



7100 Commerce Way
Suite 285
Brentwood, TN 37027
(866) 270-5223
TTY (800) 848-0298
FAX (615) 782-7827

WHP PRACTITIONER CHECKLIST Recredentialing Application-[MedicareExtra](#)

- Signed and completed Application/Attestation Statement
- Signed and completed Provider Release of Information
- Signed and completed State Volunteer Authorization Release
- Copy of [current](#) Medical License(s)
- Copy of [current](#) DEA License or Certificate of Fitness
- Chemical Substances or Alcohol Abuse Information Form
- Copy of Malpractice Insurance Certificate(s) **within past 5 years unless in a residency program**
- Explanation of Malpractice History ([see page 5](#))
- Signed and completed W-9 form
- Copy of current Curriculum Vitae or Work History
- Medical Condition Information Form
- Chemical Substances or Alcohol Abuse Information Form

In order to expedite the recredentialing process and assure that there are no gaps in network participation please return all requested documentation with the application. Thank You.

Windsor Health Plan

Practitioner **RECREDENTIALING** Application- MedicareExtra

**DO NOT refer to Curriculum Vitae. All information must be filled in on application.
All Blanks must be filled in. Curriculum Vitae should be attached.**

Initial Credentialing Date: _____ **Xcelys No.** _____

Last Recredentialing Date: _____

(Internal use only)

General Information

Last Name: _____ First Name: _____ MI: _____

Professional Degree: _____

List any other names under which you have been known? _____

Social Security #: _____ Sex: M ___ F ___ Date of Birth: _____

Practice Name: _____

Billing Address: _____ (_____) _____
(Billing Agent Location) (Facility) (City) (State) (ZIP Code) (Phone)

Billing Contact: _____ Phone: (_____) _____ Fax: (_____) _____

Physical Address: _____ (_____) _____ (_____) _____ (_____) _____
(Primary Office Location) (Site) (City) (State) (ZIP Code)

County: _____ Telephone: _____ Fax: _____

Handicap Accessible? Y ___ N ___ Accept assignment? Y ___ N ___

Accepting new WHP patients? Y ___ N ___ Patient age/type restrictions? _____

E-Mail Address to send Health Plan Correspondence: _____

Office Manager: _____

Office Hours: Sun: ___ Mon: ___ Tues: ___ Wed: ___ Thurs: ___ Fri: ___ Sat: ___

Your Schedule: if different than office hours: _____

Secondary Office Address: _____ City _____ State ___ ZIP _____

Handicap Accessible? Y ___ N ___ Office Manager: _____

Phone: (_____) _____ Fax: (_____) _____ County: _____

Office Hours: Sun: ___ Mon: ___ Tues: ___ Wed: ___ Thurs: ___ Fri: ___ Sat: ___

Your after-hours telephone number / answering service number: _____

Federal Tax ID#: _____ Medicaid Group Provider #: _____
Medicaid Individual Provider #: _____ Medicare Group Provider #: _____
Medicare Individual Provider #: _____ National Provider ID #: _____
(Required as of May 2007; contact CMS for more info)

Participation Status

Please confirm the level at which you are applying to participate:

_____ Primary Care Physician (PCP)

Eligible areas of specialty include Family Practice, General Practice, Internal Medicine, Pediatrics, Family Nurse Practitioners. Applicants should be willing and able to provide comprehensive primary care services, including preventive care services and case management. Physician applicants should be board-certified, or at least have fully completed a primary-care residency training program. Any applicant who does not have privileges at an in-network hospital should provide a signed copy of the Covering Physician Agreement for admissions purposes.

_____ Specialty Care Specialty area: _____ Appear in Directory? Y _____ N _____

Certification:

Please indicate your practice specialty area and board certification status:

_____ Board certified? Y _____ N _____ Eligible? Y _____ N _____
(Primary Specialty)

Board Certification #: _____ Date Certified: _____ Expiration date: _____

_____ Board certified? Y _____ N _____ Eligible? Y _____ N _____
(Secondary Specialty)

Board Certification #: _____ Date Certified: _____ Expiration date: _____

Licensure

License number: _____ State: _____ Date issued: _____ Expiration date: _____

License number: _____ State: _____ Date issued: _____ Expiration date: _____

DEA #: _____ Date issued: _____ Expiration date: _____

Allied Health Practitioners forward a copy of your protocol if applicable.

Name of Supervising Physician: _____

Signature of Supervising Physician

Professional Work History (REQUIRED)

Chronologically list all professional activities since last credentialed. Explain any gaps in chronology. Additional information may be attached on a separate page, if noted in this section.

