Centralized Credentials Verification Service, Inc.

A Statewide service for Healthcare Professionals, Hospitals and Managed Care Organizations

2201 West Broad St, Suite 205
Richmond, Virginia 23220

phone: 804-643-2287 fax: 804-643-2291

website: www.ramdocs.org

Credentials Application

Name: ____________________

Date: ____________________

CREDENTIALING APPLICATION

(Please type in all fields that apply)

(Use the TAB key to move between fields and the SPACE bar to check boxes)

PERSONAL INFORMATION

Name ______ Sex ______
Last First Initial Suffix Maiden name

Date of Birth ______ Marital Status: ______ Name of Spouse: ______

Place of Birth ______ Social Security # ______ U.P.I.N. # ______

Citizenship ______ E-Mail Address ______

NPI # (National Provider Identifier) ______

Provider Type: ___ MD ___ DO ___ DDS ___ DMD ___ DPM Other ______

LIST ALL ADDRESSES:

(Check preferred mailing address. If not currently at this address **- expected starting date**: ______)

___ #1 Office Address ______ Phone ______
Street Address

______ FAX # ______
City State Zip

___ #2 Office Address ______ Phone ______
Street Address

______ FAX # ______
City State Zip

___ #3 Office Address ______ Phone ______
Street Address

______ FAX # ______
City State Zip

___ Residence Address ______
Street Address

______ Phone ______
City State Zip

PRACTICE STATUS: Group ____ Partnership ____ Individual ____

Practice Name ________________ Tax ID # ________

List names of all physicians in your practice:

____

____

Office Manager/Contact Person ________________ Direct Phone # ________

Billing Address ________________________________

Answering Service # ________________ Pager # ________________

Name of back-up physician(s) [PCP must have at least one back-up who is also a member of same network]:

a) ________________ ________________

Name Day Phone # After Hours #

Address ________________________________

b) ________________ ________________

Name Day Phone # After Hours #

Address ________________________________

Name of physicians who share call if outside your group:

a) ________________ ________________

Name Day Phone # After Hours #

Address ________________________________

b) ________________ ________________

Name Day Phone # After Hours #

Address ________________________________

c) ________________ ________________

Name Day Phone # After Hours #

Address ________________________________

d) ________________ ________________

Name Day Phone # After Hours #

Address ________________________________

PREMEDICAL EDUCATION (Please account for any time gaps during your educational history):

Institution: ________ Degree: ________

City/State: ________ Dates: ________ to ________

Institution: ________ Degree: ________

City/State: ________ Dates: ________ to ________

MEDICAL EDUCATION:

Institution: ________ Degree: ________

City/State: ________ Dates: ________ to ________

Institution: ________ Degree: ________

City/State: ________ Dates: ________ to ________

INTERNSHIP(S):

Institution: ________ Dates: ________ to ________

________ Address ________ City ________ State ________ Zip

Program Director: ________ Specialty ________ Completed Y N*

Institution: ________ Dates: ________ to ________

________ Address ________ City ________ State ________ Zip

Program Director: ________ Specialty ________ Completed Y N*

RESIDENCY(IES):

Institution: ________ Dates: ________ to ________

________ Address ________ City ________ State ________ Zip

Program Director: ________ Specialty ________ Completed Y N*

Institution: ________ Dates: ________ to ________

________ Address ________ City ________ State ________ Zip

Program Director: ________ Specialty ________ Completed Y N*

***If answered No, please explain why:** ________

FELLOWSHIP(S):

Institution: Dates: to

Address City State Zip

Program Director: Specialty Completed Y N*

Institution: Dates: to

Address City State Zip

Program Director: Specialty Completed Y N*

***If answered No, please explain why:**

LIST TEACHING OR UNIVERSITY APPOINTMENTS HELD.

LIST ALL MEDICAL AND SURGICAL EXPERIENCES IN THE ARMED SERVICES AND/OR PUBLIC HEALTH SERVICE, WITH DATES AND LOCATIONS.

Position: Hospital/Clinic:

Supervisor Who Can Confirm Service:

Address/City/State/Zip

Phone: Fax:

Position Hospital/Clinic:

Supervisor Who Can Confirm Service:

Address/City/State/Zip

Phone: Fax:

Position: Hospital/Clinic:

Supervisor Who Can Confirm Service:

Address/City/State/Zip

Phone: Fax:

ECFMG # ______ Date Certification Was Issued ______

Please include a copy of your ECFMG certificate.

