PRIME
HEALTH SERVICES

INITIAL CREDENTIALING PROVIDER APPLICATION

331 MALLORY STATION ROAD
FRANKLIN, TN 37067
PHONE: 615-329-4098
FAX: 615-329-4751
www.primehealthservices.com

Prime Health Services thanks you in advance for taking the time to complete the credentialing process. Please follow the general instructions below and return application to: credentialing@primehealthservices.com, or fax it to 615-329-4751.

Last Name	First Name	NPI #	CAQH #

General Instructions

1. The application should be legibly handwritten or typed in BLACK or BLUE ink.

2. Please include an answer to every question before submitting the Application. Write "n/a", if the question is not applicable. No question should be left blank.

3. Sign and Date the Application Attestation, Consent and Release form located at the end of the Application. *No Stamped Signatures – an Original Signature is required.*

4. Any corrections, alterations, or deletions should be initialed and dated by the provider. Deletions should not be lined through, erased, or covered with white out.

5. Detailed information must be submitted on additional sheets of paper and attached to the application, if there is not enough sufficient space for the answer.

6. In addition to the completion of the Application, please supply the following documents:
   - Copy of the provider's current state professional license for each state he/she currently practices
   - Copy of the provider's current DEA Certification, if applicable
   - Copy of the provider's current CDS (state controlled substance certification), if applicable
   - Copy of the provider's current certificate of Board Specialty, if applicable
   - Copy of the provider's certificate of completion for Professional Education, Medical School, Internship, Residency, etc., if applicable
   - Copy of the provider's current Curriculum Vitae
   - Copy of a W-9 Form

Please remember that the omission of information from the application will result in the return of your application to your office and a delay in your participation status.

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Should a provider be terminated for any reason a written termination notice will be sent by Certified Mail within seven (7) days. A provider will have sixty (60) days from the date of the notification to appeal the decision of denial or termination. Written appeal must be received within sixty (60) days of notice of termination. Appeals may be sent to:

Prime Health Services
331 Mallory Station Road
Franklin, TN 37067

INDIVIDUAL INFORMATION

MD___ DO___ DPM___ DC___
OD___ PhD___ DDS___ DMD___
LCSW___ PsyD___ Other_____

LAST NAME	FIRST NAME	M.I.	SUFFIX	DEGREE

OTHER USED NAME	SOCIAL SECURITY NUMBER	DOB	SEX
	-- --	/ /	

PRACTICE INFORMATION

Years/Months at Current Location? _____

GROUP NAME (if applicable) TAX ID

PRIMARY OFFICE ADDRESS	CITY	STATE	ZIP	DAYS/ HOURS OF OPERATION

PHONE	FAX	E-MAIL	WEBSITE

SECONDARY OFFICE ADDRESS	CITY	STATE	ZIP	DAYS/ HOURS OF OPERATION

PHONE	FAX	E-MAIL	WEBSITE

ADDITIONAL OFFICE ADDRESS	CITY	STATE	ZIP	DAYS/ HOURS OF OPERATION

PHONE	FAX	E-MAIL	WEBSITE

BILLING ADDRESS (IF SAME AS PRIMARY OFFICE, CHECK HERE ☐)

CONTACT NAME	PHONE NUMBER	FAX NUMBER	LANGUAGES (besides English)

1. **Accepting new patients?** ..... ☐ YES ☐ NO
2. **Accept Medicare?** ..... ☐ YES ☐ NO
3. **PCP Provider** ..... ☐ YES ☐ NO
4. **Have 24hr / 7days a week call coverage?** ..... ☐ YES ☐ NO

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5. **Handicap Accessibility?** ..... ☐ YES ☐ NO

