SC Uniform Managed Care Provider Credentialing Application

I. PERSONAL INFORMATION

Solo Practice or 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

Male Female (*OPTIONAL). 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: Expiration Date:

2. Additional Medical State Licenses and Numbers:

State: License Number: Issue Date: Expiration Date:

State: License Number: Issue Date: Expiration Date:

State: License Number: Issue Date: Expiration Date:

3. DEA No.: Expiration Date: SC Cont. Drug Perm. No.: Expiration. Date:

History of Previous Licensure in all Jurisdictions (indicate if not applicable): NA

State: License Number: Issue Date: Expiration Date:

State: License Number: Issue Date: Expiration Date:

State: License Number: Issue Date: Expiration Date:

III. EDUCATION/TRAINING/HOSPITAL PRIVILEGES

1. Medical School Institution:

City: State: Country:

Date of Entry: Graduation Date (MMYY): Degree:

Internship Institution: Specialty:

City: State: Country:

Program Completed: Yes No Date of Entry (MMYY): Completion Date (MMYY):

Residency Institution: Specialty:

City: State: Country:

Program Completed: Yes No Date of Entry (MMYY): Completion Date (MMYY):

Fellowship Institution: Specialty:

City: State: Country:

Program Completed: Yes No Date of Entry (MMYY): Completion Date (MMYY):

2. CME REQUIREMENTS:

Number of CME credits completed in the last two years:

3. HOSPITAL STAFF PRIVILEGES

Name:

Address:

Department: Dates of Affiliation: From (MMYY): To (MMYY):

Status of Privileges: % of Admissions:

Additional Hospital Name:

Address:

Department: Dates of Affiliation: From (MMYY): To (MMYY):

Status of Privileges: % of Admissions:

Additional Hospital Name:

Address:

Department: Dates of Affiliation: From (MMYY): To (MMYY):

Status of Privileges: % of Admissions:

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

Provider Initials: **Date:**

IV. MEDICAL SPECIALTIES

MEDICAL SPECIALTIES	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 carrier(s) for past five years:

CARRIER NAME/ADDRESS	POLICY NUMBER	EFFECTIVE DATE	EXPIRATION DATE	AMOUNT OF COVERAGE

VI. Five Year Work History *(CV can not be used in lieu of completing this section)*

NAME OF PREVIOUS/CURRENT EMPLOYER(S)	DATE OF EMPLOYMENT (MM/DD/YY-MM/DD/YY)
1.	
2.	
3.	
4.	
5.	

Please provide an explanation of any gaps in employment:

Signature: Date:

RUBBER STAMPED AND ELECTRONIC SIGNATURES ARE NOT ACCEPTABLE

Please print name:

VII. PLEASE ANSWER THE FOLLOWING QUESTIONS
(This section must be completed by practitioner)

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, 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

(THE ABOVE INFORMATION WILL BE HELD STRICTLY CONFIDENTIAL.)