North Carolina Department of Insurance

Uniform Application
To Participate as a Health Care Practitioner

with Crescent Health Solutions

The following application is a form approved by the North Carolina Department of Insurance, in accordance with North Carolina General Statute 58-3-230. Every insurer that provides a health benefit plan and credentials providers for its network is required to use this form and the insurer may not require an applicant to submit information that is not required by this form Only the Commissioner of Insurance is authorized to make changes, deletions or additions to this form.

CRESCENT
HEALTH SOLUTIONS

Credentialing Checklist

The following items must be included with the Provider's credentialing application.
Please include this completed checklist when submitting the application to Crescent Health Solutions.
NOTE: Incomplete applications cannot be processed until all information and documentation is received.

Provider _____ **Title** _____

Practice Name _____

Check each item to confirm its inclusion in the submitted packet; indicate N/A if not applicable to the Provider.

_____ **North Carolina Uniform Application -** All information must be current, and all fields must be completed. Attach separate pages if needed.

_____ **Attestation -** Must be signed and dated by Provider

_____ **Anti-Trust Policy -** Must be signed and dated by Provider

_____ **Copy of original NC Medical License -** *Initial Provider* ***Credentialing only***

_____ **Current NC Medical Board Registration -** Must have valid issue and expiration dates

_____ **Practice W9 Form -** For multiple participating practices, provide a W9 for *each* Tax ID

_____ **Copy of current NC DEA Certificate -** Valid issue in NC with current address.
If provider has a DEA license from another state, but will practice in NC, inform who will write prescriptions.

_____ **Certificate of Liability Insurance, Copy of Current Face Sheet**
Indicating by name, Provider(s) covered, coverage amounts, effective date, policy number

_____ **Complete Curriculum Vitae - must include: first five years of employment after receiving license and practice for which provider is applying to be credentialed. Work history must be in month + year format. Work gaps greater than 6 months must be explained.**

_____ **For physicians: Copy of certificate from national specialty board -** Internship will be be verified for physicians not board-certified. For non-physicians, provide certificate of certified specialty affiliation (i.e., NCCPA, AANP)

_____ **for PAs and PA-Cs: Supervising Letter from MD -** Must state supervising physician and be signed and dated by the supervising physician

_____ **For Foreign Graduates (outside U.S. and Canada) - Copy of Educational Commission of Foreign Medical Graduates Certificate (ECFMG)**

_____ **Copy of CLIA/ACR (Clinical Laboratory Improvement Amendments, American College of Radiology)**
If applicable

A. DEMOGRAPHIC AND PERSONAL DATA:

1. **Name of Applicant:** (Last) (First) (Middle) (Maiden)

2.

Date of Birth (mo/day/yyyy):	**Place of Birth:**
Social Security Number:	**Sex:** **Male** ☐ **Female** ☐

3.

Type of Practice: **Primary Care:** ☐ **Specialist:** ☐ **FQHC:** ☐ **Rural Healthcare Provider:** ☐	
(Primary Specialty)	(Secondary Specialty)
Please Identify Areas of Clinical Expertise:	
What population(s) do you treat (e.g. geriatric, all ages):	

4. **Name of Practice:**

5. **Primary Office Address** (If you maintain more than one office, list each office, address, and hours of operation)

Practice Name:

Address: (Street, City, State, Zip and County)

Handicapped Accessible? **YES** ☐ **NO** ☐ **Office Phone:** **Fax:**

E-mail address:

Accepting New Patients? **YES** ☐ **NO** ☐ **Restrictions:** (Please list or indicate none)

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Secondary Office Address

Practice Name:

Address: (Street, City, State, Zip and County)

Handicapped Accessible? **YES** ☐ **NO** ☐ **Office Phone:** **Fax:**

E-mail address:

Accepting New Patients? **YES** ☐ **NO** ☐ **Restrictions:** (Please list or indicate none)

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

Additional Office Address or Billing Address, if different (check one) ☐ **Billing** ☐ **Office**						
Name:						
Address: (Street, City, State, Zip and County)						
Handicapped Accessible? YES ☐ **NO** ☐ **Office Phone:** **Fax:**						
Accepting New Patients? YES ☐ **NO** ☐ **Restrictions:** (Please list or indicate none)						
Office Hours:						
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

6. **Name other provider(s) in your practice (if not enough space, please attach additional sheet):**

7. **Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? YES** ☐ **NO** ☐
(If yes, please attach proof of professional liability insurance and proof of employment for those individuals)

8.

