group health Cooperative of eau claire

Network Participant
Credentialing Application

Please:
- Type or print legibly
- Complete all items. **If an item does not apply, enter "NA"**. Do not leave any items blank.
- Include the following with your application, **if applicable**:

___ Copy of professional license(s)

___ Copy of Diploma

___ Copy of Board Certification certificate

___ Copy of DEA Certificate

___ Copy of liability face sheet with effective/expiration dates and coverage limitations

___ Signed release of information

___ Signed agreement relating to credentialing process

- Keep a copy for your records.

NOTE
- If this application was completed more than 180 days prior to the date of your signature, information on the application must be updated and a new "Authorization for Release of Information" must be completed. Please review carefully and provide any current information you may have.
- Incomplete applications will be returned for completion.

RETURN COMPLETED FORM TO:

Group Health Cooperative of Eau Claire
Attn: Credentialing Department
PO Box 3217 | Eau Claire, WI 54702-3217
Fax: (715) 552-3500
Email: credentialing@group-health.com

CHECK APPLICATION STATUS OR QUESTIONS:

Phone: (715) 852-2093 Or **Email:** credentialing@group-health.com
Response provided within five business days.

Personal Information		
Full Legal Name (Last, First, MI Name)		Professional Credentials
List Other Names (if different)		Locum Tenens? ☐ Yes ☐ No
Home Address (Street, City, State, ZIP+4)		
Phone Number	Other Language(s) Spoken (if applicable)	
Social Security Number	Date of Birth	NPI

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Location Information

Primary Practice	Location Name	Address (Street, City, State, ZIP+4)	
	Credentialing Contact	Phone	Fax
	Effective Date	Email	
Secondary Location	Location Name	Address (Street, City, State, ZIP+4)	
	Credentialing Contact	Phone	Fax
	Email		
Billing Office	Location Name	Address (Street, City, State, ZIP+4)	
	Credentialing Contact	Phone	Fax
	Email		

Hospital Privileges

Please designate the hospital(s) in which you have primary admitting privileges and the status of those privileges.

Hospital 1	Hospital Name	Types of Privileges ☐ Active ☐ Other, explain:	
	Address (Street, City, State, ZIP+4)		
	Staff Category	Department	Duration (mo/yr - mo/yr)
Hospital 2	Hospital Name	Types of Privileges ☐ Active ☐ Other, explain:	
	Address (Street, City, State, ZIP+4)		
	Staff Category	Department	Duration (mo/yr - mo/yr)
Hospital 3	Hospital Name	Types of Privileges ☐ Active ☐ Other, explain:	
	Address (Street, City, State, ZIP+4)		
	Staff Category	Department	Duration (mo/yr - mo/yr)

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EDUCATION & PROFESSIONAL EXPERIENCE

Account for all time from undergraduate school to present.

College or University	Institution Name	Year Graduated	Degree
	Address (Street, City, State, ZIP+4)		
	Institution Name	Year Graduated	Degree
	Address (Street, City, State, ZIP+4)		
Medical School	Institution Name	Year Graduated	Degree
	Address (Street, City, State, ZIP+4)		
Internship	Institution Name	Year Graduated	Degree
	Address (Street, City, State, ZIP+4)		

Residency	Program Name	Duration (mo/yr - mo/yr)	Specialty
	Address (Street, City, State, ZIP+4)		
	Program Name	Duration (mo/yr - mo/yr)	Specialty
	Address (Street, City, State, ZIP+4)		
	If your residency was not successfully completed, please explain:		

Fellowship/Preceptorship

Primary Practice	Program Name	Duration (mo/yr - mo/yr)	Specialty
	Address (Street, City, State, ZIP+4)		
	Professional Society Memberships/Fellowships:		

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Credentialing Application

Professional Information (Attach copies of professional licenses and DEA certificate if applicable.)		
WI License Number		Expiration Date
Other License Number		Expiration Date
DEA Number	Expiration Date	ECFMG Number
Federal Tax ID #		UPIN or NPI Number
Do you currently accept Medicare patients? ☐ Yes ☐ No		Medicare Provider Number
Do you currently accept WI Medicare patients? ☐ Yes ☐ No		WI Medicare Number

Medical Specialty (For licensed physicians only.)		
Are you providing primary care? ☐ Yes ☐ No	Primary Care Specialty	
Are you board certified? ☐ Yes ☐ No	Date Certified	Expiration Date
If yes, name of board certification		
Secondary Medical Specialty		
Are you board certified? ☐ Yes ☐ No	Date Certified	Expiration Date
If yes, name of board certification		
If no, are you board eligible? ☐ Yes ☐ No If not eligible, why not?		

Professional Certification		
Program Name	Duration (mo/yr - mo/yr)	Specialty
Address (Street, City, State, ZIP+4)		

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Credentialing Application

PROFESSIONAL LIABILITY CARRIER

Submit a copy of the declaration page of your present malpractice liability policy showing the effective/expiration dates and coverage limitations.

Carrier Name		Phone
Policy Number	Effective Date	Expiration Date
Maximum allowable malpractice amount per claim ($)		
Aggregate maximum allowable malpractice amount per year ($)		

Professional Certification (Provide a minimum of 5 years of history.)

Current Practice	Duration (mo/yr - mo/yr)
Address (Street, City, State, ZIP+4)	
Past Practice	Duration (mo/yr - mo/yr)
Address (Street, City, State, ZIP+4)	
Past Practice	Duration (mo/yr - mo/yr)
Address (Street, City, State, ZIP+4)	

If there have been interruptions of more than 6 months in your professional career provide the following:

Duration (mo/yr - mo/yr)	Activity

Do you currently engage in the illegal use of drugs?

