



The New Mexico Physician and Practitioner Credentials Application ©

ADVANTAGE CARE NETWORK, INC./FORESIGHT TPA., INC

Name(s) of Health Care Organization(s) to Which Application is Being Made

Date of Application: _____

Name: _____
Last First Middle Other Names Used

Circle all that apply and for which you are currently licensed: MD DO DDS DC DPM OD PA CNM
CNP CRNA RN PT OT ST DOrienMed Acup Clin Psych Psych Assoc LMHC LPAT LADAC
LISW LMSW LPC LPCC LMFT CNS/Psych CNS/Medical Spch Path
Other: _____ Specialty: _____

Gender: [] F [] M Citizenship: _____ Place of Birth: _____
Social Security Number: _____ Date of Birth: _____
State Tax ID#: _____ [] Pending Federal Tax ID#: _____ [] Pending
Medicare #: _____ [] Pending Medicaid #: _____ [] Pending
Unique Physician Identification Number (UPIN): _____ [] Pending
Office Manager or Contact Person and telephone number: _____

Practice/Group Name: _____ Effective Date: _____
Street Address: _____
City, State and Zip Code: _____
Telephone Number: _____ Facsimile Number: _____
E-Mail Address: _____ Answering Service Number: _____
Can we contact you by e-mail for credentialing correspondence? [] Yes [] No
Foreign Languages (spoken fluently by practitioner): _____
Foreign Languages (spoken fluently at practice): _____

Current Mailing Address (if different from above): [] Same As Above
Street Address: _____
City, State and Zip Code: _____
Telephone Number: _____ Facsimile Number: _____

Are you requesting to be credentialed as a primary care provider (PCP)? [] Yes [] No
Do you deliver babies? [] Yes [] No

Billing Address (if different from mailing address):

Same As Mailing Address

Contact Person: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Number: _____ Facsimile Number: _____

Other Practice Locations: (Attach a separate page for additional practice locations.)

Practice Name: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Number: _____ Facsimile Number: _____

Home Address:

Street Address: _____

City, State and Zip Code: _____

Telephone Number: _____ Pager Number: _____

Spouse's Name (Optional): _____

Practice Associates:

Call Coverage (if different):

_____/_____
_____/_____
_____/_____
_____/_____

What are the office hours for your Practice or Group Practice? (Provide days/hours):

What provisions have been made for after hours? _____

PROFESSIONAL REFERENCES

Please list five professional peers with the same type of license or a higher level of licensure who are familiar with your professional performance in the past five (5) years (not including current or impending partners or associates in practice).

Name and Title: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Name and Title: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Name and Title: _____
Street Address: _____
City, State, Country and Zip Code: _____
Telephone Number: _____ Facsimile: _____

Name and Title: _____
Street Address: _____
City, State, Country and Zip Code: _____
Telephone Number: _____ Facsimile: _____

Name and Title: _____
Street Address: _____
City, State, Country and Zip Code: _____
Telephone Number: _____ Facsimile: _____

EDUCATION

Undergraduate Education:

College or University: _____
Street Address: _____
City, State, Country and Zip Code: _____
Dates Attended: From _____ To _____ Degree Earned: _____

Graduate Education: (List all medical, osteopathic, dental or podiatric schools attended.)

College or University: _____
Street Address: _____
City, State, Country and Zip Code: _____
Dates Attended: From _____ To _____ Degree Earned: _____

POST GRADUATE TRAINING N/A

List all hospitals where you received training and attach a copy of your certificate. Disclose every residency program initiated, whether completed or not, and all completed programs. Attach a separate page, if necessary.

_____ Specialty: _____
Specify Internship, Residency, or Fellowship
Institution: _____ Dates Attended: From _____
Street Address: _____ To _____
City, State, Country and Zip Code: _____

_____ Specialty: _____
Specify Internship, Residency, or Fellowship
Institution: _____ Dates Attended: From _____
Street Address: _____ To _____
City, State, Country and Zip Code: _____

Specialty: _____

Specify Internship, Residency, or Fellowship

Institution: _____ Dates Attended: From _____

Street Address: _____ To _____

City, State, Country and Zip Code: _____

Teaching Appointments N/A

Institution: _____

Street Address: _____

City, State, Country and Zip Code: _____

Dates Attended: From _____ To _____ Department/Position: _____

WORK HISTORY

Please list all previous experience for the past fifteen (15) years, including months and years, listing the most recent first. Attach a separate page, if necessary. ***Please provide a written explanation for any gaps in work history of six (6) months or more.***

