# Provider Information Request

## Idaho and Montana

PacificSource HEALTH PLANS

**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
☐ Change information
☐ Add provider to new/additional location
☐ Add provider at hospital-based location only[1]

Effective date at your organization _____
CAQH # _____
☐ Termination Date _____
Reason _____

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

☐ Organizational provider ☐ Individual Practitioner (PCP) ☐ Individual Practitioner (Specialist)

Name _____ SSN _____ Birth date _____ ☐ Male ○ Female

NPI _____ Degree _____

Medical license number _____ DEA number _____

PTAN number (if applicable) _____

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 _____

[1]***Hospital-based providers*** *are those who practice exclusively in an in-patient setting; a credentialing application is not required.*

**Montana:** Mail: 828 Great Northern Blvd., Ste. 101, Helena, MT 59601 Fax: 406-422-1010
Email to: MTProvNet@PacificSource.com

**Idaho:** Mail: 408 E Parkcenter Blvd., Ste. 100, Boise, ID 83706 Fax: 208-433-4634 Email: IDProvNet@PacificSource.com

# Practitioner credentialing

## Qualifying criteria checklist and applicant rights

Thank you for your interest in becoming an in-network provider with PacificSource Health Plans. PacificSource Health Plans makes every effort to contract with highly qualified practitioners by using clear and standardized credentialing requirements. Prior to execution of a new contract or addition to an existing group contract, you must complete the credentialing process, which includes submitting an application supported by qualifying criteria.

**Please complete the credentialing application and return to the PacificSource Health Plans Credentialing team.** Credentialing applications will be processed within 90 days of receipt. Applications with missing information will be returned, which will delay the credentialing process.

### Qualifying criteria checklist

Please provide the following documents to our Credentialing team for verification:

- ☐ Submit an application, completed 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 in each state 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.

Continued on next page >

## Other qualifying considerations

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

Medicare's opt-out list will be reviewed to ensure those listed are not applying for a Medicare Advantage plan network.

**You will be notified if anything is missing.** Be sure to submit the necessary information by the deadline to keep your application under consideration.

## Applicant rights

- 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.

- 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 notified promptly via email, telephone, fax, or mail, that their explanation and/or supporting documents have been received.

- 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.

- 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.

- PacificSource will take steps to protect the confidentiality of information obtained and generated during the credentialing/validation process.

- 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 **208-333-1513** or IDMTCredentialing@PacificSource.com.

NOTE: Highlighted areas are REQUIRED, all other areas should be completed as applicable

# Universal Provider Credentials Verification Application

**To use the Universal Provider Application (UPA), follow these instructions**

- 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 12 and 13. Please document any YES responses on the Attestation Question page.
- Prior to submitting this application to any health care related organization, inquire with the organization, as you may need authorization (through a pre-application process) before the application is accepted. Identify the health care 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.
- If a section does not apply to you, please check the provided box at the top of the section.

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 providers). If not available, indicate why.

- State Professional License(s)
- DEA Certificate w/ current address
- ECFMG (if applicable)
- State Controlled Substance Certificate (if applicable)
- 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. Provider 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 | E-mail address |
| Home mailing address | City | State | Zip code |
| Birth date | Birth place (city, state, country) | Social security number | Medicare Opt-Out - §1128 of the Social Security Act ☐ Yes ☐ No |
| Languages spoken by provider | Type of Provider ☐ PCP ☐ Urgent Care ☐ Specialist | Opt-Out Start Date | Opt-Out End Date |
| Individual NPI # | Individual Medicare Number | Individual Medicaid number(s) | Gender ☐ Male ☐ Female |
| Specialty at the primary practice location: | Taxonomy (10-digit code identifying specialty or subspecialty) | | 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 Universal Provider Application may invalidate the application.**

## 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** _____

| | | | |
|---|---|---|---|
| Name of secondary practice, affiliation or clinic name | | Department name (if hospital based) | |
| 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

| | | |
|---|---|---|
| State professional license/registration/certificate number | | Status ☐ Active ☐ Inactive ☐ Temporary |
| 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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(*Do not abbreviate*) (Attach additional sheet if necessary)

## 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

(*Do not abbreviate*) (Attach additional sheet if necessary)

## VIII. Graduate Education

Institution — **Does Not Apply** ☐

Program or course of study | Faculty director

Mailing address | City | State | Zip code

Dates attended ( / ) - ( / ) | Phone | Fax

(*Do not abbreviate*) (Attach additional sheet if necessary)