Name and address of provider(s) who share call with you (if not enough space, please attach additional sheet):	
Name:	**Name:**
Address:	**Address:**

9. **Arrangements for 24 hour/7 day coverage:**

10. **Administrative Contact:** (Name, Title, Phone Number)

11. **IRS requires reimbursement be made payable to name of practice affiliated with Federal Tax ID Number:**

Federal Tax ID Number:
Name (if different from practice name):
Billing Address (if different from practice address):

12.

UPIN Number:	**Medicare/Medicaid Number:**
National Provider Identifier (NPI):	

13. **DEA Number:** (Attach copy of license to application) **Exp. Date: (mo/yyyy):**

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

COMPLETE ONLY IF LICENSED IN SOUTH CAROLINA

SC Controlled Drug Substance Certificate: (Attach a copy to application) Expiration Date (mo/yyyy):

14. **Provide the following information for each state in which you are currently or were previously licensed to Practice** (If not enough space please attach additional sheet)

STATE	DATE OF LICENSE (mo/yyyy)	LICENSE NUMBER	STATUS Active, Inactive, Suspended	EXPIRES (mo/yyyy)

PLEASE ATTACH A COPY OF EACH STATE LICENSE CERTIFICATE

15. **Certification of Specialty Boards as applicable:**

a. If you are certified by a specialty board, indicate name of board and date of certificate.

Primary Specialty Board	Date Certified (mm/yyyy):	Exp. Date (mo/yyyy):
Secondary Specialty Board	Date Certified (mm/yyyy):	Exp. Date (mo/yyyy):

b.. Are you listed in the American Board of Medical specialists? YES ☐ NO ☐

c. If you have applied to a specialty board for examination, give the name of board and the date of scheduled examination.

	Date (mo/day/yr):

d. If you have not applied to a specialty board, please explain:

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

16. **List the dates of all current professional memberships in societies, including state and county societies:**

	FROM (mo/yyyy)	TO (mo/yyyy)

17. **List all hospitals where you currently have privileges and indicate the type and status of those privileges:**
(Type: active, admitting, associate, consulting, courtesy. Status: pending, provisional, suspended, temporary, visiting)

Hospital	Privilege and Status of Privilege	Estimated % of Admission
(primary admitting facility)		

18. **If you do not have admitting privileges, who admits for you?**

Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**

B. EDUCATION AND PRACTICE HISTORY

1.

Medical, Dental, or other Professional School Attended		
Institution:		
Address**:**		
Degree:	To (mm/yyyy):	To (mm/yyyy):

If degree is from outside of the US, attach ECFMG (Educational Commission of Foreign Medical Graduate Certificate).

2.

Internship		
Institution:		
Address**:**		
Specialty:	To (mm/yyyy):	To (mm/yyyy):

3.

Residency		
Institution:		
Address**:**		
Specialty:	From (mm/yyyy):	To (mm/yyyy):

4.

Other Residency / Fellowship – (specify)		
Institution:		
Address**:**		
Specialty:	From (mm/yyyy):	To (mm/yyyy):

B. EDUCATION AND PRACTICE HISTORY (Continued)

5. **List specific work history since beginning of medical, dental, or other professional school.** If not enough space, attach additional sheet. Gaps in work greater than 6 mos. must be explained.

	FROM (mo/yyyy)	**TO (mo/yyyy)**
(Current Practice)		
(Previous Practice)		
(Previous Practice)		
(Previous Practice)		
(Previous Practice)		

6. **List other training and/or education (including CME) within the last three years, if applicable.**

7. **Have you involuntarily or voluntarily withdrawn or been suspended from any internship, residency or fellowship training program? Please explain:**

8. **Please explain any incident(s) in which you have involuntarily or voluntarily withdrawn your application for appointment, clinical privileges or reappointment before a decision was made by a hospital or healthcare facility's governing board.**

C. PROFESSIONAL INFORMATION

Check Yes or No for each question and complete the attached Supplemental Form for any question answered Yes. Sign and date the Attestation page; if the application does not have the provider's signature, it cannot be accepted.

