ State _____ Zip ________

Dates attended ______________________ Phone ____________ Fax ____________

Internship/PGYI

Institution ______________________________________ Does not apply

Mailing address ______________________ City ____________ State _____ Zip ________

Start date (MM/YY) _______ Completion date (MM/YY) _______ Phone ____________ Fax ____________

Type of internship ______________________ Specialty ______________________

Did you successfully complete the program? Yes No If no, explain: ______________________

Residencies

Institution ______________________________________ Does not apply

Mailing address ______________________ City ____________ State _____ Zip ________

Start date (MM/YY) _______ Completion date (MM/YY) _______ Phone ____________ Fax ____________

Type of residency ______________________ Specialty ______________________

Did you successfully complete the program? Yes No If no, explain: ______________________

Institution ______________________________________ Does not apply

Mailing address ______________________ City ____________ State _____ Zip ________

Start date (MM/YY) _______ Completion date (MM/YY) _______ Phone ____________ Fax ____________

Type of residency ______________________ Specialty ______________________

Did you successfully complete the program? Yes No If no, explain: ______________________

Fellowships

Institution ______________________________ Does not apply

Mailing address ______________________ City ____________ State _____ Zip ________

Start date (MM/YY) _______ Completion date (MM/YY) _______ Phone __________ Fax __________

Course of study ______________________________

Did you successfully complete the program? Yes No If no, explain: ______________________

Institution ______________________________ Does not apply

Mailing address ______________________ City ____________ State _____ Zip ________

Start date (MM/YY) _______ Completion date (MM/YY) _______ Phone __________ Fax __________

Course of study ______________________________

Did you successfully complete the program? Yes No If no, explain: ______________________

Board certification

Are you board or otherwise professionally certified? Does not apply

No If no, describe your intent for certification, if any, and dates of testing for certification:

____

____

Yes If yes, please complete the information below.

Issuing board/entity	Certificate number	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 ______________________________

Inpatient coverage plan

This section only applicable for those without admitting privileges. Does not apply

Provider may attach signed letter of agreement from the physician or group representative that admits and manages the inpatient care for your patients.

Name of participating admitting physician/practice/clinic/group	Hospital where privileged

Hospital and other institutional affiliations

In the sections below, please list in reverse chronological order (with the current affiliations first) all institutions where you: Does not apply

- have current affiliations
- applications in process
- have had previous affiliations

This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheets. List only affiliations here; list employment in Work History section.

Current affiliations

Name of primary facility ________________ Do you have admitting privileges? Yes No

Department ________________ Department/clinical chair ________________

Status (active, provisional, courtesy, temporary) ________________

Mailing address ________________ City ________ State ____ Zip ______

Phone number ________ Fax number ________ Appointment date (MM/YY) ______

Name of secondary facility ________________ Do you have admitting privileges? Yes No

Department ________________ Department/clinical chair ________________

Status (active, provisional, courtesy, temporary) ________________

Mailing address ________________ City ________ State ____ Zip ______

Phone number ________ Fax number ________ Appointment date (MM/YY) ______

Name of other facility ________________ Do you have admitting privileges? Yes No

Department ________________ Department/clinical chair ________________

Status (active, provisional, courtesy, temporary) ________________

Mailing address ________________ City ________ State ____ Zip ______

Phone number ________ Fax number ________ Appointment date (MM/YY) ______

Applications in process

Hospital/institution ________________

Mailing address ________________ City ________ State ____ Zip ______

Phone number ________ Fax number ________ Date application submitted (MM/YY) ______

Hospital/institution ________________

Mailing address ________________ City ________ State ____ Zip ______

Phone number ________ Fax number ________ Date application submitted (MM/YY) ______

Hospital/institution ________________

Mailing address ________________ City ________ State ____ Zip ______

Phone number ________ Fax number ________ Date application submitted (MM/YY) ______

Hospital/institution ________________

Mailing address ________________ City ________ State ____ Zip ______

Phone number ________ Fax number ________ Date application submitted (MM/YY) ______

Previous affiliations

Name of facility ____________________ Does not apply

Department ____________________ Department/clinical chair ____________________

Previous status (active, provisional, courtesy, temporary) ____________________

Mailing address ____________________ City ____________ State ______ Zip ________

Phone number ____________ Fax number ____________ Appointment date (MM/YY) ________

Reason for leaving ____________________

Name of facility ____________________

Department ____________________ Department/clinical chair ____________________

Previous status (active, provisional, courtesy, temporary) ____________________

Mailing address ____________________ City ____________ State ______ Zip ________

Phone number ____________ Fax number ____________ Appointment date (MM/YY) ________

Reason for leaving ____________________

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 vita may be substituted as long as it is current and has exact dates of employment.