Organization: _____ Dates: From _____ To _____
Mo/Yr Mo/Yr

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Contact Person: _____

Organization: _____ Dates: From _____ To _____
Mo/Yr Mo/Yr

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Contact Person: _____

Organization: _____ Dates: From _____ To _____
Mo/Yr Mo/Yr

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Contact Person: _____

Organization: _____ Dates: From _____ To _____
Mo/Yr Mo/Yr

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Contact Person: _____

Organization: _____ Dates: From _____ To _____
Mo/Yr Mo/Yr

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Contact Person: _____

HOSPITAL AND HEALTHCARE AFFILIATIONS

Are you a: Doctor of Medicine (MD)? Yes No
Doctor of Osteopathic Medicine (DO)? Yes No
Certified Nurse Practitioner (CNP) as well as a primary care provider (PCP)? Yes No
Certified or Licensed Nurse Midwife (CNM or LNM)? Yes No

If yes, you must:

- (a) Have admitting privileges at a hospital (list below) **OR**
- (b) Provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

Do you have courtesy or consulting privileges at your current primary admitting facility? Yes No

If yes, do these courtesy or consulting privileges allow you to admit patients? Yes No

If no, provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

Please list all hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years, and your status (active, courtesy, consulting, etc.). If an institution is no longer in existence, please provide an alternative source of verification. Use a separate page, if necessary.

Current Primary Admitting Facility (Hospital Name): _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Appointment Dates: From _____ To _____ Type of Appointment/Status: _____

Privileges Assigned: _____

Facility Name: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Appointment Dates: From _____ To _____ Type of Appointment/Status: _____

Privileges Assigned: _____

Facility Name: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Appointment Dates: From _____ To _____ Type of Appointment/Status: _____

Facility Name: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Appointment Dates: From _____ To _____ Type of Appointment/Status: _____

MILITARY SERVICE

Branch: _____ Dates: From _____ To _____
Rank: _____ Type of Discharge: _____

LICENSURE-REGISTRATION-CERTIFICATION INFORMATION

List all licenses held in all jurisdictions. Attach a separate page, if necessary.

State Professional License/Certification Number: _____ Pending
State: _____ Issue Date: _____ Expiration Date: _____

State Professional License/Certification Number: _____ Pending
State: _____ Issue Date: _____ Expiration Date: _____

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State: _____ Issue Date: _____ Expiration Date: _____

State Professional License/Certification Number: _____ Pending
State: _____ Issue Date: _____ Expiration Date: _____

ECFMG (Educational Commission for Foreign Medical Graduates) Number (if applicable): _____
Date Issued: _____ Please attach a copy of your ECFMG certificate.

Federal Drug Enforcement Administration (DEA) Registration: Pending N/A
DEA Number: _____ Expiration Date: _____

State Controlled Substance Registration (CSR): Pending N/A
CSR Number: _____ Expiration Date: _____ State: _____

Immigration Status: _____ Immigration Certification Number: _____
CLIA Number (if applicable): _____ Approval Level: _____ Expiration Date: _____

PROFESSIONAL LIABILITY INSURANCE

Do you have current liability insurance? Yes No
Please list liability insurance carriers for the past fifteen (15) years. Attach a separate page, if necessary.

Current Carrier: _____ Coverage Limits: _____
Street Address: _____ Current Pending
City, State, Country and Zip Code: _____
Dates Insured: From: _____ To: _____ Policy Number: _____

Carrier: _____ Coverage Limits: _____
Street Address: _____
City, State, Country and Zip Code: _____
Dates Insured: From: _____ To: _____ Policy Number: _____

Carrier: _____ Coverage Limits: _____
Street Address: _____
City, State, Country and Zip Code: _____
Dates Insured: From: _____ To: _____ Policy Number: _____

SPECIALTY BOARD CERTIFICATIONS

Are you Board Certified? Yes No N/A

If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted by examination in your specialty, please give a brief explanation on an attached sheet. Explain any gaps or delays in achieving Board certification by the recognized Board in your specialty area.

Certified/Recertified by the Board of: _____

Date Certified:_____ Date Last Recertified:_____ Expiration Date:_____

Certified/Recertified by the Board of: _____

Date Certified:_____ Date Last Recertified:_____ Expiration Date:_____

Accepted for Examination by the Board of: _____

Until (Expiration Date):_____ If not accepted, have you made application? Yes No

If no, provide an explanation:_____

Certified/Recertified by the Subspecialty Board of:_____

Date Certified:_____ Date Last Recertified:_____ Expiration Date:_____

Certified/Recertified by the Subspecialty Board of:_____

Date Certified:_____ Date Last Recertified:_____ Expiration Date:_____

Accepted for Examination by the Subspecialty Board of:_____

PROFESSIONAL PRACTICE QUESTIONS

Please answer the following Yes or No questions. Note that "N/A" is not an acceptable response; you must answer the question. **If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.**