1.	Has your license to practice in any jurisdiction ever been limited, restricted, reduced, suspended, voluntarily surrendered, revoked, denied or not renewed; have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license; are you under investigation by any licensing or regulatory agency? (*If yes, please complete Supplemental Question No. 1*.)	**Y** ☐	**N** ☐
2.	Has your professional employment or membership in a professional organization ever been subject to disciplinary proceedings, denied, limited, restricted, reduced, suspended, revoked, not renewed, or voluntarily relinquished during or under threat of termination for any reason? (*If yes, please complete Supplemental Question No.2*.)	**Y** ☐	**N** ☐
3.	Has your Drug Enforcement Agency registration or other controlled substance authorization ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your registration during or under the threat of an investigation or are any such actions pending? (*If yes, please complete Supplemental Question No.3*.)	**Y** ☐	**N** ☐
4.	Have you ever been sanctioned or suspended by Medicare or Medicaid? (*If yes, please complete Supplemental Question No.4*.)	**Y** ☐	**N** ☐
5.	To your knowledge, have you ever been reported to the National Practitioner Data Bank or the North/South Carolina Board of Medical Examiners? *(If yes, please complete Supplemental Question No.5*.)	**Y** ☐	**N** ☐
6.	Have you ever been convicted of a felony or misdemeanor, or are you under investigation with respect to such conduct? (*If yes, please complete Supplemental Question No.6*.)	**Y** ☐	**N** ☐
7.	Has a professional liability claim been assessed against you in the past five years, or are there any professional liability cases pending against you? (*If yes, please complete Supplemental Question No.7*.)	**Y** ☐	**N** ☐
8.	Has any liability insurance carrier canceled, refused coverage, or rated up because of unusual risk or have any procedures been excluded from your coverage? (*If yes, please complete Supplemental Question No. 8*.)	**Y** ☐	**N** ☐
9.	Have you ever practiced without liability coverage? (*If yes, please complete Supplemental Question No.9*.)	**Y** ☐	**N** ☐
10.	Do you currently have any medical, chemical dependency or psychiatric conditions that might adversely affect your ability to practice medicine or surgery or to perform the essential functions of your position? (*If yes, please complete Supplemental Question No.10*.)	**Y** ☐	**N** ☐
11.	Have your Hospital and/or Clinic privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of an investigation or are any such actions pending? (*If yes, please complete Supplemental Question No. 11*).	**Y** ☐	**N** ☐

SUPPLEMENTAL FORM

Provider Name:	***Provider ID#*** (if applicable)

1. License Limited, Reprimanded, etc.

List State(s) where action took place:		
Date(s) License revoked, suspended, etc.	From (mo/day/yyyy)	To (mo/day/yyyy)
Please explain:		

2. Employment/Membership Suspended, Limited, etc.

List State(s) where action took place:
List Professional Organization:
Please explain:

3. Drug Enforcement Agency (DEA) Explanation.

List State(s) where action took place:
Please explain:

SUPPLEMENTAL FORM

***Provider Name*:**	***Provider ID#*** (if applicable)

4. Medicare/Medicaid Sanction Disciplinary Action(s)

Disciplined Action(s):		
List State(s):		
Date(s) of action.	From (mo/day/yyyy)	To (mo/day/yyyy)
Please explain:		

5. National Practitioner Data Bank Report(s)

Please explain the NPDB report (*if you have a copy please attach):*

6. Felony or Misdemeanor

Did you serve a sentence: Y ☐ N ☐	If YES, check how many years: 1☐	2☐	3☐	4☐	5☐	6☐	Other:	
List State(s):								
Please explain charge and verdict:								

SUPPLEMENTAL FORM

Provider Name:	***Provider ID#*** (if applicable)

7. Named in Professional Liability Judgment, Settlement, etc.

Please explain, include dates & amounts:

8. Cancelled, Refused Coverage, etc.

Please list Insurance Carrier(s):
Please explain:

9. Practiced Without Liability Coverage

Please explain:

SUPPLEMENTAL FORM

Provider Name:	***Provider ID#*** (if applicable)

10. Medical, Chemical Dependency, or Psychiatric Conditions

Please explain in detail:

11. Hospital or Clinic Privileges Revoked, Restricted, etc.

List Hospital(s):		
Date privileges revoked, etc.	From (mo/day/yyyy)	To (mo/day/yyyy)
Please explain:		

Attestation Statement

(IMPORTANT: Submit Original Only)

This application is to be signed by each individual provider submitting an application.

Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in CRESCENT , I signify my willingness to appear for interview in regard to my application. I authorize CRESCENT to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to CRESCENT materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of CRESCENT of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of CRESCENT for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to CRESCENT in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to CRESCENT.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, CRESCENT , may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in CRESCENT , I hereby consent to CRESCENT for inspection of my patient records relating to CRESCENT enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify CRESCENT in a timely manner (not to exceed 30 days) of any changes to the information on the initial application.

_____

PRINT NAME OF PROVIDER

_____

SIGNATURE OF PROVIDER

_____

DATE (mo/day/yyyy)

Please Sign and Complete this Application