CHRONOLOGICAL LISTING OF MEDICAL PRACTICE SINCE MEDICAL TRAINING (MONTH/YEAR/ LOCATION). PLEASE ACCOUNT FOR ANY GAPS IN TRAINING OR PRACTICE.

Practice Name ______ Date: ______ To: ______

Address/City/State/Zip

Reason for leaving: ______

Phone: ______ Fax: ______

Practice Name ______ Date: ______ To: ______

Address/City/State/Zip

Reason for leaving: ______

Phone: ______ Fax: ______

Practice Name ______ Date: ______ To: ______

Address City State Zip

Reason for leaving: ______

Phone: ______ Fax: ______

Practice Name ______ Date: ______ To: ______

Address City State Zip

Reason for leaving: ______

Phone: ______ Fax: ______

Practice Name ______ Date: ______ To: ______

Address City State Zip

Reason for leaving: ______

Phone: ______ Fax: ______

PRESENT AND PREVIOUS HOSPITAL/HEALTH CARE FACILITY AFFILIATION(S) (DO NOT LIST HOSPITALS WHICH ARE PART OF YOUR INTERNSHIP(S) AND RESIDENCY(IES) SINCE YOU ONLY ROTATE THROUGH THESE FACILITIES AS PART OF YOUR TRAINING. PLEASE ACCOUNT FOR ANY GAPS IN PRACTICE. IF ADDITIONAL SPACE IS NEEDED) PLEASE COPY THIS SECTION OR ATTACH A SEPARATE SHEET. PLEASE NOTE: "SEE CV' AND "SEE ATTACHED" ARE NOT ACCEPTABLE:

Facility: ______ Dates: ______ To ______

______
Address City State Zip

Position/Category: ______ Reason for Leaving: ______

Facility: ______ Dates: ______ To ______

______
Address City State Zip

Position/Category: ______ Reason for Leaving: ______

Facility: ______ Dates: ______ To ______

______
Address City State Zip

Position/Category: ______ Reason for Leaving: ______

Facility: ______ Dates: ______ To ______

______
Address City State Zip

Position/Category: ______ Reason for Leaving: ______

Facility: ______ Dates: ______ To ______

______
Address City State Zip

Position/Category: ______ Reason for Leaving: ______

Facility: ______ Dates: ______ To ______

______
Address City State Zip

Position/Category: ______ Reason for Leaving: ______

MEDICAL PRACTICE:

GIVE A NARRATIVE DESCRIPTION OF YOUR MEDICAL PRACTICE, INCLUDING SPECIFIC INTERESTS.

*Attention emergency room MDs, radiologists, pathologists and anesthesiologists: Please provide hospitals in which you render service under a contract with the facility or as an employee.

IS YOUR PRACTICE LIMITED TO A SPECIALTY OR SUBSPECIALTY? IF SO, PLEASE INDICATE.

Do you place any age limitations on your type of patient population? ___ Yes ___ No if yes, list:

Medicaid #: ______

Medicare #: ______

Your Medigap payment should be mailed to: ___ the provider ___ the insured

Your FEP Medigap should be mailed to: ___ the provider ___ the insured

Are you fluent in languages other than English? ___ Yes ___ No

If yes, what languages? ______

Do you perform the following procedures or treat any of the following conditions in your office?

___ Lab ___ Cardiac stress test ___ X-rays

___ Pulmonary functions ___ EKGs ___ Allergy injections

___ Care of minor lacerations

___ Other: ______

CERTIFICATION BY SPECIALTY BOARD

If you are *certified* by a specialty board, indicate the

Name of the board ____________________

Date certification will expire ____________ Date of certification ____________

Name of the board ____________________

Date certification will expire ____________ Date of certification ____________

If you have *applied* to a specialty board for examination, give the Name of the board:

____

Application Date: ____________ Date of exam: ____________

If you have taken and failed to pass a specialty board examination please list the board's name and date of examination(s): ____________________

If status is one of eligibility, indicate date eligibility status will terminate under rules of that specific board: ____________

LICENSURE: Virginia Board of Medicine (include a copy of current license):

Number ____________ Expiration Date ____________

DEA REGISTRATION (narcotic license: include a copy of your current DEA Certificate)

Number ____________ Expiration Date ____________

CDS CERTIFICATION (state narcotic license: include a copy of your current CDS Certificate

Number ____________ Expiration Date ____________

PLEASE LIST ALL OTHER STATES OR LOCALITIES WHERE YOU HOLD, OR HAVE HELD, A MEDICAL LICENSE. LIST THE LICENSE NUMBER AFTER EACH STATE OR LOCALITY, AND PROVIDE A COPY OF THE LICENSE.

