SC Uniform Managed Care Provider Credentialing Application

I. PERSONAL INFORMATION

☐ Solo Practice ☐ Group Practice

Name: Last _____ First _____ M.I. _____ Suffix _____ Degree _____

Maiden and/or other name _____ List W-9 name if different _____

Place of birth: City _____ State _____ Date of birth _____

If you are not a U.S. citizen, do you have authorization to work in the U.S.? ☐ Yes ☐ No

(OPTIONAL) ☐ Male ☐ Female *This information will not be used by the Managed Care Organization in making its determination regarding your participation.*

Social Security number _____ NPI _____ UPIN number _____

Practice name _____

Tax ID number _____ Group NPI _____

E-mail address of practitioner _____

II. MEDICAL LICENSE/REGISTRATION

A. If you are a family practitioner, do you offer OB care? ☐ Yes ☐ No

B. Do you speak any foreign language fluently that you would like added to the directory? ☐ Yes ☐ No

If yes, please specify _____

C. ECFMG number _____

Current professional license number(s) *(indicate if not applicable)*: ☐ NA

1. SC Medical License number _____ Issue date _____ Exp. date _____

2. Additional medical state licences and numbers:

State _____ License number _____ Issue date _____ Exp. date _____

State _____ License number _____ Issue date _____ Exp. date _____

State _____ License number _____ Issue date _____ Exp. date _____

3. DEA # _____ Exp. date _____ SC Cont. Drug Perm. # _____ Exp. date _____

History of previous licensure in all jurisdictions *(indicate of not applicable)*: ☐ NA

State _____ License number _____ Issue date _____ Exp. date _____

State _____ License number _____ Issue date _____ Exp. date _____

State _____ License number _____ Issue date _____ Exp. date _____

III. EDUCATION, TRAINING AND HOSPITAL PRIVILEGES

A. Medical school institution _____

City _____ State _____ Country _____

Date of entry _____ Graduation date _____ Degree _____

Internship institution _____ Speciality _____

City _____ State _____ Country _____

Program completed ☐ Yes ☐ No Date of entry (MMYY) _____ Completion date (MMYY) _____

Residency institution _____ Speciality _____

City _____ State _____ Country _____

Program completed ☐ Yes ☐ No Date of entry (MMYY) _____ Completion date (MMYY) _____

Fellowship institution _____ Speciality _____

City _____ State _____ Country _____

Program completed ☐ Yes ☐ No Date of entry (MMYY) _____ Completion date (MMYY) _____

B. CME Requirements

Number of CME credits completed in the last two years _____

C. Hospital Staff Privileges

Hospital name _____

Address _____

Department _____ Dates of affiliation (MMYY): From _____ To _____

Status of privileges _____ % of admissions _____

Additional hospital name _____

Address _____

Department _____ Dates of affiliation (MMYY): From _____ To _____

Status of privileges _____ % of admissions _____

Additional hospital name _____

Address _____

Department _____ Dates of affiliation (MMYY): From _____ To _____

Status of privileges _____ % of admissions _____

If you do not admit, please describe arrangements to provide hospital care _____

_____

Provider initials _____ Date _____

IV. MEDICAL SPECIALITIES

Medical Specialities	Certifying Board	Date Certified	Expiration Date
Primary:			
If not Board certified, do you plan to take certifying exam?	☐ Yes (Date:)	☐ No	
Secondary:			
If not Board certified, do you plan to take certifying exam?	☐ Yes (Date:)	☐ No	

Under which specialty do you wish to be listed in the directory? _____

Are you applying for participation as: ☐ Primary care physician ☐ Specialist ☐ Non-Physician practitioner

V. MALPRACTICE INFORMATION

You are required to maintain malpractice insurance of an adequate and acceptable amount reflective of your specialty as a prerequisite for participating in a managed care organization. Please ***attach*** a copy of your most recent malpractice insurance binder.

List current and previous malpractice insurance carriers for the past five years:

Carrier Name & Address	Policy Number	Effective Date	Expiration Date	Amount of Coverage

VI. FIVE YEAR WORK HISTORY *(CV cannot be used in lieu of completing this section)*

	Name of Current/Previous Employer(s)	Dates of Employment (MMDDYY)		
1.			to	
2.			to	
3.			to	
4.			to	
5.			to	

Please provide an explanation of any gaps in employment _____

Signature _____ Printed name _____ Date _____

Rubber-stamped and electronic signatures are not acceptable.

VII. BACKGROUND INFORMATION: PLEASE ANSWER THE FOLLOWING QUESTIONS

This section must be completed by the practitioner. This information will be held strictly confidential.

Managed Care Organizations must have complete liability information and written explanations to begin the credentialing process. (If you answer "Yes" to any of the questions listed below, please enclose a detailed explanation.)

1. Do you have any pending misdemeanor or felony charges? ☐ Yes ☐ No

2. Have you ever been convicted of a felony? ☐ Yes ☐ No

3. Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited? ☐ Yes ☐ No

4. In the past five years and up to and including the present, have you had any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? ☐ Yes ☐ No

5. Considering the essential functions of a practitioner in your area of practice, in the past five years and up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients? ☐ Yes ☐ No

6. Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board? ☐ Yes ☐ No

7. Has your DEA certification or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited? ☐ Yes ☐ No

8. Have any of your privileges or memberships at any hospital or institution ever been denied, suspended, reduced, revoked, not renewed or otherwise limited? ☐ Yes ☐ No

9. Has your participation in Medicare, Medicaid or any other government program ever been limited or curtailed, or have you voluntarily excluded yourself from any of these programs? ☐ Yes ☐ No

10. Has your participation in an insurance company network ever been limited or terminated? ☐ Yes ☐ No

11. In the past five years and up to the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? ☐ Yes ☐ No

12. In the past five years and up to and including the present, have you had or do you have any mental or physical condition or do you take any medications that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? ☐ Yes ☐ No

13. Has any malpractice carrier ever made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf or are any medical malpractice suits pending against you? ☐ Yes ☐ No

14. Has your professional liability insurer ever placed conditions or restrictions on your coverage or ability to obtain coverage? ☐ Yes ☐ No

VIII. AUTHORIZATION

I CERTIFY THAT ALL INFORMATION CONTAINED IN THIS APPLICATION AND ALL ITS ATTACHMENTS ARE ACCURATE, COMPLETE AND TRUE.

