PROVIDER CREDENTIALING APPLICATION

Please return this application and any current and applicable supporting documents within thirty (30) days. This application is not complete until all requested information is received.

- ☐ Copy of W9/ Clinics W9
- ☐ Copy of current unexpired state license (*include date issued*)
- ☐ Copy of current unexpired Guam Board Medical License
- ☐ Copy of current unexpired Guam Allied Health License
- ☐ Copy of current Guam Business License
- ☐ Copy of Medical Degree/Undergraduate Degree/Diploma/Certificates
- ☐ Copy of ECFMG (*If foreign graduate*)
- ☐ Updated resume/ curriculum vitae (*use month and year to indicate time for education, training and work history, all gaps in time must be accounted for*)
- ☐ Copy of current unexpired DEA (*Federal Drug Enforcement Administration*)
  Must indicate current practice location
- ☐ Copy of current unexpired CSR (*Local Controlled Substance Registration*)
  Must indicate current practice location

Note: For Local CSR or Local DEA if you're waiting on the credential(s) or they just do not have a CSR or DEA please provide a prescribing letter of the doctor whom will be prescribing for the provider while he/she is without a Local CSR or DEA.

- ☐ Copy of Board Certificate (*if board certified*)
- ☐ Copy of Clinic's Malpractice declaration sheet/ Professional Liability Insurance (*evidence of professional liability insurance which indicates coverage limits and expiration dates*)
- ☐ Copy of ANCC certificate (*Nurses*)
- ☐ Copy of ACNM certificate (*Nurse Midwife*)
- ☐ Copy of NCCPA certificate (*Physician Assistant*)
- ☐ Copy of AANA certificate (*Nurse Anesthetist*)

Please insure that the attestation and release forms are signed and dated. If the application is not complete, signed and dated, it is not considered complete and will not be processed until all information is received.

Each applicant has the right to review, upon request to the NetCare Life and Health Insurance Company's Credentialing Department, the information submitted and obtained in support of his or her credentialing application

NetCare
Life & Health Insurance

PROVIDER CREDENTIALING APPLICATION

Provider Information

Provider Name: _____ Date of Birth: _____

Gender: _____ Social Security Number: _____

Individual NPI: _____

Specialties

	Additional Specialties:	Types:
Specialty: _____	_____	_____
Type: _____	_____	_____
	_____	_____

Board(s)

Board Status: _____ Certification Date: _____ Expiration Date: _____

Specialty Board Name: _____

License (s)

	State:	License #:	Date Issued:	Expiration Date:
DEA	_____	_____	_____	_____
CSR	_____	_____	_____	_____

Insurance

Carrier: _____ Policy #: _____ Coverage End Date: _____

NetCare
Life & Health Insurance

PROVIDER CREDENTIALING APPLICATION

Hospital Privileges/ Work History

Type: _____ Category: _____

Institution Name: _____

Hospital Privileges/ Updates

Please review the information contained within this section and include updates below; please provide the name, appointment date and staff category below (use separate sheet if needed):

Hospital Name: _____

Appointment Date: _____ Staff Category: _____

Work History Changes/ Updates

Please review the above information and include updated to your work history below. Please provide the employment dates and place of employment including address (use a separate sheet if needed or provide a current CV):

From: _____ To: _____

Name: _____

Address: _____

State, City: _____ Zip: _____

From: _____ To: _____

Name: _____

Address: _____

State, City: _____ Zip: _____

PROVIDER CREDENTIALING APPLICATION

Primary Address

Group Name: _____

Physical Address: _____

Tax-ID: _____ Group NPI: _____

W9 Name: _____

Office Phone#: _____ Office Fax #: _____

Office Email: _____

Primary location in the directory?

☐ YES ☐ NO

Primary Contact (PC)Person: _____ PC Email: _____

PC Phone#: _____ PC Fax #: _____

Phone number for primary practice location is for appointments only fax number for primary practice location is for referrals/ Authorizations only

Billing Address

Billing Address: _____

Billing Address 2: _____

City: _____ State: _____

Zip: _____

Office Phone#: _____ Office Fax #: _____

Office Email: _____

Billing Contact (BC)Person: _____ BC Email: _____

BC Phone#: _____ BC Fax #: _____

Mailing Address

Mailing Address: _____

Mailing Address 2: _____

City: _____ State: _____

Zip: _____

NetCare
Life & Health Insurance

PROVIDER CREDENTIALING APPLICATION

A written explanation is required for any question(s) answered "YES." Please provide the explanation on a separate sheet. If you do not provide the information, your application approval will be delayed and could result in denial for non-compliance by the NetCare Life and Health Insurance Co. Credentialing Committee.

