PRIMECARE[SM]
ADMINISTRATORS

For Credentialing Staff Use Only

Specialty_____

Date Application Received_____

Date Application Signature_____

Attach a recent 2" x 2" passport size photograph for the master file and each facility marked on this application

PERSONAL DATA

1. Name_____

2. Other Name(s) Previously Used_____ Effective _____

3. Social Security Number_____4. Medicaid _____

5. NPI (National Provider Identifier)_____

6. Tax ID# _____Name Affiliated with Tax ID#_____

6A. Other Tax ID's (Attach separate sheet if applicable)

7. Place of Birth _____ Date of Birth _____

8. Gender_____ 9. Citizenship_____

10. If Not US Citizen: Visa #_____ Status_____ Expiration Date_____

OFFICE INFORMATION

11. Local Primary Practice/Group Name_____

_____

Complete Office Address

_____

Office Phone FAX Number E-Mail

Preferred Method of Contact_____ Phone _____ FAX _____ E-Mail _____

11A. Other Practice Locations (Please attach a separate sheet)

12. Office/Credentialing Contact Name & Address_____

_____

Title Phone Number FAX Number E-Mail Address

13. Secondary/Billing Office Address_____

_____

Office Phone FAX Number E-Mail

14. Practitioner's Beeper/Cell Number_____ Answering Service Number_____

15. Practitioner Call Coverage_____

16. Are you currently accepting new patients into your practice? ☐ YES ☐ NO
(If NO, your name may not appear in the Managed Care directory)

17. Describe after-hours patient care operation._____

18. Any practice restrictions? (Specify)_____

19. Office accessible to disabled pursuant to ADA guidelines? ☐ YES ☐ NO

20. Languages (other than English) Spoken in Your Office

A. By Provider_____

B. By Staff_____

21. Do you wish to have these languages listed in a Provider Directory? ☐ YES ☐ NO

PROFESSIONAL LICENSES

Attach copies of license(s)

22. Nevada Medical/Dental/AHP license #_____Date Issued_____ Date Expires _____

Other State Licenses:

State Number Issue Date Expiration Date

_____

_____

_____

_____

_____

DEA AND NEVADA STATE PHARMACY REGISTRATION

Attach copies of certificates

23. Federal DEA Registration #_____ Date Expires_____

Nevada State Pharmacy #_____ Date Expires_____

Other State Pharmacy Licenses:

State	Number	Issue Date	Expiration Date

24. Other Training or Certification (Check and complete all that apply)

TYPE	Date of Certification	Expiration Date
CPR	_____	_____
ACLS	_____	_____

EDUCATION/TRAINING

25. Pre-Medical/Dental/AHP Education

_____

Facility Name

_____

Mailing Address

_____

Phone FAX

_____

FROM : Mo/Yr TO : Mo/Yr Degree Earned

26. Medical/Dental/AHP Education

_____

Facility Name

_____

Mailing Address

_____

Phone FAX

_____

FROM : Mo/Yr TO : Mo /Yr Degree Earned

27. **Internship** (if applicable) Type_____(Specialty)

_____

Facility Name

_____

Mailing Address

_____

Phone FAX

_____

FROM : Mo/Yr TO : Mo /Yr Program Director

28. **Residency** (if applicable) Type_____(Specialty)

_____

Facility Name

_____

Mailing Address

_____

Phone FAX

_____

FROM: Mo/Yr TO: Mo/Yr Program Director

29. **Other Residency** (if applicable) Type_____(Specialty)

_____

Facility Name

_____

Mailing Address

_____

Phone FAX

_____

FROM : Mo/Yr TO : Mo /Yr Program Director

30. **Fellowship** (if applicable) Type_____(Specialty)

_____

Facility Name

_____

Mailing Address

_____

Phone FAX

_____

FROM : Mo/Yr TO : Mo /Yr Program Director

OTHER POST GRADUATE EDUCATION

List in chronological order and include copies of certificates

31. _____

Facility Name Specialty & Degree Awarded

_____

Mailing Address

_____

Phone FAX

_____

FROM : Mo/Yr TO : Mo /Yr Program Director

32. _____

Facility Name

_____

Mailing Address

_____

Phone FAX

_____

FROM : Mo/Yr TO : Mo /Yr Program Director

BOARD CERTIFICATIONS

Attach copy of certificate(s)

This section pertains to specialty boards that are organized and recognized by the American Board of Medical Specialties or American Osteopathic Association. (AHPs List Board certification as applicable)

33. _____

Name of Specialty Board

_____

Mailing Address

Date of Certification _____Expiration Date_____

If **not** certified, indicatecurrent status_____

If **not** certified, are you scheduled to take the exam? If so, when?_____

EMPLOYED FACULTY POSITIONS AND ACADEMIC AFFILIATIONS

List in chronological order. Do not include hospital staff memberships or surgical center affiliations.

