CREDENTIALING ELIGIBILITY CRITERIA

IPN maintains a Credentialing/Recredentialing Program to assist in selection and reevaluation of all providers within its delivery system. All providers must successfully complete the credentialing process to be approved as IPN Participating. The provider has the right to review information obtained in the process of evaluating the credentialing and recredentialing application exclusive of peer review information. **Included, as a requirement for completion of the attached application, is the signature and dating of page 2 of these Criteria Sheets which are to be returned as a part of the submitted application.**

Provider Criteria Consists of the Following:

1. Completion of the Universal Provider Credentialing Application to include:
   - Reasons for any inability to perform the essential functions of the position with or without accommodation
   - Lack of present illegal drug use
   - History of loss of license and or felony convictions
   - History of loss or limitation of privileges or disciplinary activity
   - Attestation to the correctness and completeness of the application
   - Malpractice history
   - History of loss of license
   - Signed release and waiver allowing access to any relevant information about the provider which may be held by third parties

2. Must hold a current unrestricted license to practice for each state as applicable.

3. Medical staff membership and unrestricted clinical staff privileges, appropriate to the provider's area of practice, in good standing, at the hospital designated by the provider as his/her primary hospital. Indicated hospital must be within a reasonable proximity to the provider's location of practice. This requirement can be waived if the provider's area of practice is exclusively in an outpatient setting with evidence of satisfactory coverage arrangements for patients who may expectantly or un-expectantly require hospital admission. *Applicant's initials and date on this document confirms review of the cover document and application and acts as an attestation of the correctness of the information provided in this application including hospital privileges information.*

4. A current DEA and State Board of Pharmacy certificates as applicable.

5. Proof of graduation from medical or professional school with completion of a residency and or fellowship in the provider's area of practice.

6. Physicians, will preferably be board certified by;
   - ABMS American Board of Medical Specialties
   - AOA American Osteopathic Association
   - ABFAS American Board of Foot and Ankle Surgery
   - ABPM American Board of Podiatric Medicine
   - ABMSP American Board of Multiple Specialties in Podiatry

7. Continuous work history of, at least, the most recent five (5) years including from and to dates MM/YYYY with an explanation of any gaps that exceed three (3) months.

8. Proof of Professional Liability insurance for at least the amount required by IPN:
   - $1,000,000 per occurrence and $3,000,000 aggregate

9. A professional liability claims history - does not exceed three (3) cases in the last five (5) consecutive years or exceed $250,000 singularly or in total within the last five (5) years. This criterion is based on date of settlement.

10. Be without sanction activity by Medicare and Medicaid.

11. Practices in a quality office/facility.

12. The applicant has the right, upon request, subject to policies and procedures, to be informed of the status of their 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 with in three (3) working days.

13. Applicants have 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 during the verification process by IPN. The provider will be notified of the discrepancies by telephone, email or written correspondence. The provider will have thirty (30) days to respond. After thirty (30) days, if no response is received, 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. All supplemental documents and correspondence is to be forwarded to the Credentialing Department at PO Box 5406 Boise, ID 83705 or faxed to (208) 433-4604.

    If information is not received by the Credentialing or Recredentialing Department within sixty (60) days of request, an updated Attestation may be required prior to final processing.

14. National Practitioner Identifier (NPI) Number.

15. Credentialing and Recredentialing is non-transferrable.

16. IPN maintains a policy and procedure for health care providers, facility/entity or organizations to enable review of decisions when denied network participation for reasons other than a failure to meet or maintain credentialing/recredentialing criteria. The policy and procedure, C-8 is available by request from the IPN Credentialing Department (208) 333-1570.

17. A copy of any portion/section of this Criteria Sheet and or Credentialing Application has the same force and effect as the original.

18. The applicant certifies by his/her signature on the application and the pages of this cover document that the information in the entire application is complete, accurate, current and acknowledges that any misstatements in or omissions from this application constitute cause for denial of membership/participation or cause for summary dismissal by the entity to which this statement has been made. A photocopy of the application has the same force and effect as the original. The applicant confirms that he/she has reviewed this information as of the most recent date listed in the application.

Return Completed application to:

IPN
Attn: Credentialing
PO Box 5406
Boise ID 83705
Fax: (208) 433-4604
Email: ipn@ipnmd.com

Signature: _____ Date: _____

Provider & or Subcontractor Ownership/Controlling Interest Worksheet

In order to comply with Federal Law (42 CFR 420.200 – 420.206 and 455.100 – 455.106), health plans with Medicare or Medicaid business are required to obtain certain information regarding the ownership and control of entities with which they contract directly or indirectly for services for which payment is made under the Medicaid or Medicare programs or any line of business that provides healthcare for federal employees.

The Centers for Medicare and Medicaid Services (CMS) requires companies to obtain this information to demonstrate that they are not contracting with providers that have been excluded from federal health programs or with an entity that is owned or controlled by any individual(s) who has been convicted of a criminal offense, has had civil monetary penalties imposed against them or has been excluded from participation in Medicare or Medicaid. Please complete the following information.

This form is required if you wish to participate with IPN. You are also reminded that pursuant to your Attestation, any changes to information contained in this application in the future must be reported to IPN.

Please make copies if you need additional space to complete your responses. If you have questions, please contact your IPN provider services representative.

Name of Provider/Subcontractor: _____

_____

Primary Address: _____

Type of Ownership: _____

(Examples: Private Practice, Corporate-Owned, Partnership, Limited Partnership, Investor-Owned or Government-Owned)

List any person that has a direct or indirect ownership interest of 5% or more; _____

_____

_____

Address: _____

List any person who is the owner of a whole or part interest in any mortgage deed of trust, note or other obligation secured, in whole or in part, by the entity or any of the property assets thereof in which whole or part interest is equal to or exceeds 5% of the total property and assets of the entity:

_____

_____

Address: _____

If the entity is a corporation or partnership, please list the officers and directors of the entity or list the partners:

_____

_____

Addresses: _____

List any managing employees: _____

(Managing employees are individual who exercise operational or managerial control over the entity or part thereof who directly or indirectly conduct the daily operations of the entity)

Addresses: _____

☐ **Check if you have included additional pages to complete the information requested.**

I certify that the information contained above is true complete and accurate.

Signature: _____ Date: _____