1. Has your professional liability coverage ever been terminated by action of the insurance company?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been denied professional liability insurance coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you ever had any sanctions imposed by Medicare and/or Medicaid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you ever been arrested, convicted of, or pled no contest to a crime or have you ever been named as a defendant in any criminal proceedings, convicted of a felony, or subject to investigation by a governmental entity that could result in sanctions or licensure adverse actions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked or not renewed, except for medical records?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Has your license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended or revoked, or are any currently held licenses pending investigation or being challenged?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or surrendered, or is it currently being challenged?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet of paper for each case. <ul style="list-style-type: none"> • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney. 	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Do you know of any reason why you cannot perform the essential duties of the clinical privileges/functions which you are requesting with or without a reasonable accommodation according to acceptable standards of professional performance and without posing a direct threat to patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Do you use illegal drugs or have you illegally used drugs in the past five years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Applicant's Attestation

I, _____, certify that the information I have provided and the statements I have made on this application are correct, true, and complete to the best of my knowledge. I will abide by the applicable bylaws, rules and regulations, and policies and procedures of the designated health care entity. I acknowledge that I have received and reviewed a copy of the bylaws, if applicable, of the designated health care entity. I further agree that, in the event there should arise an adverse ruling with respect to my status and/or clinical privileges, I will exhaust the administrative remedies afforded by the entity's bylaws before resorting to litigation.

Signature stamps and date stamps are not acceptable.

Signature

Date

All applicants have the right to be informed of their application status. Application status inquiries should be directed to the appropriate health care organization.

Hospital Services Corporation, a subsidiary of the New Mexico Hospitals and Health Systems Association, maintains this form, as well as a user's mailing list, to distribute any subsequent revisions. If you have any questions about this form or if you would like to be included on the user's list, please contact one of our credentials analysts at (505) 343-0070, or by e-mail at cv@nmhsc.com. This application has been copyrighted and is intended for the sole use of our customers and approved users.

CHECKLIST OF DOCUMENTS TO BE RETURNED BY APPLICANT

- Completed and signed application (and supplemental documents required by the healthcare organization, if applicable). Signature stamps and date stamps are not acceptable.
- Completed and signed release, with all organizations to which you are applying identified in the first line of the release. Please note that if you do not provide the authority to redisclose, you will be required to sign a separate release for any additional healthcare organizations to which you have made application. Signature stamps and date stamps are not acceptable.
- Current curriculum vitae or resume including months and years for all places of employment during the past fifteen years. Explain any gaps of six months or more during the past five years.
- Copy of latest professional state license/certificate or registration. Pending
- Proof of current professional liability coverage that includes the effective date, amount and type of coverage. If your coverage will be expiring within the next sixty days, please provide a copy of the renewal certificate. Pending
- Copy of current state Controlled Substance Registration. If your registration will be expiring within the next sixty days, please provide a copy of the renewal certificate. Pending
- Copy of current federal DEA registration certificate. If your registration will be expiring within the next sixty days, please provide a copy of the renewal certificate. Pending
- Completed privileges forms, as appropriate. For hospital appointments, please attach privileges requested. For health plan panel membership, all MD's and DO's, and all Nurse Practitioners and Nurse Midwives who are primary care providers (PCP's), must either have admitting privileges or a letter explaining the arrangements that have been made with a physician to admit patients, along with a signed letter from this physician confirming the arrangement.
- Copy of ECFMG Certificate, if foreign medical graduate.
- Any additional attachments required by the application.

Return to:

Hospital Services Corporation
Credentials Verification Services
P. O. Box 92200
Albuquerque, NM 87199-2200
Telephone: (505) 343-0070
Facsimile: (505) 346-0288

Rev. October, 2003

**HOSPITAL SERVICES CORPORATION
CREDENTIALS VERIFICATION SERVICE
DESIGNATION AND AUTHORIZATION FOR RELEASE AND REDISCLOSURE OF INFORMATION
("Release")**

Authority to Release: I have applied to participate as a provider for ADVANTAGE CARE NETWORK, INC.
FORESIGHT TPA, INC.

Print the names of all organizations to which you are applying.

and its authorized representatives (hereafter "Health Care Entity") which has designated Hospital Services Corporation's Credentials Verification Service ("HSC") as their agent. I consent to complete disclosure by the recipient of this release to HSC of all relevant information pertaining to my professional qualifications, moral character, physical and mental health (hereinafter "qualifications"). I authorize the recipient to make available and/or disclose to HSC all such information in its files from any university, professional school, licensing authority, accreditation board, hospital, physician, dentist, professional society, insurance carrier, law enforcement agency, military service, or any other person or entity deemed necessary or appropriate in the investigation and processing of my application.

