# Idaho Practitioner Credentials Verification Checklist

The following documentation is required when submitting a practitioner credentialing application. Please complete the information below and return this page with the application.

| *Documentation |
|---|
| ☐ Complete Provider Information form |
| ☐ Current medical malpractice insurance face sheet |
| ☐ Provider Authorization and Release of Information page; signed and dated |
| ☐ Complete Attestation (action history) |
| ☐ DEA or prescription plan (MD, DO, DPM, PA, NP, CRNA) |
| ☐ Completed hospital admitting privileges or admit plan (MD, DO, PA, NP) |
| ☐ Current and active license in the state of practice |
| ☐ Attestation of Collaborative Practice Agreement for Physician Assistants (PA only) |

**Please be advised that IPN will hold an application for 10 days from the date received and will resume processing if required documentation is received during this time. After 10 days, IPN will return the incomplete application and discontinue the credentialing process.*

| Completed By (print name): | |
|---|---|
| Email: | Phone: |

# Provider Information

Return to: PO Box 5406, Boise ID 83705
Fax to: 208-433-4605
Email to: ipn@ipnmd.com
Website: www.ipnmd.com

**The information provided on this form is required for claims processing and directory information.**

*Please use additional forms for additional practice locations or practitioners/organizations.*

**EFFECTIVE DATE OF CHANGE:** **PLEASE NOTE: IPN IS UNABLE TO GUARANTEE A RETROACTIVE PAYOR IMPLEMENTATION DATE**

☐ Add Provider to Group ☐ Change Information ☐ Add a New Location ☐ Add Provider to Hospital Based Location[1]

☐ Termination **Reason:**

## Provider Information (name as shown on CMS 1500 Field 31 OR UB box 1)

| | | | | |
|---|---|---|---|---|
| ☐ Individual Practitioner<br>☐ Organizational Provider | Name: | | | |
| NPI: | SSN<br>(TRICARE required): | Degree: | DOB: | ☐ Male<br>☐ Female |
| License No.: | DEA No.: | Is Practitioner Currently Active Military or Reserve?<br>☐ Yes ☐ No | | |

## Practice Location Information (for patient visits and directory listing)

| | |
|---|---|
| Practice Name<br>(as it should appear in directories): | |
| Physical Address<br>(Address, City, State, Zip): | County: |
| **Required eff. 1/1/2022 per Title I – No Surprises Act, Sec. 116*<br>***Office Email:** | **Required eff. 1/1/2022 per Title I – No Surprises Act, Sec. 116*<br>***Web Address:** |
| Practitioner Specialty<br>(as practicing at this location): | |
| Location to appear in a directory for this practitioner? ☐ Yes ☐ No | |
| Location NPI: | Tax ID No.<br>(Attach IRS W9): |
| Practice Phone<br>(where patients call to make an appointment): | Practice Fax: |
| ☐ Clinic Hours of Operation (complete specific hours below) (*ex. 8-5 – do not include midday closures*) | ☐ Hospital Based Location[1] (hours are 24/7) |
| Mon \|Tues \|Wed \|Thurs \|Fri \|Sat \|Sun | |
| Practice Contact<br>Name: | Practice Contact<br>Email: |

## Billing Information (as billed on CMS 1500 Field 33 OR UB box 2)

| | |
|---|---|
| Billing Name<br>(as it should appear on claims): | |
| Billing Address<br>(Address, City, State, Zip): | County: |
| Billing Contact<br>Name: | Billing Contact<br>Email: |
| Billing Contact<br>Phone: | Billing Contact<br>Fax: |

## Summary of Changes/Notes

| | | |
|---|---|---|
| Form completed by<br>(Name): | Email: | Phone: |

[1]**Hospital-Based Provider:** A practitioner is not required to credential with IPN and is considered "Hospital-Based" if he/she:

1. Provides health care services within an IPN-credentialed hospital,
2. Is privileged by the hospital,
3. Does not accept appointments for health care services at the hospital, and
4. Exclusively sees patients who have been directed to the hospital for health care services.

*If the practitioner provides health care services at any other location not identified as a hospital, credentialing is required.*

# Credentialing Eligibility Criteria and Provider Rights and Responsibilities

IPN maintains a Credentialing/Recredentialing Program to assist in selection and reevaluation of providers within its delivery system. To participate with IPN, providers must successfully complete the credentialing process and be approved. Information provided on this application and acquired during the credentialing process may be provided to our clients.