I understand that:

A. Any misrepresentation, misstatement or omission of a relevant fact in connection with this application may result in denial of my application or termination of my participation in the Managed Care Organization;

B. It is my responsibility to promptly advise the Managed Care Organization in writing within 30 days of any changes or additions to the information contained in this application;

C. All the information contained in this application, or its attachments, is subject to the Managed Care Organization's investigation and review and;

D. This is an application only and my submission of this application does not automatically result in participation with the Managed Care Organization.

NOTICE: The National Practitioner Data Bank will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating, or omitting a relevant fact in connection with your application, the rejection may be reported to The National Practitioner Data Bank.

I authorize the Managed Care Organization to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been or am currently associated, and with others, including without limit past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further consent to the inspection by agents, employees, contractors, affiliates or other representatives of the Managed Care Organization of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications.

I release from liability the Managed Care Organization and all representatives of the Managed Care Organization for their acts performed in good faith and without malice or negligence in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations who provide information to the Managed Care Organization in good faith and without malice or negligence concerning my professional competence, character and ethics. I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension, or curtailment of participation status, membership and/or privileges of any type to or from the Managed Care Organization.

Signature of applicant _____ Date _____

Name of applicant (print or type) _____

Must be signed in ink

EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE.

Rubber-stamped and electronic signatures are not acceptable.

Practitioners have the right to review information obtained to evaluate their credentialing and recredentialing applications.

SC Uniform Managed Care Provider Office Information

I. GENERAL INFORMATION

A. Do you accept Medicaid patients?

☐ Yes (Medicaid ID # _____) ☐ No

B. Have you signed an agreement to participate with Medicare in the past twelve months?

☐ Yes (Medicare Group ID # _____) ☐ No

C. Are you accepting new patients? ☐ Yes ☐ No

D. Are there any age limitations? ☐ Yes (Minimum age _____ Maximum age _____) ☐ No

E. Are there gender restrictions? ☐ Males only ☐ Females only ☐ Both/no restrictions

F. Please describe any other patient limitations: _____

_____

II. OFFICE INFORMATION

A. Office address (physical)

1. Practice name _____ EIN # _____

2. Street _____ City _____ County _____ State _____ Zip _____

3. Appointment phone _____ Fax _____

4. Office contact person _____ 5. Credentialing contact phone _____

6. List all practitioners (including physician extenders) who are at this location. Indicate their status as (P) for Participating or (A) for Applying by each name. If you need more room, attach a separate sheet.

Status	Practitioner

Status	Practitioner

7. Do you offer 24-hour/7-day coverage? ☐ Yes ☐ No Describe: _____

_____

8. List physicians who are not a part of your practice with whom you share calls: _____

_____

9. What hours are you available to see patients in this office?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From-To							

10. After-Hours phone number(s) _____

11. Is your office equipped with telecommunications devices for the deaf (TDD)? ☐ Yes ☐ No

12. Is sign language assistance available? ☐ Yes ☐ No

13. List languages spoken by office staff: _____

14. Is your office handicap accessible? ☐ Yes ☐ No

B. Billing address (if different)

1. Name claims payable to _____

2. Street/PO Box _____ City _____ State _____ Zip _____

3. Phone _____ Fax _____

C. Mailing address (if different)

1. Street/PO Box _____ City _____ State _____ Zip _____

2. Phone _____ Fax _____

D. Office e-mail address (if any) _____

E. Practice Website address (if any) _____

III. SATELLITE OFFICE INFORMATION *(Duplicate this page for each satellite office location)*

A. Satellite office address (physical)

1. Practice name _____ EIN # _____

2. Street _____ City _____ County _____ State _____ Zip _____

3. Appointment phone _____ Fax _____

4. Office contact person _____ 5. Credentialing contact phone _____

6. List all practitioners (including physician extenders) who are billing at this location. Indicate their status as (P) for Participating or (A) for Applying by each name. If you need more room, attach a separate sheet.

Status	Practitioner

Status	Practitioner

7. Do you offer 24-hour/7-day coverage? ☐ Yes ☐ No Describe: _____

_____

8. List physicians who are not a part of your practice with whom you share calls: _____

_____

9. What hours are you available to see patients in this office?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From-To							

10. After-Hours phone number(s) _____

11. Is your office equipped with telecommunications devices for the deaf (TDD)? ☐ Yes ☐ No

12. Is sign language assistance available? ☐ Yes ☐ No

13. List languages spoken by office staff: _____

14. Is your office handicap accessible? ☐ Yes ☐ No

B. Billing address (if different)

1. Name claims payable to _____

2. Street/PO Box _____ City _____ State _____ Zip _____

3. Phone _____ Fax _____

C. Mailing address (if different)

1. Street/PO Box _____ City _____ State _____ Zip _____

2. Phone _____ Fax _____

D. Office e-mail address (if any) _____

E. Practice Website address (if any) _____