Community Care Network of Virginia – Credentials Application

CCNV
Community Care Network of Virginia, Inc.

Please Mail Completed Applications and all required documents to:

6802 Paragon Place, Suite 630
Attention: Credentialing
Richmond, VA 23230

PLEASE
ATTACH
PASSPORT
PHOTO
HERE

NAME:_____

DATE:_____

This application is not complete unless it is accompanied by all required documents (see page 11)

Personal Information

Practitioner Name _____
Last First Middle

Prior names, including maiden and previous married _____

Home Address _____
Street City State Zip

Phone Number _____ Social Security Number _____

E-mail address **(required)** _____

Date of Birth _____ Place of Birth _____ Gender (M/F) _____

Citizenship _____ Do you speak and write English fluently? (Y/N) _____

Are you eligible to work in the United States? (Y/N) _____

List other languages spoken _____ Do you use sign language? (Y/N) _____

Professional Degree (MD, DO, DDS, DMD, DPM, DC, NP,PA, etc) _____ PCP or Specialist? _____

Practice Information Corporate Name (As it appears on W-9) _____

Office Name _____

Address _____

Phone _____ Fax _____

Office Contact Name: _____ Email address **(required)** _____

What is your expected **start** date? _____ **Date of hire**? _____

Do you have any practice limitations? (Y/N) _____ If yes, indicate: _____

MID-LEVEL PROVIDERS – PLEASE INDICATE YOUR SUPERVISING PHYSICIAN AND THEIR SPECIALTY: _____

Please indicate your office hours in the chart below.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Employment status (FT/PT) _____ If you are working **part-time** for CCNV, please list your **Primary office address, contact name & phone**: _____

_____

Additional Offices you may be providing services for within the **CCNV Network**

Office name _____

Address _____

Phone _____ Fax _____

Original Effective 10/08/99
Last Revised:: 07/17/06; 01/09/08; 02/17/09

Practice Information cont.

Please indicate <u>your</u> office hours at this location in the chart below.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

List practitioners, outside your practice, who provide coverage after hours or in your absence.

Full Name (Last, First, MI)	Specialty

Do you have Workman's Compensation experience? (Y/N) _____ # Years _____ % of practice _____

<u>License/Registration/Numerical Information</u> (Attached current certificates for all active license(s) and DEA/CDS (Attach another page if needed)

License # _____ State of registration_____ Type of license (MD, DO, PA, NP, etc.) _____

Date issued _____ Expiration date _____

License # _____ State of registration_____ Type of license (MD, DO, PA, NP, etc.) _____

Date issued _____ Expiration date _____

DEA registration # _____ Date issued _____ Expiration date _____

CDS registration # _____ Date issued _____ Expiration date _____

ECFMG # _____ (copy of certificate) Medicare # _____ NPI # _____

If CCNV will be maintaining your NPI and/or CAQH, the information below is required.

NPI#_____ User Name _____Password_____

CAQH #_____CAQH User Name_____ CAQH Password_____

Original Effective 10/08/99
Last Revised:: 07/17/06; 01/09/08; 02/17/09

Hospital Affiliations. List all hospitals where you had or currently have privileges, indicate status.

Do you currently admit and care for patients on your own service? (Y/N) _____

- *If hospital privileges are pending, or you do not have hospital privileges, please include documentation of arrangements made to provide care to your patients when hospitalized.*

Institution Name/Address Indicate Primary Admitting with an *	% total annual admits	Privilege Status				
		Active	Courtesy	Provisional	Allied	Other

Education and Training (Attach copies of diplomas and training certificates)

Please provide appropriate information to enable us to contact the institutions listed, including correct campus name and complete mailing address.

Medical/Professional School Name _____

Address _____
Street City State Zip

Degree obtained _____ Start date _____ End date _____
(Month/Day/Year) (Month/Day/Year)

Internship Specialty _____ Program Director Name _____

Institution Name _____

Affiliated University _____

Address _____
Street City State Zip

Start date _____ End date _____ Fax Number _____
(Month/Day/Year) (Month/Day/Year)

Residency Specialty _____ Program Director Name _____

Institution Name _____

Affiliated University _____

Address _____
Street City State Zip

Start date _____ End date _____ Fax Number _____
(Month/Day/Year) (Month/Day/Year)

Education and Training cont.

Fellowship Specialty _____ Program Director Name _____

Institution Name _____

Affiliated University _____

Address _____
Street City State Zip

Start date _____ End date _____ Fax Number _____
(Month/Day/Year) (Month/Day/Year)

Board or Professional Certification (Submit a copy of Certificate)

Primary practice specialty _____ Board certification (Y/N) _____

Name of certifying board _____

(Month/Day/Year)

Sub-specialty _____ Board certification (Y/N) _____

Name of certifying board _____

(Month/Day/Year)

➢ **If you are not Board Certified, indicate any of the following that apply**:

_____ I have taken the Board exam for _____ (board), results pending.

_____ I intend to sit for the Board exam for _____ (board), on

_____ (date).

_____ I am not planning to take the Boards. Number of years in practice: _____

CME Credits: If you are not Board Certified ~ please provide a list of CME's in the last 2 years.