**Credentialing Eligibility Criteria**

- Complete Universal Provider Credentialing Application
- Current, unrestricted license to practice for each state, as applicable
- Current DEA and State Board of Pharmacy certificates for each state, as applicable OR written Prescription Plan
- Proof of professional liability insurance for minimum of $1,000,000 per occurrence and $3,000,000 aggregate

**Provider Rights and Responsibilities**

The provider has the right to review information obtained in the process of evaluating the credentialing and recredentialing application exclusive of peer review information.

The provider has the right, upon request and subject to policies and procedures, to be informed of the status of the application. The Credentialing Department will make every effort to provide status at the time of request and, if unable, will respond by telephone or in writing within three (3) business days.

The provider has the right to revise, supplement or correct erroneous information to the Credentialing and recredentialing applications. This may be done at the provider's discovery or if deficiencies are discovered by IPN. The provider will be notified by telephone, email or written correspondence and will have thirty (30) days to respond. After thirty (30) days without response, the application will be withdrawn from the review process. When additional information is provided by the provider within the thirty (30) days but continues to fall short of meeting criteria requirement(s) the provider will be notified by telephone, email or written correspondence allowing the provider an additional thirty (30) days to respond.

*If information is not received by the Credentialing Department within sixty (60) days of request, an updated attestation may be required.*

A copy of any portion of the Universal Provider Credentialing Application has the same force and effect as the original.

Credentialing and recredentialing is non-transferrable.

# Attestation of Collaborative Practice Agreement
# For Physician Assistants

**Effective July 1, 2021, the State of Idaho no longer requires physician assistants (PAs) to report a direct supervising physician. Instead, PAs are required to enter into a collaborative practice agreement (CPA) if they are not employed by a facility who has a credentialing and privileging program in place.*

Please complete the following attestation for PAs and return with the credentialing or re-credentialing application.

| **Attestation** |
|---|
| ☐ I have entered into a CPA with my provider group and can provide a copy, if requested. |
| ☐ I am employed by a facility who has a credentialing and privileging program in place; therefore, a CPA is not required. |

**Senate Bill #1093*

| Printed Name: | Date: |
|---|---|
| Signature: | |

Note: Highlighted areas are REQUIRED, all other areas should be completed as applicable

# Universal Provider Credentials Verification Application

**To use the Universal Provider Application (UPA), follow these instructions**

- Complete the application in its entirety using black or blue ink. **Keep an unsigned and undated copy of the application on file for future requests.** When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate. Please sign and date pages 12 and 13. Please document any YES responses on the Attestation Question page.
- Prior to submitting this application to any health care related organization, inquire with the organization, as you may need authorization (through a pre-application process) before the application is accepted. Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- Attach copies of requested documents each time the application is submitted.
- If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- If a section does not apply to you, please check the provided box at the top of the section.

This application is submitted to:

## I. Instructions

This form should be **typed or legibly printed in black or blue ink**. If more space is needed than provided, attach additional sheets and reference the question being answered. *Please do not use abbreviations*. **Current copies of the following documents must be submitted with this application** (all are required for MDs, DOs; as applicable for other health providers). If not available, indicate why.

- State Professional License(s)
- DEA Certificate w/ current address
- ECFMG (if applicable)
- State Controlled Substance Certificate (if applicable)
- Passport photo (for hospitals only)
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

**** All sections must be completed in their entirety****

## II. Provider Information

| | | | |
|---|---|---|---|
| Last name (include suffix; Jr., Sr., III) | First (do not abbreviate) | Middle (do not abbreviate) | |
| Other name(s) under which you have been known by reference, licensing and or educational institutions? | | Degree(s) | |
| Home telephone number | Pager number | Cell number | E-mail address |
| Home mailing address | City | State | Zip code |
| Birth date / Birth place (city, state, country) | Social security number | Medicare Opt-Out - §1128 of the Social Security Act ☐ Yes ☐ No | |
| Languages spoken by provider | Type of Provider ☐ PCP ☐ Urgent Care ☐ Specialist | Opt-Out Start Date | Opt-Out End Date |
| Individual NPI # | Individual Medicare Number | Individual Medicaid number(s) | Gender ☐ Male ☐ Female |
| Specialty at the primary practice location: | Taxonomy (10-digit code identifying specialty or subspecialty) | | Subspecialties: |