☐ Yes ☐ No

Health Status

Are you able to perform the essential functions of your profession with or without accommodations for any condition (physical or mental) that you may have? ☐ Yes ☐ No

Do you currently engage in the illegal use of drugs?

☐ Yes ☐ No

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DISCIPLINARY ACTIONS

Have any of the following ever been, or are currently in the process of being reviewed, denied, revoked, suspended, reduced, limited, placed on probation, not reviewed, or voluntarily relinquished? If yes, provide full explanation on a separate sheet with supporting documentation. Per NCQA standards, please review previous 10 years

1. Medical license in any state	☐ Yes ☐ No
2. Other professional registration/license (e.g., DEA)	☐ Yes ☐ No
3. Membership on any medical/hospital staff	☐ Yes ☐ No
4. Clinical privileges	☐ Yes ☐ No
5. Any other type of professional sanction	☐ Yes ☐ No
6. Government (Medicare/Medicaid) or third party payor?	☐ Yes ☐ No
7. Have you ever been convicted of a felony or misdemeanor?	☐ Yes ☐ No
8. As a medical provider, has your employment ever been terminated by an employer for quality of care or professional conduct reasons?	☐ Yes ☐ No
9. Has your professional liability insurance ever been denied, suspended, canceled, or not renewed?	☐ Yes ☐ No
10. Has any claim or suit for any alleged malpractice been brought against you?	☐ Yes ☐ No
11. Have you ever been found negligent in any malpractice suit or action?	☐ Yes ☐ No
12. Has any malpractice claim settlement ever been paid by you or paid on your behalf?	☐ Yes ☐ No
13. Do you have any legal action pending regarding any malpractice claims?	☐ Yes ☐ No

If you answered yes on any of questions 9-13, attach the following information for each malpractice claim:

- Date and details of the incident(s) leading to the suit or settlement
- Date of suit or settlement
- Professional liability insurer involved
- Your status in any suit or other legal actions (primary defendant, co-defendant, other)
- Subsequent events, including patient outcomes
- Current status of suit or other
- Amount reserved by carrier for each claim, or amount paid as an out-of-court settlement or amount of jury award or court settlement

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AGREEMENTS RELATING TO CREDENTIALING PROCESS

I am submitting an application for credentialing with Group Health Cooperative of Eau Claire. In submitting my application to the Cooperative, I am agreeing to the following:

- The undersigned hereby certifies that the information requested on this application by Group Health Cooperative is truthful, correct and complete in all aspects. The undersigned further understands the intentional submission of false or misleading information or the withholding of relevant information is grounds for termination as a participating provider with Group Health Cooperative.
- I agree to Comply with the Cooperative's policies and procedures; and to participate in the Cooperative's Quality improvement Program.
- I agree to update the Cooperative within ten (10) days on any changes in the information submitted in my application and agree to provide such additional information and execute such additional forms as may be requested by the Cooperative in order to evaluate my professional qualifications, competence and conduct.
- As an applicant for credentialing with Group Health Cooperative, I have the right to review the information submitted and obtained in support of my credentialing application. I understand that References, Recommendations and Peer-review protected information will not be disclosed. Requests for review of submitted information can be made to: Credentialing@group-health.com.
- As an applicant for credentialing with Group Health Cooperative, I have the right to correct all erroneous information in my application. I understand that I should submit the corrections within 30 days of the initial application, with erroneous information crossed out (no white-out), and resubmitted to: Credentialing@group-health.com.

All policies of Group Health Cooperative are administered without regard to race, gender, ethnicity, national origin/identity, ancestry, age, sexual orientation, handicap, sex, marital status, or the types of patients in which the practitioner specializes.

Signature and Professional Credentials	Date
Name (print)	

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STATEMENT OF PROVIDER CONSENT TO RELEASE OF INFORMATION

(Please read carefully before signing)

In order to completely evaluate my request and application for participation with Group Health cooperative, I hereby give permission to the Cooperative, or its agent, to solicit qualifications, competence, character and ethical information about myself.

Specifically included in this consent are Chief(s) of Clinical Departments of the hospital(s) in which I currently have staff privileges, the State Board of Professional Regulation, institutions of higher education, physician colleague(s) currently participating with the Cooperative, other hospitals and professional sources with whom I have been associated, and any other agency or person who might provide pertinent information.

A photocopy of this permission will serve as the original. I understand that the Cooperative will use this information solely in confidence and in conjunction with my application that the information is not subject to re-disclosure other than under provisions of Federal or State law.

I hereby release from any liability and hold harmless any person or entity who is approached and furnished information.

I hereby release from all liability Group Health Cooperative of Eau Claire and its directors, officers, employees and authorized representatives and agents and third parties for any acts performed in good faith in providing or receiving information, reports or other documents relating to, or in evaluating, my professional qualifications and schooling, competence or conduct. This release from liability shall include, but not be limited to, actions relating to the following:

- My application to be a participating provider with the Cooperative;
- Periodic appraisals undertaken for recredentialing, utilization review or otherwise for quality management with in-person appraisals allowing access to private office; and
- Proceedings for termination, suspension or restriction of my status as a participating provider with Group Health Cooperative or any other disciplinary action.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

This authorization is valid for a period of 36 months from the date of signature.

Name (please print or type)	
Signature	Date

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Attn: Credentialing Department
PO Box 3217 | Eau Claire, WI 54702-3217
Fax: (715) 552-3500
Email: credentialing@group-health.com

Questions? Feel free to give us a call at **(715) 852-2093** and we will help you through the process.