6. **Lab Services?** ..... ☐ YES ☐ NO

7. **In-office drug testing**..... ☐ YES ☐ NO

8. **Currently see Workers' Compensation Patients?** ..... ☐ YES ☐ NO

9. **Proprietary Interest in any health/medical organization?** ..... ☐ YES ☐ NO

(if yes, provide explanation)_____

_____

CREDENTIALS

STATE MEDICAL LICENSE #: _____ **STATE:** _____ **ISSUED:** _____ **EXPIRATION:** _____

ADDITIONAL STATE LICENSE #: _____ **STATE:** _____ **ISSUED:** _____ **EXPIRATION:** _____

DEA NUMBER: _____ **ISSUED:** _____ **EXPIRATION:** _____

CDS NUMBER: _____ **STATE:** _____ **ISSUED:** _____ **EXPIRATION:** _____

NPI #_____ **MEDICARE #**_____ **UPIN #**_____

SPECIALTY & BOARD INFORMATION

PRIMARY SPECIALTY ****ISSUING BOARD**

/ / / / / /

ORIGINAL EFFECTIVE DATE **LAST RECERTIFICATION DATE** **EXPIRATION DATE**

SECONDARY SPECIALTY ****ISSUING BOARD**

/ / / / / /

ORIGINAL EFFECTIVE DATE **LAST RECERTIFICATION DATE** **EXPIRATION DATE**

ADDITIONAL SPECIALTY ****ISSUING BOARD**

/ / / / / /

ORIGINAL EFFECTIVE DATE **LAST RECERTIFICATION DATE** **EXPIRATION DATE**

NOTE: If not Board Certified, please indicate the following:

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☐ **In process of taking specialty boards**

Which specialty? _____

Examination Date? _____

☐ **Not eligible to take specialty boards**

Explanation_____

_____

_____

☐ **Not planning to take specialty boards**

Explanation_____

_____

_____

EDUCATION/TRAINING

MEDICAL SCHOOL		**DATE GRADUATED**	
ADDRESS	**CITY**	**STATE**	**ZIP**
INTERNSHIP DATE	**TYPE**	**START DATE**	**END**
ADDRESS	**CITY**	**STATE**	**ZIP**
RESIDENCY DATE	**TYPE**	**START DATE**	**END**
ADDRESS	**CITY**	**STATE**	**ZIP**
ADDITIONAL RESIDENCY	**TYPE**	**START DATE**	**END DATE**
ADDRESS	**CITY**	**STATE**	**ZIP**
FELLOWSHIP	**TYPE**	**START DATE**	**END DATE**
ADDRESS	**CITY**	**STATE**	**ZIP**

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LIABILITY/MALPRACTICE INSURANCE

PRESENT CARRIER		**POLICY NUMBER**		
ADDRESS	**CITY**		**STATE**	**ZIP**
ORIGINAL ISSUE DATE	**EXPIRATION DATE**	**LIMITS (per occurrence / aggregate)**		
STATE INSURANCE FUND (if applicable)		**POLICY NUMBER**		
ADDRESS	**CITY**		**STATE**	**ZIP**
ORIGINAL ISSUE DATE	**EXPIRATION DATE**	**LIMITS (per occurrence / aggregate)**		
PREVIOUS CARRIER (to account for past 5yrs)		**POLICY NUMBER**		
ADDRESS	**CITY**		**STATE**	**ZIP**
ORIGINAL ISSUE DATE	**EXPIRATION DATE**	**LIMITS (per occurrence / aggregate)**		

PRACTICE HISTORY
Must equal five years with no unexplained gaps

NAME OF PRACTICE/GROUP	**CITY**	**STATE**
START DATE (MONTH & YEAR)	**END DATE (MONTH & YEAR)**	
NAME OF PRACTICE/GROUP	**CITY**	**STATE**
START DATE (MONTH & YEAR)	**END DATE (MONTH & YEAR)**	
NAME OF PRACTICE/GROUP	**CITY**	**STATE**
START DATE (MONTH & YEAR)	**END DATE (MONTH & YEAR)**	

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NAME OF PRACTICE/GROUP | CITY | STATE

START DATE (MONTH & YEAR) | END DATE (MONTH & YEAR)

NAME OF PRACTICE/GROUP | CITY | STATE

START DATE (MONTH & YEAR) | END DATE (MONTH & YEAR)

EXPLANATION FOR ANY GAPS OVER THIRTY DAYS:

MILITARY SERVICE OR PUBLIC HEALTH (attach copy of DD214)