1. ______ # ____________ Exp. Date ______ 4. ______ # ____________ Exp. Date ______
2. ______ # ____________ Exp. Date ______ 5. ______ # ____________ Exp. Date ______
3. ______ # ____________ Exp. Date ______ 6. ______ # ____________ Exp. Date ______

LIABILITY INSURANCE (Please list each carrier for the last **FIVE** years. **Include** carrier(s) during residency or fellowship training if applicable):

a. Amount of coverage ______ Insurance carrier ______
Policy # ______ Policy in force from ______ to ______
Agent ______
Agent's Address ______

b. Amount of coverage ______ Insurance carrier ______
Policy # ______ Policy in force from ______ to ______
Agent ______
Agent's Address ______

c. Amount of coverage ______ Insurance carrier ______
Policy # ______ Policy in force from ______ to ______
Agent ______
Agent's Address ______

d. Amount of coverage ______ Insurance carrier ______
Policy # ______ Policy in force from ______ to ______
Agent ______
Agent's Address ______

Verification of Malpractice Insurance and Claims History for the last five years is one of the items that causes a delay in the application process. By providing us with more information (ie, copies of current and expired certificates) you will assist us in obtaining this vital information in a more timely manner.

PROFESSIONAL FELLOWSHIPS, MEMBERSHIPS AND SOCIETIES (List all past and present, including state and county medical societies, with dates).

____

____

____

____

____

CME CREDITS

For the past three calendar years please provide a list of CME credits earned each year; along with copies of all available certificates.

____ List & Certificates Attached ____ N/A - Recent completion of training

PROFESSIONAL REFERENCES: List three physicians who have worked extensively with you or have been responsible for professional observation of your work. If you are completing training, please use your Residency/Fellowship Program Director and/or the Chairperson of the Department. (Please limit to one office associate. At least one reference should be if possible from a physician in your specialty.)

1. Name ____________________ Title ____________
   Address ______________________________
   City, State, Zip ____________ ______ ______
   Phone ____________ **FAX** ____________

2. Name ____________________ Title ____________
   Address ______________________________
   City, State, Zip ____________ ______ ______
   Phone ____________ **FAX** ____________

3. Name ____________________ Title ____________
   Address ______________________________
   City, State, Zip ____________ ______ ______
   Phone ____________ **FAX** ____________

IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED IN THE AFFIRMATIVE, PLEASE PROVIDE A FULL EXPLANATION ON A SEPARATE SHEET OF PAPER:

__ Yes __ No Do you presently have, or ever had, any physical or mental condition which would affect your ability to exercise the clinical privileges requested or would require an accommodation in order for you to exercise the privileges requested safely and competently?
(Regardless of how the applicant answers this question, the application will be processed in the usual manner.)

__ Yes __ No Have you had any professional liability cases brought against you in the last five years?

__ Yes __ No Have any final judgments or settlements on malpractice claims ever been paid by you or on your behalf by another entity? (If a settlement was made by your insurance carrier without your consent, please note.)

__ Yes __ No Do you currently have any pending malpractice cases?

__ Yes __ No Has your liability coverage ever been canceled?

__ Yes __ No Has your license to practice medicine in any jurisdiction ever been limited, suspended, not renewed, refused, voluntarily or involuntarily relinquished, or revoked (i.e. stipulations)?

__ Yes __ No Have you ever had any disciplinary actions taken by any board you have been/are licensed by (including reprimands, censures, probation, etc.)?

__ Yes __ No Are you currently charged with or have you ever been convicted of a felony or misdemeanor (other than a minor traffic violation)?

__ Yes __ No Have you ever been refused membership on a hospital medical staff

__ Yes __ No Has your request for specific clinical privileges ever been denied or granted with stated limitations, or have your hospital privileges ever been voluntarily or involuntarily suspended, limited, revoked, or not renewed? If so, at which hospitals?

__ Yes __ No Have you ever voluntarily or involuntarily relinquished your hospital clinical privileges or medical staff memberships? if so, which hospital(s)?

__ Yes __ No Has your DEA number (narcotics license) or other controlled substance authorization or any state pharmaceutical certificate ever been suspended or revoked, denied, reduced or not renewed?

