



PRACTITIONER CREDENTIALING APPLICATION

Notice to applicants: Encore conducts continuous open enrollment for new practitioners who meet minimum criteria. Minimum criteria for consideration by Encore Credentialing Committee are:
Unrestricted, non-probationary license to practice, current DEA certificate if prescribing controlled substances, board certification or completion of an approved residency program in practicing specialty, adequate professional liability insurance, admitting privileges at Encore participating hospitals for those who normally admit, lack of Medicare/Medicaid sanctions, signed Encore agreement for participation. Providers not meeting the minimum criteria above need not apply.

CHECKLIST

Please if all items are enclosed:

- Attestation and release form is signed and dated with current date.
- Copy of State License(s), billfold size.
- Copy of DEA Certificate(s) – If a physician has more than one office where controlled substances are administered and/or dispensed, each office must be registered. However, if a physician only administers and/or dispenses at the principal office and only writes prescription orders at the other office or offices, only the principal office need be registered, provided each office is within the same state.
- Copy of Controlled Substances Registration Certificate.
- Copy of Board Certification, if applicable.
- Copy of ECFMG Certificate, if applicable.
- Copy of Professional Liability Certificate.
- Education – List dates attended (From – To).
- Completed malpractice detail for all cases within the past five (5) years which are pending or closed.
- Work History – Must be current. List start and end dates for all employment for the past five (5) years.
- HCFA 1500-Complete a sample for billing address verification.
- W-9 – Tax Identification Number

In case we have questions, please supply the name of the person whom we should contact:

| | | |
|------|-------|-------|
| Name | Title | Phone |
| | | Fax |

Return to: Encore Health Network
ATTN: Provider Relations Department
1776 N. Meridian St., #200
Indianapolis, IN 46202-1404

Revision 022309

Practitioner Rights: You have the right to review information submitted in support of your application, to correct erroneous information and to receive the status of your application, upon request.



Physician Application Form

PLEASE TYPE OR PRINT. FILL IN ALL SECTIONS. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

I. DEMOGRAPHICS

Name (Last, First, Middle) _____ Title _____

Home Address/Street _____

City/State/ZIP _____

List Other Names Used (Last, First, Middle) _____

Former Address/Street _____

City/State/Zip _____

Date of Birth (for Data Bank Query) _____ Sex: Male Female

Citizenship _____ Do You Have the Legal Right to Work in the US? Y N

Corporate Name (if different from name above) _____ SS# _____

II. OFFICE/PRACTICE INFORMATION

(PLEASE INCLUDE ALL OFFICES/PRACTICES, USING THE ATTACHED ADDITIONAL SHEETS IF NECESSARY)

Participation Status For Which You Are Applying: (INDICATE SPECIALTY)

Primary Care Specialty Care Specialty: _____ Subspecialty: _____

PRIMARY OFFICE ADDRESS/STREET _____

City/State/Zip _____

Office Phone _____ Office Fax _____

Office Manager _____ Federal Tax ID# _____

Billing Address/Street (if different from above) _____

Billing City/State/Zip _____

Office Hours

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|--------|---------|-----------|----------|--------|----------|--------|
| | | | | | | |

Languages Spoken by Physician or Staff (other than English)

MD: _____ Staff: _____

Are Interpreters Available? Y N

After-Hours Telephone Number _____

Does Your Office: (CIRCLE ONE)

| | | | | | |
|---|----------------------------|----------------------------|---|----------------------------|----------------------------|
| Make 24-Hour Phone Coverage Available? | <input type="checkbox"/> Y | <input type="checkbox"/> N | Employ Allied Health Professionals? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Have Capability for Electronic Billing? | <input type="checkbox"/> Y | <input type="checkbox"/> N | Provide Child Care Services? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Meet ADA Accessibility Standards? | <input type="checkbox"/> Y | <input type="checkbox"/> N | Have Public Transportation Accessibility? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

Type of Practice: Solo Single Specialty Group Multispecialty Group Other

If Group Practice, Please List Other Members of Your Practice, Their Specialties, & Coverage Arrangements