MILITARY | DATES

PUBLIC HEALTH | DATES

HOSPITAL PRACTICE

PRIMARY HOSPITAL | TYPE OF PRIVILEGES

ADDRESS | CITY | STATE | ZIP

ADDITIONAL HOSPITAL | TYPE OF PRIVILEGES

ADDRESS | CITY | STATE | ZIP

ADDITIONAL HOSPITAL | TYPE OF PRIVILEGES

ADDRESS | CITY | STATE | ZIP

ADDITIONAL HOSPITAL | TYPE OF PRIVILEGES

ADDRESS | CITY | STATE | ZIP

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ADDITIONAL HOSPITAL	TYPE OF PRIVILEGES		
ADDRESS	CITY	STATE	ZIP

PEER REFERENCES

NAME		AFFILIATION	
ADDRESS	CITY	STATE	ZIP
TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS	

NAME		AFFILIATION	
ADDRESS	CITY	STATE	ZIP
TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS	

NAME		AFFILIATION	
ADDRESS	CITY	STATE	ZIP
TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS	

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CONFIDENTIAL QUESTIONAIRE

ATTENTION: If any of the following questions are answered "Yes", please attach an explanation for each answer. If any questions do not apply to you, please answer "No". Failure to check an answer or provide explanations for "Yes" answers, may delay the processing of your application.

LICENSURE INFORMATION:

1. Has your professional license ever been denied, limited, suspended, revoked, or subject to probation or any other conditions in any state? ☐ YES ☐ NO
2. Have you ever been disciplined, suspended, sanctioned, or otherwise restricted from participating in any private, Federal, or state health program (for example, Medicare, Medicaid), professional society, MCO, state board of medical examiners, or professional conduct board? ☐ YES ☐ NO
3. Has your State Controlled Dangerous Substance (CDS) and/or your Federal DEA ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you ever voluntarily surrendered or limited your registration with either/both of these agencies? ☐ YES ☐ NO

CRIMINAL HISTORY

4. Have you ever been indicted/convicted of a felony, or are you currently under investigation with respect to such conduct? ☐ YES ☐ NO

EDUCATION/TRAINING/BOARD CERTIFICATION

5. During any period of your professional education, including but not limited to medical school, internship, residency, fellowship, preceptorship, or any other additional training, were you ever disciplined, suspended, placed on probation, formally reprimanded, or asked to resign? ☐ YES ☐ NO
6. Has your specialty board certification or eligibility ever been denied, revoked, relinquished, not renewed, or suspended? ☐ YES ☐ NO
7. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? ☐ YES ☐ NO

INSURANCE INFORMATION

8. Has any insurance carrier terminated, refused coverage, or rated up because of unusual risk or have any procedures been excluded from your coverage? ☐ YES ☐ NO
9. Are you currently uninsured for professional liability (malpractice insurance) coverage? ☐ YES ☐ NO
10. Are you currently involved in any pending professional liability suits, claims, and/or actions? ☐ YES ☐ NO
11. Have any judgments ever been made against you in professional liability cases or claims, or have you ever entered into any settlements? ☐ YES ☐ NO
12. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank? ☐ YES ☐ NO

HEALTH STATUS

13. Do you currently have any medical, chemical dependency, or psychiatric conditions that might adversely affect your ability to practice medicine or surgery or to perform the essential functions of your professional position? ☐ YES ☐ NO
14. Are you currently participating in or under the supervision of a Physician or Recovery Network or any other applicable recovery program? ☐ YES ☐ NO

HOSPITAL/OTHER AFFILIATIONS

15. Have your hospital and/or clinical privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of investigation? ☐ YES ☐ NO

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PROFESSIONAL LIABILITY ACTION EXPLANATION FORM

Please complete a separate form for EACH pending, closed and/or settled professional liability **action, and/or any payment made on your behalf within the past five years. Please photocopy this form if additional sheets are needed. All questions MUST be answered completely in order to process your application.**

PROVIDER'S LAST NAME **FIRST NAME** **M.I.** **SOCIAL SECURITY NUMBER**

DATE OF OCCURRENCE OR ALLEGED INCIDENT **DATE CLAIM OR SUIT FILED**

PATIENT'S LAST NAME and PLAINTIFF'S NAME, IF OTHER THAN THE PATIENT

YOUR INVOLVEMENT IN THE CASE (attending, consulting, etc.)

YOUR STATUS IN THE CASE (primary defendant, co-defendant, etc.)