Name of current practice/employer ____________________

Contact name ____________________ Phone number ____________ Fax number ____________

Mailing address ____________________ City ____________ State ______ Zip ________

Date started (MM/YY) ____________________ Date left (MM/YY) ____________________

Reason for leaving ____________________

Name of practice/employer ____________________

Contact name ____________________ Phone number ____________ Fax number ____________

Mailing address ____________________ City ____________ State ______ Zip ________

Date started (MM/YY) ____________________ Date left (MM/YY) ____________________

Reason for leaving ____________________

Name of practice/employer ____________________

Contact name ____________________ Phone number ____________ Fax number ____________

Mailing address ____________________ City ____________ State ______ Zip ________

Date started (MM/YY) ____________________ Date left (MM/YY) ____________________

Reason for leaving ____________________

Please account for all gaps in time between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity, and names where applicable.

Activity/name	From (MM/YY)	To (MM/YY)

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 ________

Email address ______________________ Phone number ____________ Cell number ____________

Name of reference ______________________ Title and specialty ______________________

Mailing address ______________________ City ____________ State _____ Zip ________

Email address ______________________ Phone number ____________ Cell number ____________

Name of reference ______________________ Title and specialty ______________________

Mailing address ______________________ City ____________ State _____ Zip ________

Email address ______________________ Phone number ____________ Cell number ____________

Professional liability

Current insurance carrier ______________________ Policy number ______________________

Mailing address ______________________ City ____________ State _____ Zip ________

Phone number ____________ Fax number ____________ Origination (retroactive) date (MM/YY) ________

Per claim amount _____ Aggregate amount _____ Effective date (MM/YY) ________ Exp. date (MM/YY) ________

Please list **all** professional liability carriers within the past five years.

Name of carrier ______________________ Policy number ______________________

Mailing address ______________________ City ____________ State _____ Zip ________

Phone number ____________ Fax number ____________ From ____________ To ____________

Name of carrier ______________________ Policy number ______________________

Mailing address ______________________ City ____________ State _____ Zip ________

Phone number ____________ Fax number ____________ From ____________ To ____________

Name of carrier ______________________ Policy number ______________________

Mailing address ______________________ City ____________ State _____ Zip ________

Phone number ____________ Fax number ____________ From ____________ To ____________

Professional liability action detail (confidential)

Provider name ____ 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 provider narrative that addresses all of the following details is an acceptable alternative.

Date (MM/YY) __________ Clinical details of the incident, with preceding events: ____________________

Your role and specific responsibility in the incident: ____________________

Subsequent events, including patient's clinical outcome: ____________________

Date suit or claim was filed (MM/YY) ________ Current status of suit or other action ____________________

Name and address of insurance carrier that handled the claim: ____________________

Your status in the legal action (primary defendant, codefendant, other) ____________________

Date of settlement, judgment, or dismissal ____________________

If case was settled out of court, or with a judgment, settlement amount attributed to you: ____________________

Universal provider attestation questions (to be completed by the provider)

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

A	Professional sanctions		Yes	No
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		
	b	Other professional registration or certification in any jurisdiction		
	c	Specialty or subspecialty board certification		
	d	Membership on any hospital medical staff		
	e	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.		
	f	Medicare, Medicaid, FDA, governmental, national or international regulatory agency or any public program		
	g	Professional society membership or fellowship		
	h	Participation/membership in an HMO, PPO, IPA, PHO, or other entity		
	i	Academic appointment		
	j	Authority to prescribe controlled substances (DEA or other authority)		
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?			
3	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?			
4	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?			
B	**Criminal history** (Please include an explanation sheet for any "Yes" answers in this section)		**Yes**	**No**
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?			
	a	Do you have notice of any such anticipated charges?		
	b	Are you currently under governmental investigation?		
C	**Affirmation of abilities**		**Yes**	**No**
1	Do you presently use any drugs illegally?			
2	Do you currently have any condition that adversely affects your ability to practice medicine in a safe, competent, ethical, and professional manner?			
	It is common for clinicians to feel overwhelmed from time to time and feel the need to seek help when appropriate. We emphasize the importance of well-being, appropriate treatment, and support for all health conditions, both mental and physical. SouthworthAssociates.net/professional-programs-idaho MontanaRecoveryProgram.com			
D	**Litigation and malpractice coverage history**		**Yes**	**No**
	If you answer "Yes" to any of the questions in this section, please document in the Professional Liability Action Detail section on page 10.			
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?			
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?			
3	Are there any such claims being asserted against you now?			
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)?			
5	Are any of the privileges that you are requesting not covered by your current malpractice coverage?			
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.			