CME credits must be in the specialty in which you will be practicing within the CCNV Network

_____List & Certificates Attached _____ N/A Recently finished training

Work History Include all positions held since completion of your professional degree. Please provide an explanation of any gaps greater than six months in your work history. **A copy of your Curriculum Vitae beginning with current employer is acceptable. Start and end dates must be in mm/yyyy format.**

Organization Name	Address	Position held	Start/End Date (mm/yyyy)	Reason for leaving

Academic Appointment

Institution name _____ Department _____

Address _____
Street City State Zip

Type of appointment _____ Start date _____ End date _____

Liability Insurance Information

Name of current carrier _____

Address _____
Street City State Zip

Agent name _____ Phone number _____

Policy # _____ Effective date _____ Expiration date _____

Amount of coverage per occurrence _____ Aggregate _____

Professional References

Please list 3 references willing to provide written comments, upon request, regarding your professional competence, ethics, character, health status and ability to work cooperatively with others. Professional references must be currently licensed, and able to adequately assess your ability to practice at your current level. If you are just completing training, please use your Residency/Fellowship Program Director and/or the Chairperson of the Department (Please limit to one office associate. At least one reference should be if possible a provider in your specialty).

Name _____

Address _____
Street City State Zip

Phone_____ Fax_____ Email_____

In what capacity did this individual observe your performance? _____

Name _____

Address _____
Street City State Zip

Phone_____ Fax_____ Email_____

In what capacity did this individual observe your performance? _____

Name _____

Address _____
Street City State Zip

Phone_____ Fax_____ Email_____

In what capacity did this individual observe your performance? _____

We are encouraging the use of email addresses for quicker processing

Confidential Information

Please answer the following questions. For any question that receives a "Yes" answer (excluding # 12), provide a complete explanation. A copy of the "Malpractice Claims Information Form" has been provided for your convenience.

Yes	No	N/A	
			1. Do you presently have, or have you ever had, any condition, mental, physical or emotional, including alcohol abuse, which would limit or has in the past limited your ability to provide safe, effective medical care to your patients, with or without accommodation? If yes, please provide details.
			2. Are you now or have you ever been an active or habitual user of any illegal or controlled substance?
			3. Are you now receiving or have you ever received treatment for any chemical dependency or substance abuse including alcohol?
			4. Have any of the following ever been or are in the process of being, voluntarily or involuntarily withdrawn, relinquished, not renewed, reduced, limited, placed on probation, denied, revoked, suspended, or investigated:
			a) State license?
			b) DEA, CDS registration or other controlled substance authorization?
			c) Hospital or other health care facility staff membership or privileges, including specific clinical privileges? If so, please list
			d) Professional organization membership?
			e) Medicare, Medicaid or other government health plan participation?
			f) HMO, PPO, PHO, IPA or any other health plan participation?
			g) Educational or training institution or program?
			h) Academic appointment?
			i) Medical or professional society or association, or professional board certification?
			5. Have you ever voluntarily or involuntarily relinquished or withdrawn your application for staff membership or clinical privileges at any hospital or other health care facility? If so, please list
			6. Are any actions currently pending against you by any federal or state regulatory authority, or by any hospital or provider?

Yes	No	N/A	
			7. Have you ever resigned in order to avoid revocation, suspension, or reduction of privileges at any facility or institution?
			8 Have you been convicted or indicted of a crime, or are you under indictment for an alleged crime, including any narcotics offense, fraud or felony offense?
			9 Are you now, or have you ever been involved in any malpractice action(s), including litigation, arbitration or mediation, regardless of the outcome that resulted?
			10. Has a payment to resolve or avoid any allegation(s) concerning your competence, conduct, or quality of care (not including litigation, arbitration or mediation) ever been paid by you or on your behalf?
			11. Has your professional liability insurance ever been limited, denied, suspended, canceled, lapsed, not renewed, special rated or experienced gaps?
			12. Do you currently have malpractice coverage?

Basic Life Support (BLS)	Yes _____	No _____	Cert. Date _____
Advanced Cardiac Life Support (ACLS)	Yes _____	No _____	Cert. Date _____
Advanced Life Support in OB (ALSO)	Yes _____	No _____	Cert. Date _____
Pediatric Advanced Life Support (PALS)	Yes _____	No _____	Cert. Date _____
Advanced Trauma Life Support (ATLS)	Yes _____	No _____	Cert. Date _____
Neonatal Advanced Life Support (NALS)	Yes _____	No _____	Cert. Date _____
Cardio-pulmonary Resuscitation (CPR)	Yes _____	No _____	Cert. Date _____

BASIC AUTHORIZATION AND RELEASE

The information provided in this application includes specific details regarding my background, character and competence. I understand that this information will be reviewed. By signing below, I:

1. Certify that all information provided by me in this application is true to the best of my knowledge and belief, and free of omissions.
2. Agree to notify CCNV Credentialing Service of any changes to the information provided within thirty (30) days of any such change.
3. Release CCNV Credentialing Service from any liability for inaccurate information provided.