LIABILITY CARRIER AT TIME OF ACCIDENT **CARRIER'S PHONE**

DESCRIBE THE ALLEGATIONS AGAINST YOU

DESCRIBE THE PATIENT'S CONDITION, DIAGNOSIS, AND THE TREATMENT RENDERED

DESCRIBE THE ALLEGED INJURY TO THE PATIENT

PRESENT STATUS OF CLAIM: **OPEN _____** **CLOSED _____** **PENDING _____**

****IF CLOSED, PLEASE INDICATE THE METHOD OF RESOLUTION (dismissed, settled, judgment, etc.):**

SETTLEMENT AMOUNT PAID ON YOUR BEHALF, **IF APPLICABLE: _____

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PROVIDER AUTHORIZATION, ATTESTATION, AND RELEASE

I hereby give permission to Prime Health Services, Inc., and or it's assigns, to request information regarding my professional credentials and qualifications for participation within the indicated network(s) and to further verify from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers. The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter applicable to the credentialing procedure. I release and agree to hold harmless Plan/Network and/or its designees and their respective officers, directors, representatives, employees and agents from any and all liability for any damages, costs and expenses which may result from the gathering or good faith use of the information gathered during the credentialing process.

I hereby authorize the education facilities, the hospital(s) which I currently have, or formerly had, privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers to submit information requested by Prime Health Services, and or its assigns, directly; including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and lawsuit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. If applicable, I hereby authorize the Physician Recovery Network or applicable recovery program to release to Plan/Network information regarding my health status and participation status in any treatment program(s). I hereby further release and agree to hold harmless all such entities referenced in the previous sentence, their representatives, employees, and agents from any and all liability for any damages which may result from providing this information as long as such release of information is done in good faith and without malice.

I understand that confidential private health information on myself that is released here, or obtained by Prime Health Services during the collection and processing of this application will be kept confidential within the terms and confines of Federal, State, and Local laws as applicable, including but not limited to the Health Insurance Portability & Accountability Act (HIPAA) and/or subsequent legislative initiatives to protect such private health information. I also understand and grant specific release here for Prime Health Services, Inc. to disburse such information insofar as may be necessary to complete this, or subsequent, credential verification efforts for participation in the Prime Health Services Network(s).

I agree that a photocopy or facsimile of this document with my signature may be accepted by any person or entity from which such information is sought with the same authority as the original, and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application by Prime Health Services and may result in denial of my application or termination of my participation in the Prime Health Services Network. I further understand that any misrepresentation, misstatement or omission from this application, if discovered after network participation has been awarded to me, may lead to immediate suspension or termination of those privileges. I agree to use my best efforts to inform Prime Health Services Network in writing within 15 days if there is any change in the information provided or the answers to question on the application as a result of developments subsequent to my signing this application.

I warrant that I have the authority to sign this application, on my behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of the application does not constitute approval or acceptance as a participating provider.

If I am accepted for participation, I consent to the inspection of my patient records for Prime Health Services, Inc., and or it's Client's, as necessary for peer and utilization review purposes and agree to be bound by the participation agreement, credentialing plan and/or provider manual (if applicable).

I understand that I have the right to review and correct erroneous information obtained by Prime Health Services to evaluate my credentialing application. This includes information obtained from any outside primary source (e.g., malpractice insurance carriers, state licensing boards, National Practitioner Data Bank (NPDB)). The review must take place within six (6) months of this application. Any corrections must be made in writing within thirty (30) days of the review. This does not require Prime Health Services Network to allow a provider to review references or recommendations or other information that is peer-review protected.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Prime Health Services Network may report the rejection to the appropriate state licensing board and/or the National Practitioner Data Bank (NPDB).

I represent the information provided in or attached to this application is accurate and complete. I attest to either having adequate current malpractice insurance or I have attached a statement regarding arrangements for meeting state financial responsibility requirements. I certify that I hold a full, unrestricted professional license in the state(s) in which I practice. I agree that I have reported any loss or limitation of hospital privileges or any disciplinary activity to Prime Health Services, and I agree I will continue to maintain active admitting and staff privileges at a Prime Health Services Network participating hospital if appropriate to my practicing specialty.

This attestation statement must be signed no more than 120 days prior to the credentialing decision.

Your signature and current date are **REQUIRED** to complete this application. Stamped signatures are NOT acceptable.

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Provider Signature (No Stamped Signatures)

Name of Person Completing This Application

Provider Name (Please Print Legibly)

Phone Number

Fax Number

Date

E-Mail Address of Person Completing This Application (REQUIRED)

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