



New West Health Plan ♦ A Division of New West Health Services

Please note: If you have not yet received a contract with New West, please check here.
If checked, please expect a telephone call from one of our Provider Services Representatives in the near future to establish a contract. Thank you.

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 declarations page showing \$1M/3M minimum coverage with an effective and termination date)*

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

APPLYING AS

Primary Care Physician Specialist Allied Health Provider Behavioral Health Provider

START DATE (i.e., date you intend to begin seeing New West members): _____

BOARD CERTIFICATION

Name of Board	Specialty	Certified	Date(s) Certified	Expiration Date
If eligible, date exam taken:		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eligible		
If eligible, date exam taken:		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 and Midwives) 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: _____

Federal Tax i.d.: _____

Foreign Languages Spoken: _____

Are you accepting new patients? [] Yes [] No Are you accepting new **Medicare** patients? [] Yes [] No

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

Are you, or do you intend to be, a contracted provider with Medicare? [] Yes [] No

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
			<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship	From: ___/___ To: ___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship	From: ___/___ To: ___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship	From: ___/___ To: ___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No

Explanation of Gap(s)

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.

QUESTIONNAIRE / PERSONAL STATEMENTS

If your answer is "Yes" to questions 2-17, a complete detailed written explanation is required on the next page. Attach additional sheets if necessary.

1	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
2	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
3	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? Have you ever been required to report to any supervising authority for any reason?	Yes	No
4	Have any disciplinary actions been initiated or are any pending against you by any state or jurisdiction licensure board?	Yes	No
5	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
6	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
7	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
8	Have you ever resigned from the staff of any medical facility, licensure board or professional organization because of problems regarding credentials or conduct?	Yes	No
9	Are you currently under investigation or have you ever been subjected to any claim(s) of unprofessional conduct?	Yes	No
10	Has any action been taken by you ever been declared to be unethical by any professional organization, society, regulatory board or institution?	Yes	No
11	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, FEHBP)?	Yes	No
12	Have you ever been arrested or charged with any offense or named as a defendant in a felony or any other criminal proceeding or placed on probation? If 'yes', please list date, offense and whether you were convicted.	Yes	No
13	Within the last 5 years, have you 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
14	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
15	Do you currently engage in the illegal use of drugs?	Yes	No
16	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
17	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

(CONTINUED NEXT PAGE)

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	
National Provider Identifier Number	
Practicing Specialty	
Board Certified or Eligible (as applicable)	
Name as it appears on your professional school degree	
Personal statement section is complete and any "Yes" answers have detailed explanations attached (excluding #1)	
#1 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 with an effective and termination date
- W-9
- Facility Information Sheet

PLEASE KEEP A COPY OF THE APPLICATION FOR YOUR RECORDS

Please allow 45 days for the processing of your application.

If your primary office location is in the counties of Lincoln, Flathead, Sanders, Lake, Mineral, Missoula, Ravalli, Granite, Powell, Deer Lodge, Silver Bow, Beaverhead or Madison please mail to New West Health Services, Attn: Hilary Ambrose, 1203 Hwy 2 West Ste 45, Kalispell, MT 59901.

If your primary office location is in the counties of Glacier, Toole, Liberty, Hill, Pondera, Teton, Choteau, Lewis & Clark, Cascade, Judith Basin, Jefferson, Broadwater, Meagher, Gallatin or Park please mail to New West Health Services, Attn: Doug Frazier, 130 Neill Ave, Helena, MT 59601.

If your primary office location is in the counties of Blaine, Phillips, Valley, Daniels, Sheridan, Roosevelt, Fergus, Petroleum, Garfield, McCone, Richland, Dawson, Prairie, Wibaux, Wheatland, Golden Valley, Musselshell, Rosebud, Custer, Fallon, Sweet Grass, Stillwater, Yellowstone, Treasure, Carbon, Big Horn, Powder River or Carter please mail to New West Health Services, Attn: Suzann Jones, 2132 Broadwater, Unit A1, Billings, MT 59102.

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 Credentialing Department.



Facility Information Form

Please fill out the following information so we can pay your claims accurately.

Date Completed: _____

Name of Facility: _____

Physical Address: _____

Mailing Address: _____

Office Phone for member calls: _____

This information is NOT published

Office Manager: _____

Office Manager phone number: _____

Fax number: _____

E-mail Address: *(for newsletters or bulletins)* _____

Billing Information

Facility Tax Identification Number: _____

Box 31 of CMS 1500: _____

National Provider Identification (NPI) # (Personal): _____ (Box J, NPI Line, CMS 1500)

Claims will be sent on a (please circle one): **UB04** **CMS 1500**

How will you be filling out Box 33 of CMS 1500 or Box 2 on UB04?

Check should be addressed to: _____

Address for sending checks: _____

National Provider Identification (NPI) # (Corporation): _____ (Box 33A of the CMS 1500, or Box 56 of the UB04)

If you have multiple locations or NPIs, please copy and complete one form for each location or facility address.