Office E-Mail address, if any: _____

Do You Currently: (CIRCLE ONE)

| | | | | | |
|---|----------------------------|----------------------------|---|----------------------------|----------------------------|
| Accept New Patients Into Your Practice? | <input type="checkbox"/> Y | <input type="checkbox"/> N | Accept New Patients From Physician Referral Only? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Have Medicare Certification? | <input type="checkbox"/> Y | <input type="checkbox"/> N | Accept Medicare Assignment? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Provide Inpatient Care? | <input type="checkbox"/> Y | <input type="checkbox"/> N | Accept Medicaid Assignment? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

SECONDARY OFFICE ADDRESS/STREET

City/State/Zip _____

Office Phone _____ Office Fax _____

Office Manager _____ Federal Tax ID# _____

Billing Address/Street (if different from above) _____

Billing City/State/Zip _____

Office Hours

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|--------|---------|-----------|----------|--------|----------|--------|
| | | | | | | |

Languages Spoken by Physician or Staff (other than English)

MD: _____ Staff: _____

Are Interpreters Available? Y N

After-Hours Telephone Number _____

Does Your Office: (CIRCLE ONE)

| | | | | | |
|---|----------------------------|----------------------------|---|----------------------------|----------------------------|
| Make 24-Hour Phone Coverage Available? | <input type="checkbox"/> Y | <input type="checkbox"/> N | Employ Allied Health Professionals? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Have Capability for Electronic Billing? | <input type="checkbox"/> Y | <input type="checkbox"/> N | Provide Child Care Services? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Meet ADA Accessibility Standards? | <input type="checkbox"/> Y | <input type="checkbox"/> N | Have Public Transportation Accessibility? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

Type of Practice: Solo Single Specialty Group Multispecialty Group Other

If Group Practice, Please List Other Members of Your Practice, Their Specialties, & Coverage Arrangements

Do You Currently: (CIRCLE ONE)

| | | | | | |
|---|----------------------------|----------------------------|---|----------------------------|----------------------------|
| Accept New Patients Into Your Practice? | <input type="checkbox"/> Y | <input type="checkbox"/> N | Accept New Patients From Physician Referral Only? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Have Medicare Certification? | <input type="checkbox"/> Y | <input type="checkbox"/> N | Accept Medicare Assignment? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Provide Inpatient Care? | <input type="checkbox"/> Y | <input type="checkbox"/> N | Accept Medicaid Assignment? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

III A. MEDICAL EDUCATION

(LIST ALL MEDICAL EDUCATION, ATTACHING ADDITIONAL SHEETS IF NECESSARY)

Medical/Professional School Name

Address/Street

City/State/Zip/Country

Dates Attended (From–To)

Degrees Awarded

III B. POSTGRADUATE TRAINING: INTERNSHIP

(ATTACH ADDITIONAL SHEETS IF NECESSARY)

Institution Name

Address/Street

City/State/Zip

Dates Attended (From–To)

Program Director

Type of Internship

III C. POSTGRADUATE TRAINING: RESIDENCY/FELLOWSHIP(S)

(ATTACH ADDITIONAL SHEETS IF NECESSARY)

Institution Name

Address/Street

City/State/Zip

Dates Attended (From–To)

Program Director

Type of Residency/Fellowship

IV A. HOSPITAL AFFILIATIONS

CURRENT PRIMARY HOSPITAL NAME

Address/Street

City/State/Zip

Status of Privileges Key

| | | | | |
|------------------------------|-------------|----------------|-----------------|---------------|
| 1 Active | 4 Associate | 7 Courtesy | 10 Provisional | 12 Consulting |
| 2 Courtesy Provisional Staff | 5 Visiting | 8 Admitting | 11 Suspended | 13 Pending |
| 3 Active Provisional Staff | 6 Temporary | 9 Senior Staff | 14 Other: _____ | |

Status of Privileges (*INDICATE BY USING KEY*)

Any Past or Present Restriction of Privileges Y N (*IF YES, EXPLAIN*)

LIST ALL OTHER HOSPITALS AT WHICH YOU CURRENTLY HAVE PRIVILEGES

(*ATTACH ADDITIONAL PAGES*)

HOSPITAL NAME

Address/Street

City/State/Zip

Any Past or Present Restriction of Privileges Y N (*IF YES, EXPLAIN*)