__ Yes __ No Have you ever voluntarily or involuntarily relinquished your DEA registration?
(ATTACH A COPY OF CURRENT CERTIFICATION)

__ Yes __ No Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization or local, state, or national professional society (including Medicare, Medicaid, any third party payor, or peer review organization)?

__ Yes __ No Are you now or within the past five years alcohol or drug dependent?

__ Yes __ No Are any actions currently pending against you by any federal or state regulatory authorities, or by any hospital or provider?

__ Yes __ No Do you perform any procedure in your office for which you do not have privileges at a hospital?

IF YOU ARE NOT JOINING ONE OF THE FACILITIES LISTED BELOW, SKIP TO THE NEXT PAGE

PLEASE INDICATE INSTITUTIONS WHERE YOU WISH TO SEEK A STAFF APPOINTMENT:

BON SECOURS FACILITIES:

_____ Memorial Regional Medical Center
_____ Richmond Community Hospital
_____ St. Mary's Hospital
_____ St. Francis Medical Center

HCA FACILITIES:

_____ CJW Medical Center
_____ Henrico Doctors' Hospital-Forest and Parham
_____ Retreat Hospital
_____ John Randolph Hospital

_____ Children's Hospital *
_____ Hanover Outpatient Surgery
_____ Hallmark Youthcare
_____ Healthsouth Rehabilitation Hospital
_____ Sheltering Arms Rehabilitation
_____ Tuckahoe Surgery Center
_____ Urological Surgery Center

CCVS Participating Managed Care Providers **

Community Health Associates (CHAPO)

***PEDIATRICS & PEDIATRIC SPECIALITIES ONLY**

****IF YOU WISH MANAGED CARE PARTICIPATION, YOU MUST CONTACT THAT CLIENT SPECIFICALLY**

Please identify primary admitting facility_______________________________________

THE FOLLOWING APPLICATIONS CAN BE AUTOMATICALLY POPULATED FOR AN ADDITIONAL CHARGE OF $10.00 PER APPLICATION. THE CAQH APPLICATION CAN BE MANUALLY FILLED OUT FOR A FEE OF $225.00.

_____ CCN
_____ C& O Employee Hospital Association
_____ CorVel Corporation
_____ First Health Network
_____ MAMSI
_____ Medicare
_____ One Health Plan
_____ PHCS

_____ TriAtlantic Healthcare
_____ TRICARE
_____ UniCare
_____ UP & UP
_____ United Healthcare of Virginia
_____ VA Premier Health Plan
_____ Virginia Health Network, Inc. (VHN)
_____ VMSO

_____ **CAQH**

PLEASE ATTACH ALL OF THE FOLLOWING TO YOUR COMPLETED APPLICATION

1. Copy of each current Medical License Certificates.
2. Copy of your current face sheet of your current professional liability insurance policy.
3. Copies of your medical degree, internship, residency and fellowship certificates.
4. Copies of ECFMG and Fifth Pathway certificates (if applicable).
5. Copy of your board certification, recertification or letter from specialty board.
6. Copies of your current DEA (Federal) certificate and your CDS certificate (if applicable).
7. Copy of your DD-214 (Prior Military only).
8. Copy of your current Curriculum Vitae.
9. Application fee ($350 for Non-RAM members, $750 for Locum Tenens, $250 for RAM members) if applicable- Make check payable to: CCVS (Centralized Credentials Verification Service, Inc.).
10. Recent passport-size photograph.
11. Copies of all CME certificates for the past three years.
12. Copies of expired medical licenses, malpractice insurances you may be able to provide
13. Evidence of annual PPD (if applicable)

MAKE SURE YOU HAVE SIGNED AND DATED THE RELEASE ON

THE LAST PAGE OF THIS APPLICATION

Please return the above attachments, completed application and signature page (p.16) to:

CENTRALIZED CREDENTIALS VERIFICATION SERVICE, INC
2201 WEST BROAD STREET, SUITE 205
RICHMOND, VA 23220

Please indicate if you also wish to belong to The Richmond Academy of Medicine:

Yes___ No___ (Note: Membership becomes effective when the application has been approved and dues have been paid to the Academy.)

Would your spouse be interested in joining the Richmond Academy of Medicine Alliance?
Yes___ No___

EACH HOSPITAL/FACILITY WILL CONSIDER THIS A PRE-APPLICATION UNTIL ELIGIBILITY OF THE APPLICANT IS ESTABLISHED. UPON ESTABLISHMENT OF ELIGIBILITY, THIS WILL BECOME AN OFFICIAL APPLICATION AND WILL BE MOVED FORWARD IN THE PROCESS. IF IT IS DETERMINED THAT THE APPLICANT IS NOT ELIGIBLE FOR APPOINTMENT, THEN THE HOSPITAL/FACILITY WILL NOTIFY THE APPLICANT.