34. _____

Facility Name FROM: Mo/Yr TO:Mo/Yr

_____

Mailing Address

_____

Phone Number FAX Number

_____

Position Department

_____

Reason for Leaving

PRIVATE PRACTICE AND OTHER

List any private practice affiliations or other employment since completion of medical/dental/AHP school. For any time period not covered by an affiliation or training, please provide a written explanation.

35. _____

Affiliated With FROM: Mo/Yr TO:Mo/Yr

_____

Person to Contact for Verification

_____

Mailing Address

_____

Phone Number FAX Number

36. _____

Affiliated With FROM: Mo/Yr TO:Mo/Yr

_____

Person to Contact for Verification

_____

Mailing Address

_____

Phone Number FAX Number

37. _____

Affiliated With FROM: Mo/Yr TO:Mo/Yr

_____

Person to Contact for Verification

_____

Mailing Address

_____

Phone Number FAX Number

38. _____

Affiliated With FROM: Mo/Yr TO:Mo/Yr

_____

Person to Contact for Verification

_____

Mailing Address

_____

Phone Number FAX Number

HOSPITAL AND OTHER HEALTH CARE ENTITY MEMBERSHIPS

List ALL hospitals and surgical centers where you currently have or have had affiliation, membership and/or have been granted privileges. If you have withdrawn an application or you are no longer affiliated with a hospital or surgical center, provide an explanation on a separate page. If an explanation is attached, make sure the original entry is denoted. For any time period not covered by an affiliation or training, please provide a written explanation.

39. **Hospital/SurgicalCenter**

_____

Affiliated With FROM: Mo/Yr TO:Mo/Yr

_____

Person to Contact for Verification

_____

Mailing Address

_____

Phone Number FAX Number

Staff Category_____( ) Check here if explanation is attached

40. **Hospital/Surgical Center**

_____

Affiliated With FROM: Mo/Yr TO:Mo/Yr

_____

Person to Contact for Verification

_____

Mailing Address

_____

Phone Number FAX Number

Staff Category_____( ) Check here if explanation is attached

41. **Hospital/Surgical Center**

_____

Affiliated With FROM: Mo/Yr TO:Mo/Yr

_____

Person to Contact for Verification

_____

Mailing Address

_____

Phone Number FAX Number

Staff Category_____( ) Check here if explanation is attached

PROFESSIONAL LIABILITY (MALPRACTICE) INSURANCE

Attach copy of present policy face sheet

42. **Present Carrier for Nevada Practice** _____

_____

Mailing Address

_____

Phone Number FAX Number

_____

Policy # Effective Date Expiration Date

Amounts of Coverage: Occurrence/Claim $_____Aggregate $_____

43. If answers to any of the following questions is YES, please provide full details on a separate sheet, to include date of occurrence, description of events and current status.

Has your license to practice dentistry in any jurisdiction **ever** 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 **ever** 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? ☐YES ☐NO

B. Has your dental/medical staff membership or dental/medical staff status at any hospital or comparable acute or long term care facility or ambulatory surgery center or comparable facility, **ever** been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care or professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced? ☐YES ☐NO

C. 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, **ever** been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care or professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends **ever** been commenced? ☐YES ☐NO

D. Have you **ever** voluntarily or involuntarily relinquished dental/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 actual or imminent commencement of a formal or informal review, or investigation of your practice, credentials or professional conduct? ☐YES ☐NO

E. Has your membership, participation, privileges, contractual affiliation or other status with any health maintenance organization, dental/medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended, restricted or limited based upon patient care or professional conduct grounds, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? ☐YES ☐NO

F. Have you **ever** voluntarily or involuntarily relinquished membership, participation, privileges, a contractual affiliation or other comparable status with any health maintenance organization, dental/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? ☐YES ☐NO

G. Has your membership or status in any state or local professional society or other comparable medical organization **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended or restricted based upon patient care or professional conduct concerns, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? ☐**YES** ☐**NO**

H. Has your status as a participating provider in the Medicare, Medicaid, or Tricare (formerly Champus) programs **ever** been sanctioned, denied, suspended, voluntarily or involuntarily terminated, limited or revoked, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? ☐**YES** ☐**NO**