## 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.)

(*Do not abbreviate*) (Attach additional sheet if necessary)

## 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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(*Do not abbreviate*) (Attach additional sheet if necessary)

## 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.)

(*Do not abbreviate*) (Attach additional sheet if necessary)

## XII. Preceptorship

Institution — **Does Not Apply** ☐

Department chairman

| Mailing address | City | State | Zip code |
|---|---|---|---|
| Start date | Completion date | Phone | Fax |

Training

(*Do not abbreviate*) (Attach additional sheet if necessary)

## XIII. Faculty Appointment

Institution — **Does Not Apply** ☐

Faculty director

| Mailing address | City | State | Zip code |
|---|---|---|---|
| Start date | Completion date | Phone | Fax |

Position

(*Do not abbreviate*) (Attach additional sheet if necessary)

## 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 | 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

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



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(*Do not abbreviate*) (Attach additional sheet if necessary)

**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.

(*Do not abbreviate*) (Attach additional sheet if necessary)

**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 | |

(*Do not abbreviate*) (Attach additional sheet if necessary)

**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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**(*Do not abbreviate*) (Attach additional sheet if necessary)**

## C. Previous Affiliations

| | | | |
|---|---|---|---|
| Name of facility | | | **Does Not Apply** ☐ |
| 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 other 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 Plan

**This Section only applicable for those without admitting privileges**

Provider may attach signed letter of agreement from the physician or group representative that admits and manages the inpatient care for your patients. **Does Not Apply** ☐

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

**(*Do not abbreviate*) (Attach additional sheet if necessary)**

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

| | | | | |
|---|---|---|---|---|
| Name of current practice/employer | | | | |
| Contact name | Telephone number | Fax number | From (mo/year) | To (mo/year) |
| Mailing address | City | State | Zip code | |
| Reason for leaving | | | | |
| Name of practice/employer | | | | |
| Contact name | Telephone number | Fax number | From (mo/year) | To (mo/year) |
| Mailing address | City | State | Zip code | |
| Reason for leaving | | | | |



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## XVII. Work History (Continued)

| Name of practice/employer | | | | |
|---|---|---|---|---|
| Contact name | Telephone number | Fax number | From (mo/year) | To (mo/year) |
| Mailing address | City | State | Zip code | |
| 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 | 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 |

| Name of reference | | Title and specialty | |
|---|---|---|---|
| Mailing address | City | State | Zip code |
| E-mail address | Telephone number | Fax number | Cell phone number |

| Name of reference | | Title and specialty | |
|---|---|---|---|
| Mailing address | City | State | Zip code |
| E-mail address | Telephone number | Fax number | Cell phone number |



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| | | | | |
|---|---|---|---|---|
| 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 |

## XX. Professional Liability

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

Provider 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 provider 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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## 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.*

| | | | Yes | No |
|---|---|---|---|---|
| **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? (Please include an explanation sheet for any "Yes" answer in this section) | | | |
| | 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 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. | | | |
| ③ | Are you unable to perform any of the services/clinical privileges required by the applicable participating provider agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance? | | | |
| **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? | | | |
| 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.

Typed or printed name _____ Signature _____ Date _____



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## Universal Provider Credentials Verification Addendum

## Supplemental Provider Authorization and Release of Information

| | |
|---|---|
| **XXII. 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.<br><br>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.<br><br>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. |
| **Medicare Opt-Out ATTESTATION** | I certify that I have not filed an opt-out notice with the Center for Medicare Services (CMS) in the prior two years; I understand that should I choose to opt-out of Medicare, I must file a notice with CMS and promptly notify IPN. |
| **XXIII. 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. |

Print Name Here _____

Signature _____

**(Stamped signature is not acceptable)**

Date _____

| **Review dates and initials** |
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**Modification to the wording or format of the Universal Provider Application may invalidate the application**.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

# Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

**Give Form to the requester. Do not send to the IRS.**

Print or type. See **Specific Instructions** on page 3.

**1** Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

**2** Business name/disregarded entity name, if different from above

**3** Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

**Note:** Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

**4** Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

*(Applies to accounts maintained outside the U.S.)*

**5** Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

**6** City, state, and ZIP code

**7** List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

**Social security number**

| | | | – | | | – | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

**or**

**Employer identification number**

| | | – | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

**Sign Here** **Signature of U.S. person** ▶ **Date** ▶

# General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments**. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

## Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See* What is backup withholding, *later.*