Activity	Location	Dates (mm/dd/yy)

THE FOLLOWING QUESTION REQUIRES AN ANSWER:

Are you proficient in any languages other than English? : Yes*: _____ No: _____

*If YES, please list: _____

Is your office capable of handling hearing- or vision-impaired individuals? Y _____ N _____

Indicate the special needs patients for which you are available:

Sensory Impairment _____ HIV/AIDS _____

Mental Health/Substance Abuse _____ Physical Disability _____

Mental Retardation/Development Disabilities _____

Other (please specify): _____

Services offered:

Chest X-Ray _____ EKG _____ Endoscopy _____

General Surgery _____ Mammogram _____ Physical Therapy _____

PAP Smears _____ Bronchoscopy _____

Primary Care _____ Hernia Repair _____ Extremity X-Rays _____

Sigmoidoscopy _____ Colonoscopy _____

List Other Services Available, including any related to endoscopy: _____

If you have an in-office lab, is it Medicare or CLIA certified? (Attach certification copy) Y _____ N _____

Current Healthcare Facility Affiliations:

Do you admit patients or provide inpatient care? Y _____ N* _____

Please provide the following information:

- Primary facility: _____ City: _____
State: _____ Phone: _____

From (mm/dd/yy): _____ To (mm/dd/yy): _____
Privileges: __ Active __ Courtesy __ Temporary __ In Process __ Other (attach full explanation)

- Secondary facility: _____ City: _____
State: _____ Phone: _____

From (mm/dd/yy): _____ To (mm/dd/yy): _____
Privileges: __ Active __ Courtesy __ Temporary __ In Process __ Other (attach full explanation)

If you do not admit patients please provide information on your admitting arrangements with a Hospitalist Group, another provider or a copy of your policy for hospital admissions.

(If you use another provider, please provide the name and phone # of the provider who will provide inpatient care.)

Name: _____

Phone #: _____

Professional Liability Insurance

*Please list on separate form(s) the following information with regard to each professional liability claim or cause of action in which you have been involved:

- (a) plaintiff's/claimant's name;
- (b) agency, court, or jurisdiction;
- (c) date filed and docket number;
- (d) description of allegations, patient outcome; and
- (e) disposition (i.e., dismissed, settled {include amount}, judgment for defendant, judgment for plaintiff {include amount}, pending, or in discovery).

***IMPORTANT NOTE: Information on closed cases (paid, settled or dismissed cases) submitted previously on your initial credentialing application does not need to be resubmitted with this application.**

If none, indicate by initialing here: _____

*Please attach copies of your **current** medical license, DEA certificate, CV, and insurance certificate face sheet. Please also provide explanations of any professional liability incidents, sanctions, restrictions or investigations you have been subject to.*

Practice Review – ATTESTATION PAGE

Are you currently, or have you ever been, subject to any of the following:

IMPORTANT: Applicant must initial answers. Do not use “check marks” as responses.
Failure to initial each response will result in rejected application.

1. Suspension, limitation, denial, or revocation of hospital or facility practice? Yes ____ No ____
2. Investigation or Sanction as a Medicare or Medicaid practitioner? Yes ____ No ____
3. Sanction as a PPO, MCO, HMO, or other third-party practitioner? Yes ____ No ____
4. Sanction by state or county medical society? Yes ____ No ____
5. Professional liability insurance restriction, limitation, denial, or cancellation? Yes ____ No ____
6. State license investigation, restriction, suspension, revocation, or denial? Yes ____ No ____
7. Arrest or conviction of a felony, moral, or ethical crime? Yes ____ No ____
8. DEA investigation, restriction, suspension, revocation, or denial? Yes ____ No ____
9. Chronic illness or physical infirmity that impairs your ability to practice? Yes ____ No ____
10. Mental illness or substance abuse (chemical dependency)? Yes ____ No ____
11. If you answered “yes” to 9 or 10, do you have full advocacy of your states’ Physicians Health Program? Yes ____ No ____
Complete Medical Condition Information Form (attachment 1) or Chemical Substances or Alcohol Abuse Information Form (attachment 2)
12. Ownership in any medical facility, or joint ownership of medical services or equipment with a facility to which you might refer patients? Yes ____ No ____

If you answered yes to any of the above questions, please provide a thorough written explanation.

Practitioner Attestation:

I certify that the information in this application is true and correct. I understand that factual misrepresentation may result in my nonselection, or, if discovered after selection, in my termination as a WHP practitioner. I understand that this application does not entitle me to participation in the WHP network. I authorize WHP to consult with and inspect all documents from individuals and organizations having information bearing on my qualifications, and authorize the copy of my signature on this application to be as binding as the original. I agree that WHP, their representatives, and any individuals or entities providing information to WHP in good faith shall not be liable for any act or occasion related to the evaluation or verification contained in this application. I agree to exhaust any and all administrative remedies available to me under any of the foregoing prior to initiating any judicial action relative to this application or my participation in a WHP practitioner panel. I further agree to notify WHP in a timely manner of any change to the information requested in this application. Information requested in this application that is not publicly available will be treated as confidential by WHP.