Signature ______________________ Name ______________________ Date ____________

Provider authorization to release information

I hereby authorize the presenter of this Release and/or its representatives to consult with others who have information bearing on my professional competence, character, professional practice, or ethical qualifications. I authorize all malpractice carriers to release coverage and/or claims history information, which may exclude direct patient identification including name, address, or telephone numbers, to the presenter of this Release and/or its representatives. I hereby further consent to the inspection by the presenter, and/or its representatives, of all documents, including medical records, which may be relevant to evaluation of my professional competence, character, professional practice or ethical qualifications. The presenter complies with the Health Insurance Portability and Accountability Act of 1996 "HIPAA" (as defined in 45 CFR § 160 et seq.) as well as other state and federal statutes, rules, and regulations relating to confidentiality and privacy. I understand that I have the right to review any information submitted in support of this Provider Application.

I hereby release from liability any and all individuals and organizations that provide information to the presenter concerning my professional competence, practices, ethics, character, or ethical qualifications for participating provider status, and hereby consent to the release of such information. I further agree to release and hold harmless from any liability the presenter and/or its representatives who participate within the scope of their duties in review of any information obtained under this Release. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, professional practice, or ethical qualifications for resolving any doubts regarding such qualifications. A copy of any portion/section of the Authorization and Release, Criteria Sheet, and/or Application has the same force and effect as the original.

I also understand that to participate, this application must be verified and I must be notified in writing whether this application has been approved or denied. I agree to immediately notify the entity to which this authorization has been given, in accordance with executed Agreements, of any change in submitted information. Failure to notify the entity of changes in the information contained in this application may result in immediate termination from participation with the entity to which this Release is given.

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.

Signature ________________________________ Name _________________________________ Date _______________

(Stamped signature is not acceptable)

How to submit form

If credentialing a new provider, email to: Credentialing@PacificSource.com.

Questions?

Please email Credentialing@PacificSource.com or call **541-225-3747.** TTY: 711. We accept all relay calls.

Provider Information Request

The information provided on this form is required for claims processing and directory listings.
Please use separate forms for additional practice locations or practitioners/organizations.

Credential new provider
Effective date at your organization ______________
CAQH # ______________

Change information
Add provider to new/additional location
Add provider at hospital-based location only*
Termination Date ______________
Termination Reason ______________

1. Provider information (name as shown on CMS 1500 field 31 or UB box 1)

Facility   Primary care practitioner   Specialist care practitioner
Name ______________ SSN ______________ Birth date ______________
NPI ______________ Specialty ______________
Medical license number ______________ DEA number ______________
Male   Female   X   Race/ethnicity (optional) ______________
Offers telehealth   Yes   No   (If it differs from practice location, list telehealth location in section 4.)

Note: Telehealth regulations require practitioners to be licensed by the state listed in section 2.

2. Practice location information (for patient visits and directory listing)

Practice name (as it should appear in directories) ______________
Address ______________
City ______________ State ______ Zip ______________ County ______________
Practitioner specialty (as practicing at this location) ______________
List this location in directories? Note: hospital-based locations will not be listed.   Yes   No
Location NPI ______________ Tax ID number (attach matching IRS W9) ______________
Practice contact name ______________ Practice contact email ______________
Practice contact phone ______________ Practice contact fax ______________

3. Billing information (as listed on CMS 1500 field 33 or UB box 2)

Same as above

Billing name (as it appears on claims) ______________
Address ______________
City ______________ State ______ Zip ______________ County ______________
Billing contact name ______________ Billing contact email ______________
Billing contact phone ______________ Billing contact fax ______________
Credentialing contact name ______________ Credentialing contact email ______________
Credentialing contact phone ______________ Credentialing contact fax ______________

4. Summary of changes/notes

____

____

Form completed by ______________
Email ______________ Phone ______________

Hospital-based providers *are those who practice exclusively in an in-patient setting; a credentialing application is not required.* (marked *)

How to submit form: If credentialing a new provider, email to: Credentialing@PacificSource.com. For all other reasons, please email form to: ProvNetSup@PacificSource.com. **Questions?** Please contact your Provider Service Representative.