## III. Practice Information

**Effective Date at Primary Practice location** _____

| | | | |
|---|---|---|---|
| Name of practice, affiliation or clinic name | | Department name (if hospital based) | |
| Primary office street address | City | State | Zip code |
| Patient appointment telephone number | Fax number | Name affiliated with tax ID number | Federal tax ID number |
| Mailing address (if different from above) | City | State | Zip code |



**Modification to the wording or format of the Universal Provider Application may invalidate the application.**

## III. Practice Information (Continued)

| | | | |
|---|---|---|---|
| Billing address (if different from above) | City | State | Zip code |
| Office manager / Administrator name | Administration telephone number | Fax number | E-mail address |
| Credentialing contact (if different from above) | Credentialing telephone number | Fax number | E-mail address |

**Effective Date at Secondary Practice location** _____

| | | | |
|---|---|---|---|
| Name of secondary practice, affiliation or clinic name | | Department name (if hospital based) | |
| Secondary office street address | City | State | Zip code |
| Patient appointment telephone number | Fax number | Name affiliated with tax ID number | Federal tax ID number |
| Mailing address (if different from above) | City | State | Zip code |
| Billing address (if different from above) | City | State | Zip code |
| Office manager / Administrator name | Administration telephone number | Fax number | E-mail address |
| Credentialing contact (if different from above) | Credentialing telephone number | Fax number | E-mail address |

**List other office locations with above information on a separate sheet.**

## IV. Professional Licensure

| | | |
|---|---|---|
| State professional license/registration/certificate number | | Status ☐ Active ☐ Inactive ☐ Temporary |
| Issue date | Expiration date | **Name of sponsor if required by licensure, (i.e. Physician's Assistant).** |
| Drug Enforcement Administration (DEA) registration number | Issue date | Expiration date |
| State controlled substance certificate number | Issue date | Expiration date |
| ECFMG number (applicable to foreign medical graduates) | | Date issued |

## V. All Other Professional Licenses

| | | | |
|---|---|---|---|
| State | License/registration/certificate number | | Date issued |
| Expiration date | Year relinquished | Reason | |
| State | License/registration/certificate number | | Date issued |
| Expiration date | Year relinquished | Reason | |
| State | License/registration/certificate number | | Date issued |
| Expiration date | Year relinquished | Reason | |

## VI. Under-graduate Education

| | | | |
|---|---|---|---|
| Name of college or university | | | **Does Not Apply** ☐ |
| Degree received | Graduation date | | |
| Mailing address | City | State | Zip code |
| Name of college or university | | | |
| Degree received | Graduation date | | |
| Mailing address | City | State | Zip code |



**Modification to the wording or format of the Universal Provider Application may invalidate the application**.

(*Do not abbreviate*) (Attach additional sheet if necessary)

## VII. Medical/Professional Education

| | | | | |
|---|---|---|---|---|
| Medical/Professional school | | | | |
| Start date | Graduation date | Degree received | | |
| Mailing address | | City | State | Zip code |
| | | Phone | Fax | |
| Medical/Professional School | | | | |
| Start date | Graduation date | Degree received | | |
| Mailing address | | City | State | Zip code |
| | | Phone | Fax | |

(*Do not abbreviate*) (Attach additional sheet if necessary)

## VIII. Graduate Education

| | | | |
|---|---|---|---|
| Institution **Does Not Apply** ☐ | | | |
| Program or course of study | Faculty director | | |
| Mailing address | City | State | Zip code |
| Dates attended ( / ) - ( / ) | Phone | Fax | |

(*Do not abbreviate*) (Attach additional sheet if necessary)

## IX. Internship/PGYI

| | | | |
|---|---|---|---|
| Institution **Does Not Apply** ☐ | | | |
| Program director | | | |
| Mailing address | City | State | Zip code |
| Start date / Completion date | Phone | Fax | |
| Type of internship | Specialty | | |
| Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.) | | | |

(*Do not abbreviate*) (Attach additional sheet if necessary)

## X. Residencies

| | | | |
|---|---|---|---|
| Institution **Does Not Apply** ☐ | | | |
| Program director | | | |
| Mailing address | City | State | Zip code |
| Start date / Completion date | Phone | Fax | |
| Type of residency | Specialty | | |
| Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.) | | | |
| Institution **Does Not Apply** ☐ | | | |
| Program director | | | |
| Mailing address | City | State | Zip code |
| Start date / Completion date | Phone | Fax | |
| Type of residency | Specialty | | |
| Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.) | | | |

