New West Health Plan A Divison of New West Health Services

INDIVIDUAL / PROFESSIONAL PROVIDER CREDENTIALING APPLICATION

PERSONAL INFORMATION
(Please Print)

Name:____
(Last) *(First)* *(MI)* *(License)*

Date of Birth: _____/_____/_____ Place of Birth: _________________________ Sex: [ ] Male [ ] Female

US Citizen? [ ] Yes [ ] No If no, are you lawfully authorized to work in the United States? [ ] Yes [ ] No

Home Address:____
(Street) *(City)* *(State)* *(Zip Code)*

Social Security Number: ___________________ National Provider Identifier Number: _______________

MALPRACTICE COVERAGE *(Please attach a current copy of your malpractice facesheet showing 1M/3M minimum coverage)*

Name of Current Carrier	Policy Number	Issue Date	Expiration Date	Coverage Amts.

APPLYING AS

[ ] Primary Care Physician [ ] Specialist [ ] Allied Health Provider [ ] Behavioral Health Provider

REQUESTED START DATE: ________________________________

BOARD CERTIFICATION

Name of Board	Specialty	Certified	Date(s) Certified	Expiration Date
If eligible, date exam taken:		☐ Yes ☐ No ☐ Eligible		
If eligible, date exam taken:		☐ Yes ☐ No ☐ Eligible		

If not Board certified, please explain why:

____

____

Limitations (PCPs Only): By Age______________ By Number ______________ Existing Only? [ ] Yes [ ] No

Do you practice outside your scope of specialty? [ ] Yes [ ] No

If yes, please explain:____

(PA-Cs) Name of Supervising Physician: ____

PRACTICE LOCATION

Practice Name: ____ Type: [ ] Solo [ ] Group [ ] Hospital-Based

Physical Location: ____
(Street) *(City)* *(State)* *(Zip Code)*

Mailing Address: ____
(Street) *(City)* *(State)* *(Zip Code)*

Billing Address: ____
(Street) *(City)* *(State)* *(Zip Code)*

Office Phone: (____)___________________ Office Fax: (____)____________ Office E-mail:________________

Business Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Sat/Sun/Holidays	Evenings

Does the office comply with the Americans with Disabilities Act (ADA) Standards? [ ] Yes [ ] No

Do you sign your own claim forms? [ ] Yes [ ] No Federal Tax ID Number:________________________

Date you began using the Federal Tax ID Number or the date you joined the group practice:_________________

Primary Office Contact:____
(Name) *(Title)* *(Telephone)*

LICENSURE HISTORY

Current Licenses Held ***(Please attach copies of all current licenses/certificates)***

State Issued By	Number	Original Issue Date	Current Dates

Previous Licenses Held

State Issued By	Number	Original Issue Date	Current Dates

DEA Certification (Please attach a current copy)

DEA Number	Issue Date	Expiration Date

ALIEN FOREIGN MEDICAL GRADUATE INFORMATION (Please attach copies of test scores)

Examination	Score	Date
Test of English as a Foreign Language		
ECFMG Certification Examination		

EDUCATION AND TRAINING

Please provide a chronological educational history to account for all time. Please explain any gaps in time.

Education	School	Address	Type of Degree Obtained	Dates Attended Month/Yr.	Name as it Appears on Degree
Undergraduate				From: ____/____ To: _____/____	
Professional School				From: ____/____ To: _____/____	

Internship (I) / Residencies (R) / Fellowships (F)

Professional Training Facility/Program	Address	Specialty	Type (I, R, F)	Dates Attended Month/Yr.	Completed
			☐ Internship ☐ Residency ☐ Fellowship	From: ___/___ To: ___/___	☐ Yes ☐ No
			☐ Internship ☐ Residency ☐ Fellowship	From: ___/___ To: ___/___	☐ Yes ☐ No
			☐ Internship ☐ Residency ☐ Fellowship	From: ___/___ To: ___/___	☐ Yes ☐ No

Explanation of Gap(s)

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CURRENT MEDICAL STAFF APPOINTMENTS & CLINICAL PRIVILEGES

Facility	Description of Privileges (e.g., medical, surgical)	Dates of Appointment
		From: ___/___ To: ___/___
		From: ___/___ To: ___/___
		From: ___/___ To: ___/___

If you do not have hospital privileges, please explain your reason for not maintaining privileges, your plan for admitting patients and describe the procedures performed in your office.

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PROFESSIONAL EXPERIENCE

Please provide a chronological professional practice experience to account for all time since graduation or completion of training, with the most recent experience first. Please explain gaps in time below.

Organization	Address	Phone	Date Month/Yr.
			From: ___/___ To: ___/___
			From: ___/___ To: ___/___
			From: ___/___ To: ___/___
			From: ___/___ To: ___/___
			From: ___/___ To: ___/___
			From: ___/___ To: ___/___
			From: ___/___ To: ___/___

Explanation of Gap(s)