I request and authorize the recipient to release the requested information and I expressly waive any claim of privilege or privacy with respect to the released information bearing on my admission to, retention or termination of medical staff appointment or clinical privileges. I release and discharge HSC, the Health Care Entity and the medical, dental, podiatry and ancillary staffs or panels, credentials committees, administrators, review and approval boards or committees, governing boards, whether or not designated by these titles, and their agents, servants or employees authorized by representatives and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquiries concerning me or disclosures made in good faith in connection with my application for appointment to the Health Care Entity's Medical Staff or Provider Panel.

Authority to Redisclose: Unless I have denied authority by initialing here _____, I authorize the Health Care Entity, the Health Care Entity's Authorized Representatives, and HSC to redisclose information concerning my qualifications, or credentials and privileges to third parties who have a need to know the information (1) based upon state or federal laws or regulations, or (2) pursuant to any health care provider agreement to which I am or will be a party and in which I have an interest as an individual health care provider.

This Release does not authorize HSC to disclose information about my qualifications to any claimant. If a claimant requests information from HSC about me or if a subpoena duces tecum is served upon HSC seeking information about me, which is in HSC's possession, I understand I will be notified immediately. If I direct HSC to resist the subpoena, I hereby agree to indemnify and hold harmless HSC, its officers, directors, employees and agents for all attorney fees, costs, fines, and expenses incurred in resisting the subpoena at my request.

This authorization is limited to the acquisition and disclosure of information required by state or federal law, and information which is acquired or disclosed pursuant to activities protected by the state's Review Organizational Immunity Act and the Health Care Quality Improvement Act of 1986. A photocopy of this Designation and Authorization for release and redisclosure of information shall be considered by the recipient to be a signed original, as long as it is transmitted to the recipient by HSC and is received within five years of its date.

The certain definitions used in this Release and set forth on its reverse side are incorporated by reference. I understand that I may withdraw or modify this authorization at any time in writing by submitting a written request to HSC. PHOTOCOPY BOTH PAGES OF THIS FORM.

Signature stamps and date stamps are not acceptable.

Applicant Signature

Printed Name

Date

DEFINITIONS of terms used in this Designation and Authorization for Release and Rediscovery of information.

“Health Care Entity” is the Health Care Entity on the front of this form.

The “Health Care Entity’s Authorized Representatives” include any management or quality assurance companies hired by the Health Care Entity or HSC; the Health Care Entity’s Board, staffs, committees, CEO, administrator medical director or other employees of the Health Care Entity whose performance of duties requires access to information about my qualifications; consultants whose contract with the Health Care Entity requires access to information about my qualifications; any independent credentialing services including HSC; and the Health Care Entity’s attorneys and insurers.

“Credentials and Privileges” means all information regarding my qualifications, my standing with the Health Care Entity, and my right to provide healthcare services at or through the Healthcare Entity. It also includes any limitations imposed upon my right to provide healthcare services and any final disciplinary action taken by the Health Care Entity with regard to my provision of healthcare services at or through the Healthcare Entity.

“Credentialing Verification Service” is the service operated by Hospital Services Corporation. HSC may be required as a condition of certification by the National Committee for Quality Assurance (NCQA) to permit audits of HSC’s system. The person providing this Release acknowledges that these audits are conducted solely for the purpose of certifying the credentialing verification service, and all information utilized by the NCQA is treated as confidential.

“Claimant” means any person, guardian, or personal representative who is asserting an administrative or legal claim against the person providing this release based in whole or in part upon allegations that the person providing this release has violated any state or federal law or regulation or has committed medical malpractice.

“Medical Staff or Provider Panel” is to be interpreted broadly to include any group of healthcare providers howsoever designated, who are authorized to provide healthcare services to patients, insureds, beneficiaries, members, or enrollees of a healthcare plan.

“Third Parties who have a need to know” include, but are not limited to governmental agencies and boards; organizations, associations, partnerships, corporations; other hospitals and clinics; managed care organizations, Independent Practice Associations (“IPA’s”), Managed Service Organizations (“MSO’s”), Physician Hospital Organizations (“PHO’s”), Preferred Provider Organizations (“PPO’s”), Health Maintenance Organizations (“HMO’s”), medical foundations, insurance underwriters, employer or employee sponsored ERISA health plans, health care alliances, or others with whom I am negotiating a health care provider agreement, presently have a health care provider agreement or with whom the Health Care Entity identified on the front page of this authorization (or the Health Care Entity’s Authorized Representatives) is negotiating a health care provider agreement or has health care provider agreement in which I have or will acquire an interest.

Rev. October, 2003