(*Do not abbreviate*) (Attach additional sheet if necessary)

## XI. Fellowships

Institution — Does Not Apply ☐

Program director

| Mailing address | City | State | Zip code |
|---|---|---|---|
| | | | |

| Start date | Completion date | Phone | Fax |
|---|---|---|---|
| | | | |

Course of study

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

Institution — Does Not Apply ☐

Program director

| Mailing address | City | State | Zip code |
|---|---|---|---|
| | | | |

| Start date | Completion date | Phone | Fax |
|---|---|---|---|
| | | | |

Course of study

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

(*Do not abbreviate*) (Attach additional sheet if necessary)

## XII. Preceptorship

Institution — Does Not Apply ☐

Department chairman

| Mailing address | City | State | Zip code |
|---|---|---|---|
| | | | |

| Start date | Completion date | Phone | Fax |
|---|---|---|---|
| | | | |

Training

(*Do not abbreviate*) (Attach additional sheet if necessary)

## XIII. Faculty Appointment

Institution — Does Not Apply ☐

Faculty director

| Mailing address | City | State | Zip code |
|---|---|---|---|
| | | | |

| Start date | Completion date | Phone | Fax |
|---|---|---|---|
| | | | |

Position

(*Do not abbreviate*) (Attach additional sheet if necessary)

## XIV. Board Certification

**Are you board or otherwise professionally certified?** Does Not Apply ☐

☐ **Yes** If "Yes", please complete below ☐ **No** If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.

| Issuing Board/Entity | Certificate Number | Specialty | Date Certified | Date Recertified | Expiration Date (if any) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Have you applied for certification other than those indicated above? ☐ Yes ☐ No

If so, list certification and date

**If you participate in a specialty which does not have board certification, please indicate specialty**

(*Do not abbreviate*) (Attach additional sheet if necessary)

**XV. Other Certifications**

| ACLS, BLS, ATLS, PALS, NRP, NALS (i.e., Fluoroscopy, Radiography, etc. – Attach certificate if applicable) | | Does Not Apply ☐ |
|---|---|---|
| Type | Number | Expiration date |
| Type | Number | Expiration date |
| Type | Number | Expiration date |
| Type | Number | Expiration date |

**XVI. Hospital and Other Institutional Affiliations**

Does Not Apply ☐

Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) have current affiliations, (B) applications in process, (C) have had previous affiliations or, if no current affiliation, (D) have a current coverage plan. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.

(*Do not abbreviate*) (Attach additional sheet if necessary)

**A. Current Affiliations**

| Name of primary facility (Do you have admitting privileges? ☐ **Yes** ☐ **No**) | | | |
|---|---|---|---|
| Department | Department / Clinical Chair | Status (active, provisional, courtesy, temporary, etc.) | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Appointment date | |
| Name of secondary facility (Do you have admitting privileges? ☐ **Yes** ☐ **No**) | | | |
| Department | Department / Clinical Chair | Status (active, provisional, courtesy, temporary, etc.) | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Appointment date | |
| Name of other facility (Do you have admitting privileges? ☐ **Yes** ☐ **No**) | | | |
| Department | Department / Clinical Chair | Status (active, provisional, courtesy, temporary, etc.) | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Appointment date | |

(*Do not abbreviate*) (Attach additional sheet if necessary)

**B. Applications In Process**

| Hospital/Institution | | | |
|---|---|---|---|
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Date application submitted | |
| Hospital/Institution | | | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Date application submitted | |

**(*Do not abbreviate*) (Attach additional sheet if necessary)**

## C. Previous Affiliations

| | | | |
|---|---|---|---|
| Name of facility | | | **Does Not Apply** ☐ |
| Department | | Department / Clinical Chair | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Previous status (active, provisional, courtesy, temporary, etc.) | |
| Reason for leaving | | Appointment date (from– to) | |
| Name of facility | | | |
| Department | | Department / Clinical Chair | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Previous status (active, provisional, courtesy, temporary, etc.) | |
| Reason for leaving | | Appointment date (from– to) | |
| Name of other facility | | | |
| Department | | Department / Clinical Chair | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Previous status (active, provisional, courtesy, temporary, etc.) | |
| Reason for leaving | | Appointment date (from– to) | |

