

Utah Practitioner Credentials Verification Application

- ❖ Complete the application in its entirety using black or blue ink. Please sign and date pages 9 and 11. Please document any YES responses on the Attestation Question page.
- ❖ Please include information on **all** current practice locations. Failure to do so can result in delay of payments.
- ❖ If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- ❖ If a section does not apply to you, please check the provided box at the top of the section.

I. INSTRUCTIONS	<p>This form should be typed or legibly printed in black or blue ink. If more space is needed than provided, attach additional sheets and reference the question being answered. <i>Please do not use abbreviations.</i> Current copies of the following documents must be submitted with this application (all are required for MDs, DOs; as applicable for other health practitioners). If not available, indicate why.</p> <ul style="list-style-type: none"> • Completed W9 for all Tax Identification Numbers • State Professional License(s) • DEA Certificate with Utah address • Face Sheet of Professional Liability Policy or Certificate • Résumé/Curriculum Vitae (Not an acceptable substitute for completing the application.) <p style="text-align: center;">** All sections must be completed in their entirety.**</p>
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II. PRACTITIONER INFORMATION	Last name (include suffix; Jr., Sr., III)		First (do not abbreviate)		Middle (do not abbreviate)	
	Other name(s) under which you have been known by reference, licensing and/or educational institutions?				Degree(s)	
	Birth date		Birth place (city, state, country)		Social security number	
	Citizenship		Languages spoken by practitioner		Type of Provider	
	<input type="checkbox"/> PCP <input type="checkbox"/> Urgent Care <input type="checkbox"/> Specialist		Gender		<input type="checkbox"/> Male <input type="checkbox"/> Female	
	NPI		Specialty		Subspecialty	
Name as it should appear in the Provider Directory					Have you voluntarily opted-out of Medicare?	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	

III. PRACTICE INFORMATION	Effective Date at Primary Practice location _____			Days per week at this location _____		
	Practice Setting: <input type="checkbox"/> Clinic/Group <input type="checkbox"/> Sole Practice <input type="checkbox"/> Home Based <input type="checkbox"/> Hospital Based <input type="checkbox"/> Other (please specify) _____					
	Name of practice, affiliation, or clinic name				Department name (if hospital based)	
	Primary office street address			City		State
						Zip code
	Patient appt. phone number		Fax number		Name affiliated with tax ID number	
						Federal tax ID number
	Mailing address (if different from above)			City		State
						Zip code
	Billing address (if different from above)			City		State
						Zip code
	Office manager / Administrator name			Administration telephone number		Administration fax number
	Credentiaing contact (if different from above)			Credentiaing telephone number		Credentiaing fax number
Office/Administrator e-mail address			Credentiaing e-mail address			
Traditional Medicare number (for this location)		Railroad Medicare number (for this location)		DME Medicare number (for this location)		
Other Medicare number (for this location)		Do not print this location in Provider Directory <input type="checkbox"/>		Location wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No		

QI Sent:	QI Date:	IND: <input type="checkbox"/>	GRP: <input type="checkbox"/>	HOS: <input type="checkbox"/>
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III. PRACTICE INFORMATION (CONTINUED)	Effective Date at Secondary Practice location _____		Days per week at this location _____		
	Practice Setting: <input type="checkbox"/> Clinic/Group <input type="checkbox"/> Sole Practice <input type="checkbox"/> Home Based <input type="checkbox"/> Hospital Based <input type="checkbox"/> Other (please specify) _____				
	Name of secondary practice, affiliation or clinic name			Department name (if hospital based)	
	Secondary office street address		City	State	Zip code
	Patient appt. phone number	Fax number	Name affiliated with tax ID number		Federal tax ID number
	Mailing address (if different from above)		City	State	Zip code
	Billing address (if different from above)		City	State	Zip code
	Office manager / Administrator name		Administration telephone number		Administration fax number
	Credentialing contact (if different from above)		Credentialing telephone number		Credentialing fax number
	Office/Administrator e-mail address		Credentialing e-mail address		
	Traditional Medicare number (for this location)		Railroad Medicare number (for this location)		DME Medicare number (for this location)
	Other Medicare number (for this location)		Do not print this location in Provider Directory <input type="checkbox"/>		Location wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No
List other office locations with above information on a separate sheet.					