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QUESTIONNAIRE / PERSONAL STATEMENTS ***If your answer is "Yes" to any of the following questions, a complete detailed written explanation is required on the next page. Attach additional sheets if necessary.***			
1	Is your DEA license or narcotics registration currently being challenged, or has it ever been limited, suspended, revoked, voluntarily or involuntarily relinquished, or are any actions pending?	Yes	No
2	Has your license to practice in any state or jurisdiction ever been denied, limited, suspended, revoked, stipulated, non-renewed, voluntarily or involuntarily relinquished or otherwise limited in any manner?	Yes	No
3	Have any disciplinary actions been initiated or are any pending against you by any state or jurisdiction licensure board?	Yes	No
4	Has your employment, staff appointment or clinical privileges at any hospital or other health care facility, ever been voluntarily or involuntarily suspended, diminished, revoked, refused, denied, stipulated, non-renewed or otherwise limited in any manner?	Yes	No
5	Are you currently or have you ever been the subject of any disciplinary proceedings or been denied membership to any hospital, health care facility, or professional organization?	Yes	No
6	Have you ever withdrawn your application for appointment, reappointment or clinical privileges or resigned from a hospital staff or health care facility before a decision was made by a hospital's or health care facility's governing board?	Yes	No
7	Have you ever resigned from the staff of any medical facility or professional organization because of problems regarding credentials or conduct?	Yes	No
8	Are you currently under investigation or have you ever been subjected to any claim(s) of unprofessional conduct?	Yes	No
9	Has any action been taken by you ever been declared to be unethical by any professional organization, society, regulatory board or institution?	Yes	No
10	Have you been the subject of an investigation, or have you been suspended, excluded, sanctioned or otherwise restricted from participating or receiving payment in any private, federal or state health insurance program (for example, Medicare, Medicaid, FEMBP)?	Yes	No
11	Have you ever been arrested or charged with any offense or named as a defendant in a felony or any other criminal proceeding? If '**yes**', please list date, offense and whether you were convicted.	Yes	No
12	Have you ever been the subject of any allegation of malpractice, arbitration, professional liability suits and/or claims, or any other lawsuit or legal proceeding regardless of the outcome, or are any presently pending? If '**yes**', please provide details including the following: incident date, narrative of case including brief case presentation, initial finds, treatment, other practitioners' involvement, if any; patient outcome and plaintiff's allegation, if reviewed; current status or disposition, including settlement amount, if any.	Yes	No
13	Is there anything that would prevent you from practicing your profession and performing the essential functions and duties required as part of your clinical practice, with or without reasonable accommodation?	Yes	No
14	Do you currently engage in the illegal use of drugs?	Yes	No
15	Are you currently under or have you ever received treatment for an alcohol or drug related condition? If 'yes', please provide an explanation about the treatment received, current status, how are you being monitored and if you are currently involved in a state substance abuse program (e.g. MPAP)? Please provide the name of your MPAP contact (if applicable).	Yes	No
16	Have you ever been licensed, certified, or accepted as a member in any educational or training program, professional organization or society under any name other than the name that you provided on this application?	Yes	No
17	**Have you completed a minimum of 50 continuing education credits within the last three years? (This requirement is 36 credits for chiropractors and 30 for PT/OT). If NO, please provide a detailed explanation on the following page.**	**Yes**	**No**

(CONTINUED NEXT PAGE)

IF YOUR ANSWER IS **YES** TO ANY OF THE PRECEEDING QUESTIONS OR **NO** TO #17, **A COMPLETE DETAILED WRITTEN EXPLANATION IS REQUIRED.**

ATTESTATION

I, ____ hereby certify and attest that all the information
(PRINT Name)

submitted by me in support of this application is true, accurate and complete to the best of my knowledge and belief. I understand and agree that substantial errors of fact involving information submitted by me may be the basis for rejection of my application or, if discovered after approval of my application, for adverse action up to and including termination.

____ ____________________________
Signature Date

New West Health Services

AUTHORIZATION FOR THE RELEASE AND INSPECTION OF RECORDS, DOCUMENTS AND OTHER INFORMATION AND RELEASE OF LIABILITY

New West Health Services

AUTHORIZATION FOR THE RELEASE AND INSPECTION OF RECORDS, DOCUMENTS AND OTHER INFORMATION AND RELEASE OF LIABILITY

I, ____ hereby authorize
(PRINT Provider's Full Name)

A third party who may have information bearing on my professional qualifications (credentials), clinical competence, mental or emotional stability, physical condition, ethics, professional conduct, or any pertinent matter bearing on my qualification for approval as a member of New West Health Services provider network to consult with and release such information to New West Health Services. I release any and all such third parties, New West Health Services, and its authorized representatives, from any and all liability for their acts performed in good faith and without malice in releasing, obtaining, verifying and evaluating such information.

This authorization shall remain in effect for twenty-four (24) months from the signature date on this authorization form unless sooner revoked in writing.

____ ________________________
Signature Date

CREDENTIALING APPLICATION CHECKLIST

In order to avoid delays in processing your application, please ensure the following are completed.

	Completed
Social Security Number	
Practicing Specialty	
Board Certified or Eligible included (as applicable)	
Federal Tax ID Number	
Name as it appears on your professional school degree	
Personal statement section is completed and any "Yes" answers have detailed explanations attached (excluding #17)	
#17 on page 6 is answered or cme documentation is attached	
Attestation form signed and dated	
Consent to the Inspection of Records signed and dated	

** COPIES OF THE FOLLOWING ITEMS MUST BE RETURNED WITH THIS APPLICATION AND MUST BE CURRENT **

[ ] State professional license and copies of current licenses in other states
[ ] DEA certificate
[ ] Malpractice insurance certificate showing 1M/3M minimum coverage
[ ] W-9
[ ] Facility Information Sheet
[ ] Signed contracts and exhibits

Please return the completed application form and the above-noted items to:

Attn: Credentialing Department
New West Health Services
130 Neill Avenue
Helena, MT 59601
Telephone (406) 457-2239 Fax (406) 457-2255

PLEASE KEEP A COPY OF THE APPLICATION FOR YOUR RECORDS

Applicants have the right to review the information submitted in support of their credentialing application and to be informed of the status of their credentialing application. Please contact the Credentialing Department to request this information. Applicants also have the right to correct erroneous information in the application. This information must be submitted in writing to the address provided above.