## D. Inpatient Coverage Plan

**This Section only applicable for those without admitting privileges**

Provider may attach signed letter of agreement from the physician or group representative that admits and manages the inpatient care for your patients. **Does Not Apply** ☐

| Name of participating admitting physician/practice/clinic/group | Hospital where privileged |
|---|---|
| | |
| | |
| | |

**(*Do not abbreviate*) (Attach additional sheet if necessary)**

## XVII. Work History

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vita may be substituted as long as it is current and has exact dates of employment.

| | | | | |
|---|---|---|---|---|
| Name of current practice/employer | | | | |
| Contact name | Telephone number | Fax number | From (mo/year) | To (mo/year) |
| Mailing address | City | State | Zip code | |
| Reason for leaving | | | | |
| Name of practice/employer | | | | |
| Contact name | Telephone number | Fax number | From (mo/year) | To (mo/year) |
| Mailing address | City | State | Zip code | |
| Reason for leaving | | | | |

## XVII. Work History (Continued)

| Name of practice/employer | | | | |
|---|---|---|---|---|
| Contact name | Telephone number | Fax number | From (mo/year) | To (mo/year) |
| Mailing address | City | State | Zip code | |
| Reason for leaving | | | | |

Please account for all gaps in time between dates of medical / professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable.

| Activity / Name | From | To |
|---|---|---|
| | | |
| | | |
| | | |

## XVIII. Professional Affiliations

| Please list membership in all professional societies. Complete Name of Society | Date Joined | Current Member | |
|---|---|---|---|
| | | Yes | No |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## XIX. Peer References

List **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. One reference must be from same discipline.

| Name of reference | | Title and specialty | |
|---|---|---|---|
| Mailing address | City | State | Zip code |
| E-mail address | Telephone number | Fax number | Cell phone number |

| Name of reference | | Title and specialty | |
|---|---|---|---|
| Mailing address | City | State | Zip code |
| E-mail address | Telephone number | Fax number | Cell phone number |

| Name of reference | | Title and specialty | |
|---|---|---|---|
| Mailing address | City | State | Zip code |
| E-mail address | Telephone number | Fax number | Cell phone number |

| | | | | |
|---|---|---|---|---|
| Current insurance carrier | | | Policy number | |
| Mailing address | City | | State | Zip code |
| Phone number | Fax number | | Origination (retroactive) date | |
| Per claim amount | Aggregate amount | | Effective date | Expiration date |

**XX. PROFESSIONAL LIABILITY**

Please list **ALL** professional liability carriers within the past ten years

| | | | |
|---|---|---|---|
| Name of carrier | | Policy number | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | From | To |
| Name of carrier | | Policy number | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | From | To |
| Name of carrier | | Policy number | |
| Mailing Address | City | State | Zip code |
| Phone number | Fax number | From | To |

**XXI. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL**

Provider name(print or type) **Does Not Apply** ☐

Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected health information (PHI). Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed provider narrative that addresses all of the following details is an acceptable alternative.

| Date and clinical details of the incident, with preceding events |
|---|
| Date Details |
| |
| |
| Your role and specific responsibility in the incident |
| |
| Subsequent events, including patient's clinical outcome |
| |
| Date suit or claim was filed |
| Name and Address of Insurance Carrier that handled the claim |
| Your status in the legal action (primary defendant, co-defendant, other) |
| Current status of suit or other action |
| Date of settlement, judgment, or dismissal |
| If case was settled out-of-court, or with a judgment, settlement amount attributed to you? **$** |

## UNIVERSAL PROVIDER ATTESTATION QUESTIONS - *To be completed by the provider*

Please answer **all** of the following questions. If your answer to any of the following questions is 'Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