IV. PROFESSIONAL LICENSURE	Utah State professional license/registration/certificate number		Status <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Temporary		
	Issue date	Expiration date	Name of sponsor if required by licensure, (i.e. Physician's Assistant).		
	Drug Enforcement Administration (DEA) registration number		Issue date	Expiration date	
	State controlled substance certificate number		Issue date	Expiration date	
	ECFMG number (applicable to foreign medical graduates)		Date issued		

V. ALL OTHER PROFESSIONAL LICENSES	State	License/registration/certificate number		Date issued
	Expiration date		Year relinquished	Reason
	State	License/registration/certificate number		Date issued
	Expiration date		Year relinquished	Reason
	State	License/registration/certificate number		Date issued
	Expiration date		Year relinquished	Reason

VI. UNDERGRADUATE EDUCATION	Name of college or university				Does Not Apply <input type="checkbox"/>	
	Degree received			Graduation date		
	Mailing address			City	State	Zip code
	Name of college or university					
	Degree received			Graduation date		
	Mailing address			City	State	Zip code

(Do not abbreviate) (Attach additional sheet if necessary)

VII. MEDICAL/PROFESSIONAL EDUCATION	Medical/Professional school				
	Start date	Graduation date	Degree received		
	Mailing address		City	State	Zip code
			Phone		Fax
	Medical/Professional School				
	Start date	Graduation date	Degree received		
Mailing address		City	State	Zip code	
		Phone		Fax	

(Do not abbreviate) (Attach additional sheet if necessary)

VIII. GRADUATE EDUCATION	Institution			Does Not Apply <input type="checkbox"/>	
	Program or course of study		Faculty director		
	Mailing address		City	State	Zip code
	Dates attended (/) - (/)		Phone		Fax

(Do not abbreviate) (Attach additional sheet if necessary)

IX. INTERNSHIP/PGYI	Institution			Does Not Apply <input type="checkbox"/>	
	Program director				
	Mailing address		City	State	Zip code
	Start date	Completion date	Phone		Fax
	Type of internship		Specialty		

Did you successfully complete the program? Yes No (If "No", please explain on separate sheet.)

(Do not abbreviate) (Attach additional sheet if necessary)

X. RESIDENCIES	Institution			Does Not Apply <input type="checkbox"/>	
	Program director				
	Mailing address		City	State	Zip code
	Start date	Completion date	Phone		Fax
	Type of residency		Specialty		
	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)				
	Institution			Does Not Apply <input type="checkbox"/>	
	Program director				
	Mailing address		City	State	Zip code
	Start date	Completion date	Phone		Fax
Type of residency		Specialty			
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)					

(Do not abbreviate) (Attach additional sheet if necessary)

XI. FELLOWSHIPS	Institution Does Not Apply <input type="checkbox"/>				
	Program director				
	Mailing address		City	State	Zip code
	Start date	Completion date	Phone	Fax	
	Course of study				
	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)				
	Institution Does Not Apply <input type="checkbox"/>				
	Program director				
	Mailing address		City	State	Zip code
	Start date	Completion date	Phone	Fax	
Course of study					
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)					

(Do not abbreviate) (Attach additional sheet if necessary)

XII. PRECEPTORSHIP	Institution Does Not Apply <input type="checkbox"/>				
	Department chairman				
	Mailing address		City	State	Zip code
	Start date	Completion date	Phone	Fax	
	Training				

(Do not abbreviate) (Attach additional sheet if necessary)

XIII. FACULTY APPOINTMENT	Institution Does Not Apply <input type="checkbox"/>				
	Faculty director				
	Mailing address		City	State	Zip code
	Start date	Completion date	Phone	Fax	
	Position				

(Do not abbreviate) (Attach additional sheet if necessary)

X BOARD CERTIFICATION	Are you board or otherwise professionally certified? Does Not Apply <input type="checkbox"/>					
	<input type="checkbox"/> Yes If "Yes", please complete below		<input type="checkbox"/> No If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.			
	Issuing Board/Entity	State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)
Have you applied for certification other than those indicated above? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If so, list certification and date						
If you participate in a specialty which does not have board certification, please indicate specialty						