1. Has your license to practice medicine in any jurisdiction been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, otherwise limited or restricted, or been made subject to a program of probation, or have you been issued a citation or letter of reprimand by the licensing agency, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced in the last three years?	Y	N
2. Has your medical staff membership or medical status at any hospital or comparable facility, been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care of professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced in the last three years?	Y	N
3. Have your admitting or clinical privilege(s) at any other hospital, or at any comparable acute or long term care facility, or ambulatory surgery center or comparable facility, been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care of professional conduct reasons, or have formal or informal proceedings, or investigations toward any of those ends ever been commenced in the last three years?	Y	N
4. Have you voluntarily or involuntarily relinquished medical staff membership or status, admitting or clinical privileges, withdrawn an application for membership or privileges at any hospital or comparable acute or long term care facility, or ambulatory surgery center or comparable facility, after notification of the acute or imminent commencement of a formal or informal review, or investigations of your practice, credentials or professional conduct in the last three years?	Y	N
5. Has your membership, participation, privileges, contractual affiliation or other status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization or any other comparable health care entity been denied, revoked, voluntarily or involuntarily terminated, suspended, restricted or limited based upon patient care of professional conduct grounds, or have formal or informal proceedings, or investigations toward any of those ends been commenced in the last three years?	Y	N
6. Have you voluntarily or involuntarily relinquished membership, participation, privileges, a contractual affiliation or other comparable status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization or any other comparable health care entity after notification of the actual or imminent commencement of a formal or informal review or investigation, of your practice or professional conduct in the last three years?	Y	N
7. Has your membership or status in any state or local professional society or other comparable medical organization been denied, revoked, voluntarily or involuntarily terminated, suspended or restricted based upon patient care of professional conduct concerns, or have formal or informal proceedings, or investigations toward any of those ends been commenced in the last three years?	Y	N

8. Has your status as a participating provider in the Medicare, Medicaid, or TRICARE programs been sanctioned, denied, suspended, voluntarily or involuntarily terminated, limited or revoked, or have formal or informal proceedings, or investigations toward any of those ends been commenced in the last three years?	Y	N
9. Has a letter of concern or reprimand been issued to you?	Y	N
10. Have you been denied professional liability insurance or has your policy been canceled in the last three years?	Y	N
11. (a) Have you been named in a complaint based on allegations of professional negligence or professional misconduct or have your received notice of intent to commence litigation of that type in the last three years? (b) With regard to any suit, has it resulted in judgment, settlement or other final disposition, or is it still pending?	Y	N
12. Does your professional liability coverage exclude you from performing any specific procedure(s) or practicing portions of your specialty for which your are requesting privileges?	Y	N
13. Has your specialty board certification or eligibility been denied , revoked voluntarily or involuntarily terminated, suspended, or have formal or informal proceedings or investigations toward any of these ends been commenced in the last three years?	Y	N
14. Has your drug enforcement agency or other controlled substances authorization been denied, revoked, voluntarily or involuntarily terminated, suspended or restricted or have formal or informal proceedings, or investigations toward any of those ends been commenced in the last three years?	Y	N
15. Have you been convicted of a criminal offense (other than a minor traffic violation, felony, fraud, narcotics offense, moral or any type of ethical crime in the last three years?	Y	N

16. Are you now or have been addicted to a controlled substance of alcohol in the past three years? If the answer is yes, please provide the name, address, and full description of any rehabilitation program in which you are now participating or in which you have participated as well as the name and title of the individual who can describe your care and participation in that program. Y N

17. Has a letter of concern or reprimand been issued to you? Y N

18. Do you have any mental or physical impairment or disability that could, without reasonable accomodation, that may significantly affect your ability to practice medicine or provide care to accepted standards of professional performance or poses a threat t o the health or safety of your patients. Y N

ATTESTATION & RELEASE

I attest to the fact that all the information submitted by me in this application is true and accurate to the best of my knowledge and belief.

I authorize NetCare Life and Health Insurance Co., it's professional staff and legal representatives for the purpose of evaluating my professional competence, character, criminal history and ethical conduct, to contact and consult with administrators and members institution, professional society, school, employer, law enforcement agency, or practice with which I have been associated. In addition, I consent to the inspection by NetCare Life and Health Insurance Co., it's professional staff and legal representatives of all records and documents, including health records and documents, including health records at other treatment facilities that may be material for evaluation of my professional qualifications. I also release from liability all individuals or organizations for their acts performed in good faith and without malice that initiate and respond to the inquires authorized for use by NetCare Life and Health Insurance Co. I agree that a photocopy of this authorization be accepted with the same authority as the original.

Signature: _____ Date: _____