| | | | Yes | No |
|---|---|---|---|---|
| **A.** | **PROFESSIONAL SANCTIONS** | | | |
| ① | Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct? (Please include an explanation sheet for any "Yes" answer in this section) | | | |
| | a. | License to practice any profession in any jurisdiction | | |
| | b. | Other professional registration or certification in any jurisdiction | | |
| | c. | Specialty or subspecialty board certification | | |
| | d. | Membership on any hospital medical staff | | |
| | e. | Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc. | | |
| | f. | Medicare, Medicaid, FDA, governmental, national or international regulatory agency or any public program | | |
| | g. | Professional society membership or fellowship | | |
| | h. | Participation/membership in an HMO, PPO, IPA, PHO or other entity | | |
| | i. | Academic Appointment | | |
| | j. | Authority to prescribe controlled substances (DEA or other authority) | | |
| ② | Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution? | | | |
| ③ | Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions? | | | |
| ④ | Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity? | | | |
| **B.** | **CRIMINAL HISTORY** (Please include an explanation sheet for any "Yes" answers in this section) | | **Yes** | **No** |
| ① | Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation? | | | |
| | a. | Do you have notice of any such anticipated charges? | | |
| | b. | Are you currently under governmental investigation? | | |
| **C.** | **AFFIRMATION OF ABILITIES** | | **Yes** | **No** |
| ① | Do you presently use any drugs illegally? | | | |
| ② | Do you have, or have you ever had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or could affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance. | | | |
| ③ | Are you unable to perform any of the services/clinical privileges required by the applicable participating provider agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance? | | | |
| **D.** | **LITIGATION AND MALPRACTICE COVERAGE HISTORY** (**If you answer "Yes" to any of the questions in this section,** please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.) | | | |
| ① | Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit? | | | |
| ② | Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit? | | | |
| ③ | Are there any such claims being asserted against you now? | | | |
| ④ | Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)? | | | |
| ⑤ | Are any of the privileges that you are requesting not covered by your current malpractice coverage? | | | |
| **E.** | **ATTESTATION** | | | |

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Typed or printed name _____ Signature _____ Date _____

## Universal Provider Credentials Verification Addendum

### Supplemental Provider Authorization and Release of Information

| | |
|---|---|
| **XXII. PROVIDER AUTHORIZATION TO RELEASE INFORMATION** | I hereby authorize the presenter of this Release and/or its representatives to consult with others who have information bearing on my professional competence, character, professional practice or ethical qualifications. I authorize all malpractice carriers to release coverage and/or claims history information which may exclude direct patient identification including name, address or telephone numbers to the presenter of this Release and/or its representatives. I hereby further consent to the inspection by the presenter, and/or its representatives, of all documents, including medical records, which may be relevant to evaluation of my professional competence, character, professional practice or ethical qualifications. *The presenter complies with the Health Insurance Portability and Accountability Act of 1996 "HIPAA" (as defined in 45 CFR § 160 et seq.) as well as other state and federal statutes, rules and regulations relating to confidentiality and privacy.* I understand that I have the right to review any information submitted in support of this Provider Application.<br><br>I hereby release from liability any and all individuals and organizations that provide information to the presenter concerning my professional competence, practices, ethics, character or ethical qualifications for participating provider status, and hereby consent to the release of such information. I further agree to release and hold harmless from any liability the presenter and/or its representatives who participate within the scope of their duties in review of any information obtained under this Release. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, professional practice or ethical qualifications for resolving any doubts regarding such qualifications. A copy of any portion/section of the Authorization and Release, Criteria Sheet and or Application has the same force and effect as the original.<br><br>I also understand that to participate, this application must be verified and I must be notified in writing whether this application has been approved or denied. I agree to immediately notify the entity to which this authorization has been given, in accordance with executed Agreements, of any change in submitted information. Failure to notify the entity of changes in the information contained in this application may result in immediate termination from participation with the entity to which this Release is given. |
| **Medicare Opt-Out ATTESTATION** | I certify that I have not filed an opt-out notice with the Center for Medicare Services (CMS) in the prior two years; I understand that should I choose to opt-out of Medicare, I must file a notice with CMS and promptly notify IPN. |
| **XXIII. ATTESTATION** | I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below. |

Print Name Here _____

Signature _____

**(Stamped signature is not acceptable)**

Date _____

| **Review dates and initials** |
|---|
| |
| |
| |
| |



**Modification to the wording or format of the Universal Provider Application may invalidate the application**.

Form **W-9**
(Rev. January 2005)
Department of the Treasury
Internal Revenue Service

# Request for Taxpayer Identification Number and Certification

**Give form to the requester. Do not send to the IRS.**

**Print or type** See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ..... ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

**Social security number**
___ ___ ___ – ___ ___ – ___ ___ ___ ___

**or**

**Employer identification number**
___ ___ – ___ ___ ___ ___ ___ ___ ___

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

**Sign Here** **Signature of U.S. person** ► **Date** ►

## Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

**U.S. person.** Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

**Note.** *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

**Foreign person.** If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.