HOSPITAL NAME

Address/Street

City/State/Zip

Any Past or Present Restriction of Privileges Y N (*IF YES, EXPLAIN*)

IV B. OTHER PRACTICE AFFILIATIONS (EG, HMOs, IPAS)

(INDICATE WHETHER EACH AFFILIATION IS CURRENT [C] OR FORMER [F])

Institution/Organization Name

Type of Affiliation

Address/Street

City/State/Zip

Phone

Fax

Institution/Organization Name

Type of Affiliation

Address/Street

City/State/Zip

Phone

Fax

V. PRACTICE SPECIALTY

PRIMARY SPECIALTY

National Board Certification

Certification Number

Name of Board

Date of Certification

Expiration Date

Date of Recertification

If Intending to Sit for Boards, Specify Date

SECONDARY SPECIALTY

Board Certification

Certification Number

Name of Board

Date of Certification

Expiration Date

Date of Recertification

If Intending to Sit for Boards, Specify Date

VI. WORK HISTORY

(WORK HISTORY MUST BE LISTED FOR THE PAST FIVE (5) YEARS. PLEASE LIST START DATE AT CURRENT POSITION)

NAME OF CURRENT PRACTICE

Contact Name

Address/Street

City/State/Zip

Phone

Fax

Dates of Employment (From-To)

NAME OF PREVIOUS PRACTICE/EMPLOYER

Contact Name

Address/Street

City/State/Zip

Phone

Fax

Dates of Employment (From-To)

NAME OF PREVIOUS PRACTICE/EMPLOYER

Contact Name

Address/Street

City/State/Zip

Phone

Fax

Dates of Employment (From-To)

VII. PROFESSIONAL CERTIFICATES/LICENSES/NUMBERS

State License Number/State of License

Expiration Date

Other State License Number/State of License

Expiration Date

Other State License Number/State of License

Expiration Date

Federal DEA Number/State of License

Expiration Date

State Medicare Number/State of License

State Medicaid Number/State of License

State Certification Number (CSR)

Expiration Date

CDS Certification

Individual National Provider Identifier/NPI#

ECFMG Number

Organizational NPI#

VIII. PROFESSIONAL LIABILITY INSURANCE

CURRENT CARRIER NAME

Address/Street

City/State/Zip

Dates of Coverage

Policy Number

Coverage Amount Per Occurrence/Aggregate

Policy Type

Occurrence(s)

Claim(s) Paid

Length of Time with Current Carrier

ALL PREVIOUS CARRIER(S) (*ATTACH ADDITIONAL SHEETS IF NECESSARY*)

Name(s)

Dates Covered (From-To)

X. ADDITIONAL QUESTIONS

(PLEASE PROVIDE AN EXPLANATION FOR ANY "YES" RESPONSES ON A SEPARATE PAGE)

- | | | |
|--|-------|-----|
| 1. Have any of your board certifications ever been suspended, revoked, or voluntarily surrendered? | Y | N |
| 2. Have you ever been named as a defendant in any criminal or civil case or convicted of a felony? | Y | N |
| 3. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified? | Y | N |
| 4. Has your malpractice insurance ever been cancelled, suspended, not renewed, restricted, or special-rated? | Y | N |
| 5. Has your license to practice medicine in any state been suspended, restricted, revoked, voluntarily surrendered, been subject to a consent order, or has probation ever been invoked? | Y | N |
| 6. Has your federal or state controlled substance license ever been suspended, revoked, or voluntarily surrendered, or has probation ever been invoked? | Y | N |
| 7. Have your privileges at any hospital or other health care setting ever been suspended, revoked, voluntarily surrendered, reduced, or restricted, or not renewed, or has probation ever been invoked? | Y | N |
| 8. Within the last five years, have you ever been a participating provider of another HMO, PPO, PHO, or MSO, etc. with which you are not affiliated at this time? | Y | N |
| 9. Have you ever received sanctions from a regulatory agency (e.g., CLIA, OSHA, etc.)? | Y | N |
| 10. Has any information on you ever been reported to the National Practitioner Data Bank? | Y | N |
| 11. Have you any inability to perform the essential functions of the position, with or without accommodation? | Y | N |
| 12. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application. Rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.) | Y | N |
| 13. Within the last five years, have you ever been reprimanded or disciplined in any manner by any state licensing authority or other professional board or peer review committee for conduct related to the use of alcohol or the use of any drug? | Y | N |
| 14. Number of Continuing Medical Education (CME's) in Category 1 for the previous 24 months. | _____ | hrs |
| 15. Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital, ambulatory surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies? If so, please provide the following information: | Y | N |