(Do not abbreviate) (Attach additional sheet if necessary)

XV. OTHER CERTIFICATIONS	ACLS, BLS, ATLS, PALS, NRP, NALS (i.e., Fluoroscopy, Radiography, etc. – Attach certificate if applicable)		Does Not Apply <input type="checkbox"/>
	Type	Number	Expiration date
	Type	Number	Expiration date
	Type	Number	Expiration date

XVI. HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS	Does Not Apply <input type="checkbox"/>
	Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you (A) have current affiliations, (B) applications in process, (C) have had previous affiliations or, if no current affiliation, (D) have a current coverage plan. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.

(Do not abbreviate) (Attach additional sheet if necessary)

A. CURRENT AFFILIATIONS	Name of primary facility (Do you have admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No)			
	Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
	Mailing address	City	State	Zip code
	Phone number	Fax number	Appointment date	
	Name of secondary facility (Do you have admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No)			
	Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
	Mailing address	City	State	Zip code
	Phone number	Fax number	Appointment date	
	Name of other facility (Do you have admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No)			
	Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
	Mailing address	City	State	Zip code
	Phone number	Fax number	Appointment date	

(Do not abbreviate) (Attach additional sheet if necessary)

B. APPLICATIONS IN PROCESS	Hospital/Institution			
	Mailing address	City	State	Zip code
	Phone number	Fax number	Date application submitted	
	Hospital/Institution			
	Mailing address	City	State	Zip code
	Phone number	Fax number	Date application submitted	

(Do not abbreviate) (Attach additional sheet if necessary)

C. PREVIOUS AFFILIATIONS	Name of facility				Does Not Apply <input type="checkbox"/>				
	Department			Department / Clinical Chair					
	Mailing address			City		State		Zip code	
	Phone number		Fax number		Previous status (active, provisional, courtesy, temporary, etc.)				
	Reason for leaving						Appointment date (from- to)		
	Name of facility								
	Department			Department / Clinical Chair					
	Mailing address			City		State		Zip code	
	Phone number		Fax number		Previous status (active, provisional, courtesy, temporary, etc.)				
	Reason for leaving						Appointment date (from- to)		
	Name of other facility								
	Department			Department / Clinical Chair					
Mailing address			City		State		Zip code		
Phone number		Fax number		Previous status (active, provisional, courtesy, temporary, etc.)					
Reason for leaving						Appointment date (from- to)			

(for those without admitting privileges)

D. INPATIENT COVERAGE PLAN	Please attach signed letter of agreement from the physician or group representative that admits and manages the inpatient care for your patients.		Does Not Apply <input type="checkbox"/>	
	Name of admitting physician/practice/clinic/group		Hospital where privileged	

(Do not abbreviate) (Attach additional sheet if necessary)

XVII. WORK HISTORY	Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vitae is <u>not</u> sufficient.				
	Name of current practice/employer				
	Contact name	Telephone number	Fax number	From	To
	Mailing address		City		State Zip code
	Name of practice/employer				
	Contact name	Telephone number	Fax number	From	To
Mailing address		City		State Zip code	
Reason for leaving					

XVII. WORK HISTORY (CONTINUED)	Name of practice/employer				
	Contact name	Telephone number	Fax number	From	To
	Mailing address		City	State	Zip code
	Reason for leaving				
	Please account for all gaps in time between date of medical / professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable.				
	Activity / Name		From	To	

(Do not abbreviate)

XVIII. PROFESSIONAL AFFILIATIONS	Please list membership in all professional societies. Complete Name of Society		Date Joined	Current Member	
				Yes	No

XIX. PEER REFERENCES	List three professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. One reference must be from same discipline.				
	Name of reference		Title and specialty		
	Mailing address		City	State	Zip code
	E-mail address	Telephone number	Fax number	Cell phone number (optional)	
	Name of reference		Title and specialty		
	Mailing address		City	State	Zip code
	E-mail address	Telephone number	Fax number	Cell phone number (optional)	
	Name of reference		Title and specialty		
	Mailing address		City	State	Zip code
	E-mail address	Telephone number	Fax number	Cell phone number (optional)	