I. Has a letter of concern or reprimand **ever** been issued to you? ☐**YES** ☐**NO**

J. Have you **ever** been denied professional liability insurance or has your policy **ever** been canceled? ☐**YES** ☐**NO**

K. (1) Have you **ever** been named in a complaint based on allegations of professional negligence or professional misconduct or have you **ever** received notice of an intent to commence litigation of that type? **Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case.** ☐**YES** ☐**NO**

(2) With regard to any suit, has it resulted in a judgment, a settlement, or other final disposition, or is it still pending? **Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case.** ☐**YES** ☐**NO**

L. Does your professional liability (malpractice) coverage exclude you from performing any specific procedures(s) or practicing portions of your specialty for which you are requesting privileges? ☐**YES** ☐**NO**

M. Has your specialty board certification or eligibility **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? ☐**YES** ☐**NO**

N. Has your Drug Enforcement Agency or other controlled substances authorization **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended, or restricted or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? ☐**YES** ☐**NO**

O. Have you **ever** been convicted of a criminal offense other than a minor traffic violation? ☐**YES** ☐**NO**

P. Are you now or have you **ever** been addicted to a controlled substance or alcohol? **If the answer to this question is yes, please provide the name, address and a 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. An organization may require that you complete a Health Status Form which provides the name and title of the individual/organization (counselor/diversion program/treating provider) who can advocate on behalf of your sobriety status.** ☐**YES** ☐**NO**

Q. Do you currently use illegal drugs? ☐YES ☐NO

R. Do you have any mental or physical condition that may significantly affect your ability to practice medicine or to exercise the particular privileges that you have requested? If so, do you believe that, with reasonable accommodation, you will be able to provide care meeting the standards controlling the award of privileges and status that you seek? ☐YES ☐NO

S. Would you require an accommodation in order for you to exercise medical staff duties or the privileges requested safely and completely? ☐YES ☐NO

STANDARD AUTHORIZATION, ATTESTATION AND RELEASE FOR PRIMECARE ADMINISTRATORS

(Not for Use for Employment Purposes)

Purpose of Form

This Standard Authorization, Attestation and Release (hereinafter "Authorization") has been developed for use by PrimeCare Administrators. Its purpose is to provide a form for use by applicants for participation as a contracted provider in the PrimeCare Administrators provider network (hereinafter "Participation").

Acknowledgements and Agreements with respect to PrimeCare Administrators

I, the applicant whose name and signature appear below, understand and agree that, as part of the credentialing application process for Participation with PrimeCare Administrators, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by PrimeCare Administrators for determining initial and ongoing eligibility for Participation. I further understand and agree that any and all credentialing decisions, including without limitation denial of credentialing, denial of recredentialing, limitations on credentialed status and inaction on an application for credentialing or recredentialing, are within the exclusive and sole discretion of PrimeCare Administrators.

By submitting this application, I agree to be bound by the bylaws, rules, regulations, policies, and code of conduct of PrimeCare Administrators. I understand that I will have the opportunity to review those bylaws, rules, regulations and policies.

I understand that my misrepresentation or material omission in this application shall constitute cause for denial of credentialing or recredentialing me for Participation, and that such misrepresentation or material omission shall also constitute cause for subsequent revocation of any credentialed status conferred upon me by PrimeCare Administrators. I understand that I will have the opportunity, upon reasonable written request, to be informed of the status of my application.

I understand that, as the applicant, I bear the burden of demonstrating that I am qualified for credentialed status and Participation. I further understand that I bear the burden of satisfactorily resolving any doubts about my qualifications for credentialed status and Participation.

In order to facilitate the evaluation of this application, I agree to meet and cooperate with the various PrimeCare Administrators officers, representatives and committees charged with responsibility for credentialing and peer review activities.

I understand and agree that if I am granted credentialed status and Participation, I will maintain an ethical dental practice and that my conduct will include, without limitation, the following:
(a) I will refrain from fee splitting or other inducements relating to patient referral; (b) I will provide for the continuous care and supervision of my patients; (c) I will abide by all applicable and generally recognized ethical principles applicable to my profession; and, (d) I will maintain the confidentiality of patient information whether received orally, by paper or by electronic means.

GENERAL ACKNOWLEDGEMENTS AND AGREEMENTS

Independent Contractors; No Employment Relationship

I acknowledge and understand that PrimeCare Administrators has its own criteria for granting or withholding credentialed status and Participation, and that credentialing and Participation are within the sole discretion of PrimeCare Administrators. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that PrimeCare Administrators will grant me credentialed status or Participation. I understand that my application submitted to PrimeCare Administrators is not an application for employment and that a granting of credentialed status and/or Participation does not constitute my employment by PrimeCare Administrators. Any relationship between myself and PrimeCare Administrators that may result from action on my application shall be that of independent contractors.