| | |
|---|--|
| Name of Organization | Type of Organization |
| Address/Street | |
| City/State/Zip | |
| Telephone Number | Tax Identification Number |
| Percent of Business Owned/Invested by Applicant | Nature of Business Interest (owner, partner, investor) |

XI. PROFESSIONAL REFERENCES

(LIST THREE PEERS WHO HAVE DIRECT KNOWLEDGE OF YOUR CLINICAL ABILITIES. DO NOT INCLUDE A SPOUSE, CHILD, OR PARENT OF THE APPLICANT.)

| | |
|----------------|-------|
| NAME | Phone |
| Address/Street | |
| City/State/Zip | |
| NAME | Phone |
| Address/Street | |
| City/State/Zip | |
| NAME | Phone |
| Address/Street | |
| City/State/Zip | |

XII. AFFIRMATION OF INFORMATION

I, the undersigned, hereby attest that the information given in or attached to this Application is correct and complete and fairly represents the current level of my training, experience, capability and competence to practice at the level requested. I specifically authorize Encore Health Network and its authorized representatives to consult with any third party who, may have information bearing on the subject matter addressed by this Application and to inspect or obtain any reports, records, recommendations or other documents or disclosures of third parties that may be material to the questions in this Application. I also specifically authorize any third parties to release information to Encore Health Network and its authorized representatives upon request. I hereby release Encore Health Network and its authorized representatives and any third parties, from any liability for any such reports, records, recommendation or any other documents of disclosures involving me that are made, requested or received by Encore Health Network, and/or your authorized representatives to, from or by any third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter addressed by this Application. I understand that falsification or omission of information can result in rejection of this Application.

Applicant Signature _____

Print Name _____

Print Degree _____ Date _____

ADDITIONAL DOCUMENTATION

PLEASE ATTACH COPIES OF THE FOLLOWING DOCUMENTS (IF APPLICABLE):

| | |
|---|---|
| Current State Licenses | ECFMG Certificate |
| Board Certification Certificate | State Controlled Substance Registration Certificate |
| Current Professional Liability Insurance Face Sheet | Current Federal DEA Registration |

CONFIDENTIAL SECTION

Do you have any liability claims that have been filed, are in process, or resolved in the past five years?

Yes No

How many cases? _____

If more than one malpractice case is in process, been filed or resolved, **make a copy of this sheet for each case and complete all blanks.** Place "N/A" in those that do not apply. Application may be considered incomplete if malpractice information is not sufficient.

Were you:

Primary Defendant

Co-Defendant

Other

Explain Other: _____

Male

Female

Age: _____

Date alleged incident occurred: _____

Date alleged incident filed: _____

Date resolved: _____

Provide complete details of the occurrence, including description of injuries or illnesses resulting from acts or omission: (continue on back if additional space is needed)

Current status of claim: (check one only)

Pending

In appeal

Dismissed

Case Dropped

Physician dropped from case

Other _____

Settled

Amount paid \$ _____

Findings of Medical Review panel:
(if convened)

In favor of physician

Against physician

Date: _____

REFERRAL AGREEMENT

If you do not have hospital privileges, please complete the information below.

Please attach a copy or summarize your referral agreement with a network M.D. or D.O., should it become necessary to admit a patient to a contracted hospital. Please note: Members must be admitted to network hospitals. If you are uncertain of the hospitals contracted with Encore, please check the Participating Hospital List enclosed in the contract packet, or request a copy of the Provider Directory.

Name, address, & phone number or network physician(s), and the name of the network hospital(s) the physician has privileges:

Physician: _____

Address: _____

Phone Number: () _____

Hospital Privileges: _____

Hospital: _____

Address: _____

Phone Number: () _____

Hospital Privileges: _____