(Do not abbreviate)

X. PROFESSIONAL LIABILITY	Current insurance carrier			Policy number		
	Mailing address		City	State	Zip code	
	Phone number		Fax number	Origination (retroactive) date		
	Per claim amount	Aggregate amount		Effective date	Expiration date	
	Please list ALL professional liability carriers within the past ten years					
	Name of carrier			Policy number		
	Mailing address		City	State	Zip code	
	Phone number		Fax number	From	To	
	Name of carrier			Policy number		
	Mailing address		City	State	Zip code	
Phone number		Fax number	From	To		
Name of carrier			Policy number			
Mailing Address		City	State	Zip code		
Phone number		Fax number	From	To		

XXI. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL	Practitioner name(print or type)		Does Not Apply <input type="checkbox"/>
	Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected health information (PHI). Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.		
	Date and clinical details of the incident, with preceding events		
	Date	Details	
	Your role and specific responsibility in the incident		
	Subsequent events, including patient’s clinical outcome		
	Date suit or claim was filed		
	Name and Address of Insurance Carrier that handled the claim		
	Your status in the legal action (primary defendant, co-defendant, other)		
	Current status of suit or other action		
Date of settlement, judgment, or dismissal			
If case was settled out-of-court, or with a judgment, settlement amount attributed to you? \$			

UTAH PRACTITIONER ATTESTATION QUESTIONS - *To be completed by the practitioner*

Please answer all of the following questions. If your answer to any of the following questions is "Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

A. PROFESSIONAL SANCTIONS			
①	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?	Yes	No
	a. License to practice any profession in any jurisdiction		
	b. Other professional registration or certification in any jurisdiction		
	c. Specialty or subspecialty board certification		
	d. Membership on any hospital medical staff		
	e. Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.		
	f. Medicare, Medicaid, FDA, governmental, national or international regulatory agency or any public program		
	g. Professional society membership or fellowship		
	h. Participation/membership in an HMO, PPO, IPA, PHO or other entity		
	i. Academic Appointment		
	j. Authority to prescribe controlled substances (DEA or other authority)		
②	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		
③	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		
④	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		
B. CRIMINAL HISTORY		Yes	No
①	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		
	a. Do you have notice of any such anticipated charges?		
	b. Are you currently under governmental investigation?		
C. AFFIRMATION OF ABILITIES		Yes	No
①	Do you presently use any drugs illegally?		
②	Do you have, or have you ever had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or could affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. <u>If the answer to this question is yes</u> , please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		
③	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		
D. LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section, please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
①	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		
②	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court-ordered damage award) in a professional lawsuit?		
③	Are there any such claims being asserted against you now?		
④	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?		
⑤	Are any of the privileges that you are requesting <u>not</u> covered by your current malpractice coverage?		
E. ATTESTATION			
I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.			
_____ Typed or printed name		_____ Signature	_____ Date

XXII. ATTESTATION

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here _____

Signature _____
(Stamped signature is not acceptable)

Date _____

Review dates and initials

Provider Release/Authorization

(Modified releases will not be accepted)

By submitting this application I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the Healthcare Organization(s)** indicated in this application (initial credentialing/recredentialing), I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and certification of CPR training. I have provided peer references familiar with my professional competence and ethical character if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.
2. I further understand and acknowledge that the Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Healthcare Organization(s) as a part of the verification and credentialing process.
3. I authorize all individuals, institutions and entities of other hospitals or institutions with which I have been associated, and all professional liability insurers with which I have had or currently have professional liability insurance who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated Healthcare Organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the Healthcare Organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.
6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the Healthcare Organization(s) designated herein, unless revoked by me in writing.
7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by the medical staff bylaws, rules, regulations and policies.
8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, policies, and/or contractual agreements of the Healthcare Organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.
10. I grant permission for the release of the credentials information contained in the practitioner application to the entities listed below.

Signature: _____

Date: _____

Name: _____

**Entity Release Name: Regence BlueCross BlueShield of Utah