AUTHORIZATION AND RELEASE OF APPLICANT
(Please read carefully before signing)

I understand and acknowledge that, as an applicant for medical staff membership at the hospital, ambulatory care center or other health care facility ("Facilities") indicated in this Application for Appointment, and/or for participation with any third party payors indicated in this Application ("Third Party Payors"), it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics and any other criteria adopted by Facilities for medical staff membership or medical surgical privileges or by Third Party Payors for participation.

I acknowledge my pledge to provide for continuous care for my patients. I further acknowledge that I am responsible for knowing the contents of the bylaws, rules and regulations of the Facilities and their medical staffs and of the Third Party Payors, and agree to be bound by them in the application process and if granted membership or participation.

I further understand and acknowledge that Centralized Credentials Verification Service ("CCVS") will investigate the information in this Application. By submitting this Application, I agree to such investigation and to the reporting and information exchange activities of CCVS, Third Party Payors and Facilities as a part of the Centralized Credentials Verification Service program, as follows:

1. **Authorization of Investigation and Release of Information Concerning Application.** I hereby authorize all individuals, institutions and entities (including but not limited to administra- tors and members of the medical staffs of other Facilities or institutions with which I have been associated; administrators, employees and participants of other Third Party Payors with which I have been associated; and all professional liability insurers with which I have had or currently have professional liability insurance) who have knowledge concerning information requested in this Application, to consult with and release relevant information to CCVS, Third Party Payors and Facilities, their medical staffs and agents. I further authorize CCVS to release all such information to all Facilities and Third Party Payors that participate in the CCVS program and with which I am affiliated.

2. A**uthorization of Release and Exchange of Disciplinary Information.** I hereby authorize any Facilities at which I have, or have had, medical staff membership and any Third Party Payors with which I participate, or have participated, to release Disciplinary Information about any disciplinary action taken against me to CCVS, its other participating Facilities, other physician- sponsored credentialing programs and their participating Facilities, and as otherwise may be required by law. I further authorize CCVS to release Disciplinary Information to all Facilities and Third Party Payors that participate in the CCVS program and with which I am affiliated. As used herein, Disciplinary Information means information concerning (i) any action taken by such Facilities, their administrators or medical staff or other committees to revoke, suspend, restrict or condition my privileges; (ii) any other denial of privileges to me; (iii) any other disciplinary action involving me; or (iv) my resignation prior to the conclusion of any disciplinary proceeding or prior

to the commencement of formal charges but after I have knowledge that such formal charges are contemplated and/or in preparation.

3. **Release from Liability**. I hereby fully, absolutely, and unconditionally release from liability Facilities (including but not limited to those participating in the CCVS program and their medical staffs), CCVS, Third Party Payors and their respective agents, and all other individuals, institutions and entities providing information in accordance with the authorizations contained herein for all their acts performed in good faith and without malice in connection with the investigation of this Application and the release and exchange of Disciplinary Information authorized above, including but not limited to the acts of preparing or completing any verifications, evaluations, recommendations, information requests, or forms that are provided by the applicant, CCVS, Facilities, or Third Party Payors. This release shall be in addition to any other applicable immunities provided by law for peer review activities or otherwise.

I understand and agree that the authorizations and releases given by me herein shall be irrevocable so long as I am an applicant for or have medical staff privileges at any Facilities participating in CCVS's credentialing program, and/or so long as I am participating with one or more Third Party Payors designated in this Application.

I acknowledge that the investigation of information in this Application and the release and exchange of Disciplinary Information by the Facilities, CCVS and Third Party Payors and their agents are done to achieve, maintain and improve the quality of patient care.

All information provided by me in the Application is correct and complete to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the Application may constitute grounds for denial of appointment or for summary dismissal from the medical staff and/or Third Party Payors. I understand and acknowledge that the Facilities shall be solely responsible for all decisions concerning medical staff membership and the granting of medical and surgical privileges, and that Third Party Payors shall be solely responsible for all decisions concerning participation with such Third Party Payors. I further understand and acknowledge that CCVS shall have no responsibility or liability with respect to medical staff membership decisions by Facilities or participation decisions by Third Party Payors.

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.

Name ______________________________
(Please Print)

Date __________________ Signature ______________________________