_____ _____

Signature (No signature stamps accepted.) Date

_____

Print Name

AUTHORIZATION AND RELEASE

I understand and acknowledge that, as an applicant for participation with Community Care Network of Virginia, Incorporated (CCNV) and other third party payors who may delegate credentialing activities to CCNV, as applicable, it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, professional competence, character, ethical qualifications and any other criteria adopted for participation, and for resolving any questions about such information.

I further understand and acknowledge that CCNV will investigate the information provided in this application. By submitting this application, I agree to such investigation and to the reporting and information exchange activities of CCNV, third party payors, and health care facilities as a part of the CCNV Credentials Program, as follows:

I hereby authorize all individuals, institutions, and entities who have knowledge concerning information requested in this application to consult with and release relevant information to CCNV, third party payors, health care facilities, their employees and agents. I further authorize CCNV to release all such information to all health care facilities and third party payors that participate in the CCNV Credentials Program and with which I am affiliated.

I hereby fully, absolutely, and unconditionally release from liability facilities, CCNV, third party payors, and their employees and agents and all other individuals, institutions and entities providing information in accordance with the authorizations contained herein for all their acts performed in good faith and without malice in connection with the investigation of this application and the release and exchange of information authorized above, including but not limited to the acts of preparing or completing any verifications, evaluations, recommendations, information requests, or forms that are provided by the applicant, CCNV, health care facilities, or third party payors. This release shall be in addition to any other applicable immunities provided by law for peer review activities or otherwise.

I understand and agree that the authorizations and releases given by me herein shall be irrevocable so long as I am an applicant for or have staff privileges at any health care facility participating in CCNV's Credentials Program, and/or so long as I am participating with one or more third party payors delegating credentialing activities to CCNV.

I understand and acknowledge that CCNV is involved in querying the National Practitioner Data Bank, American Medical Association, Board of Medicine, and other entities as recommended by The National Committee for Quality Assurance.

I acknowledge that the investigation of information in this application and the release of information by the facilities, CCNV, and third party payors and their employees and agents are done to improve the quality of patient care.

All information provided by me in this application is true to the best of my knowledge and belief, and free of omissions. I understand and agree that any material misstatement in or omission from this application may constitute grounds for denial of participation or for summary dismissal from the medical staff and/or third party payors. I understand and acknowledge that participation in CCNV applies to participation in the Network activities only, and that health care facilities shall be solely responsible for all decisions concerning medical staff membership, and that third party payors shall be solely responsible for all decisions concerning participation with such third party payors. I further understand and acknowledge that CCNV shall have no responsibility or liability with respect to medical staff membership decisions by health care facilities or participation decisions by third party payors.

I understand and agree that I have the right to review information submitted in support of my application and to correct erroneous information provided by either myself or an outside organization.

I further acknowledge that I have read and understand the foregoing authorization and release.

A photocopy of this Authorization and Release shall be as effective as the original.

Signature (No signature stamps accepted.) _____ Date _____

Print Name _____

CONFIDENTIAL **Community Care Network of Virginia, Inc.** **CONFIDENTIAL**
Malpractice Claims Information Form

Please complete this form if you answered yes to the question concerning malpractice actions on your Credentials or Reappointment application. All questions must be answered completely. If additional space is needed, please attach additional pages. A separate form must be completed for each malpractice claim, so please photocopy this page prior to completing if you will be describing more than one.

Date of occurrence _____ Date claim was filed _____
Your professional liability carrier involved _____
Patient name _____
Name of plaintiff, if other than patient _____
Location of incident _____
You were: (circle one) Primary defendant Co-defendant
Other defendants (if any) _____
Describe in detail the allegation(s) against you _____

Describe in detail the alleged injury to the Patient _____

Was suit filed in court? Yes No
State Court Case Number _____ State _____ County/Parish _____
Federal Court (US District Court) Case Number _____ District _____
Present status of the claim/case (include amount awarded/attributed/of settlement)

- ☐ Pending
- ☐ Settled
- ☐ Dismissed
- ☐ Mediated
- ☐ Arbitrated
- ☐ Adjudicated (to verdict)
- ☐ On Appeal
- ☐ Other

Amount sued for _____
Amount of award/settlement _____

Provide any additional information you would like the committee to consider _____

I certify that the information provided in this document is complete and accurate. I understand that any misrepresentation may result in my non-selection, or if discovered after selection, in my termination as a network provider. I understand that this document, as part of my CCNV application, does not entitle me to participate in the CCNV Network. I agree to notify CCNV in a timely manner of any change to the information requested in this application.

Name (please print or type) _____
Signature _____ Date _____
(Original Signature required)