Authorization of Investigation Concerning Application for Credentialing and/or Participation

I expressly authorize the following individuals, including without limitation PrimeCare Administrators, its representatives, employees, and/or designated agent(s), affiliated entities and their representatives, employees, and/or designated agents, and PrimeCare Administrator's designated professional credentials verification organization (collectively referred to as "Agents"), to obtain and investigate information about me, which includes oral, written and electronically transmitted statements, records, and documents, that may be relevant to my application for credentialed status and/or Participation. I expressly authorize, and agree to allow, PrimeCare Administrators and/or its Agent(s) to obtain and inspect all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Credentialing and/or Participation

I expressly authorize any third party, including without limitation individuals, government agencies, dental/medical groups or professional societies, entities responsible for credentials verification, corporations, companies, current employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other academic institutions, military services, accreditation agencies, the Federation of State Medical Boards , the National Practitioner Data Bank and the Health Care Integrity and Protection Data Bank, to release to PrimeCare Administrators or its Agent(s) any and all information about me that may relate to my qualifications for credentialing and/or Participation, including otherwise privileged or confidential information such as alcohol or chemical dependency history, diagnosis and/or treatment.

I also expressly authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any of the individuals or organizations described above who provide information based upon this Authorization.

Authorization for Release and Exchange of Disciplinary Information

I expressly authorize any third party at which I currently have credentialed status or provider status, or at which I had such status in the past, and/or each third party's agents to release "Disciplinary Information," as defined below, to PrimeCare Administrators and/or its Agent(s). I hereby further expressly authorize the release of Disciplinary Information about any disciplinary or professional review action taken against me. As used herein, "Disciplinary Information" means information concerning: (a) any action taken by health care organizations, managed care organizations, health plans, insurance companies, preferred provider organizations, their officers, directors, administrators, credentialing or peer review committees or other committees to revoke, deny, suspend, restrict, limit or condition my credentialed status or provider status or to impose a corrective action plan; (b) any other disciplinary or professional review action involving me, including without limitation discipline in the employment context; and, (c) my resignation prior to the conclusion of any disciplinary or professional review action, or prior to the commencement of formal charges but after I had knowledge that such formal charges were being (or are being) contemplated and/or were, or are, in preparation.

Authorization for Disclosure and Receipt of Protected Health Information

I understand and agree that some of the information about me that may be disclosed pursuant to this Authorization may include information that is "protected health information" as defined under 45 CFR parts 160 and 164, and may also include information protected under Nevada law or other federal law, including without limitation blood, breath or urine test results, communicable disease information, information about sexually transmitted disease, (including HIV and AIDS), information about mental health treatment I have sought and/or received and information about drug and/or alcohol abuse treatment I have sought and/or received.

I acknowledge: (a) that I have the right to revoke this Authorization as it relates to my protected health information; and, (b) that I understand that once my protected health information is disclosed, it may no longer be protected by applicable federal privacy law. I further acknowledge that I may revoke this Authorization with respect to disclosure of my protected health information only in a writing sent by certified mail to PrimeCare Administrators. Any written revocation will be effective only upon receipt by PrimeCare Administrators. Except with respect to my protected health information, this Authorization is irrevocable.

Release from Liability

I expressly release from any and all liability, and hold harmless, PrimeCare Administrators, its Agent(s), officers, directors, employees and representatives for their acts or omissions in the investigation and evaluation of my application for credentialed status and Participation, including without limitation the collection and use of information about me that is obtained pursuant to this Authorization. I further expressly agree not to pursue or commence any action at law or in equity against PrimeCare Administrators, its Agent(s), officers, directors, employees and representatives for their acts or omissions in the investigation and evaluation of my application for credentialed status and Participation, including without limitation the collection and use of information about me that is obtained pursuant to this Authorization. This release from liability shall survive the denial of my application, the termination of any credentialed status that may be conferred upon me and/or the termination of my Participation, if any. This release from liability shall be in addition to, and in no way limits, any other applicable immunities or privileges provided by law to PrimeCare Administrators, including without limitation privileges for peer review and credentialing activities.

I hereby warrant and certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will immediately notify PrimeCare Administrators in writing of any update to my application for events of any kind that occur during the pendency of my application.

I further acknowledge that I have read and understand the foregoing Authorization and I agree that a facsimile or photocopy of this Authorization shall be as effective as the original.

Dentist's Signature:_____ Date:_____/_____/_____