Signature

Date

Provider Release of Information

I, _____, (print name) authorize any organization or individual from whom information is requested by WHP to release to WHP all information in the possession of that individual or organization related to my professional credentials, qualifications, competence, or utilization or practice patterns and liabilities claims history. I release the Federation of State Medical Boards from any liability whatsoever for provision of information to WHP. I release any individual or organization providing information pursuant to this authorization from any and all liability resulting from the release of such information.

I understand that I have the right to correct erroneous information and the right to review information obtained to evaluate my credentialing application unless disclosure is prohibited by law or the information is protected by peer review.

Signature

Date

AUTHORIZATION AND RELEASE

To: State Volunteer Mutual Insurance Company
From: _____

Policy #: _____
Medical License #: _____

Re: Release of Information to WHP

State Volunteer Mutual Insurance Company (SVMIC) is the carrier of my medical professional liability insurance, and, as such, SVMIC maintains certain information regarding my medical practice, and specifically, the history of any malpractice claims against me. I understand that this information is extremely sensitive and confidential. I acknowledge that SVMIC is protective of this information, and will only release it upon my express and unambiguous consent and direction.

Therefore, I request that SVMIC deliver to WHP information relating to the following:

A report of any medical professional liability claims activity against me on record with SVMIC, but specifically limited to: 1) claims that have resulted in paid losses (settlements); and/or 2) lawsuits (open or closed).

I hereby authorize SVMIC to release the information requested to
WHP

Attention: Credentialing Department
7100 Commerce Way, Suite 285
Brentwood, TN 37027
(fx) 615-782-7823

I HEREBY RELEASE SVMIC, ITS OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS FROM ANY CLAIMS, LIABILITIES, ACTIONS, DAMAGES, OR OTHERWISE, FOR THE RELEASE OF SUCH INFORMATION IF SUCH RELEASED INFORMATION IS DELIVERED IN GOOD FAITH AND WITHOUT MALICE. I ALSO ACKNOWLEDGE THAT MISTAKES MAY OCCUR IN THE PROVISION OF SUCH INFORMATION, AND, WITHOUT LIMITING THE FOREGOING, I SPECIFICALLY RELEASE SVMIC, ITS OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS FROM ANY CLAIMS DUE TO INCORRECT, MISDELIVERED, OR OTHERWISE INAPPLICABLE INFORMATION IF SUCH ERRORS OCCURRED IN GOOD FAITH, AND UPON DISCOVERY, SVMIC TAKES REASONABLE CORRECTIVE ACTIONS.

Date

Signature of Insured

**MEDICAL CONDITION INFORMATION FORM
(Attachment 1)**

**DUPLICATE this form as necessary to complete a separate sheet for EACH condition.
Use reverse side of this form if additional space is needed.**

Applicant: _____
Last name First name Middle name

Describe this medical condition: _____

To what extent does or could this condition affect your ability to practice medicine in your specialty area or perform a full range of clinical activities? _____

What is the current status of your condition? _____

Provide the name and address of your personal physician/health care practitioner who can provide information about your health condition: _____

Name Area Code Telephone

Address City State Zip Code

If none, check here and sign & date below

Applicant Signature: _____ Date: _____

CHEMICAL SUBSTANCES OR ALCOHOL ABUSE INFORMATION FORM (Attachment 2)

**DUPLICATE this form as necessary to complete a separate sheet for EACH condition.
Use reverse side of this form if additional space is needed.**

Applicant: _____
Last name First name Middle name

Describe the substance(s) abused: _____

To what extent does or could this condition affect your ability to practice medicine in your specialty area
or perform a full range of clinical activities? _____

What is the current status of your condition? _____

_____ Or, Abstinent since (mm/yy): _____

Monitored by State Board Mandate:

Monitored Voluntarily

Name of Monitoring Entity/Agency/Individual

Name of Monitoring Entity/Agency/Individual

Address City State ZIP code

Address City State Zip code

(____) _____
Telephone

(____) _____
Telephone

Other information about the current status of your use of substances: _____

Provide the name and address of your personal physician/health care practitioner who can provide
information about your health condition:

Name

(____) _____
Area Code Telephone

Address City State Zip Code

If none, check here and sign & date below

Applicant Signature: _____

Date: _____