North Carolina Department of Insurance

Uniform Application
To Participate as a Health Care Practitioner

Note: Please send completed applications directly to the organizations with which you seek to contract.

The following application is a form approved by the North Carolina Department of Insurance, in accordance with North Carolina General Statute 58-3-230. Every insurer that provides a health benefit plan and credentials providers for its network is required to use this form and the insurer may not require an applicant to submit information that is not required by this form Only the Commissioner of Insurance is authorized to make changes, deletions or additions to this form.

INSTRUCTIONS

Before submitting the Application, make sure you have completed the following:

Include an answer in **all** spaces. Indicate "N/A", if the question is not applicable.

The provider has signed and dated the last page of the Application.

Before submitting the Application, make sure you have enclosed the following, *if applicable:*

Copy of the provider's original state(s) license(s) and current registration.

Copy of current DEA certificate. (Must have a valid date and refer to current address.)

Copy of South Carolina Controlled Drug Substance Certificate and DEA information.

Copy of the face sheet of your current professional liability insurance policy, indicating by name, provider(s) covered, coverage amounts, effective date, expiration date, and policy number. Attach previous carrier face sheet.

Proof of professional liability insurance for non-physician providers who care for patients in your practice.

Copy of certificate from the Specialty Board.

Copy of Educational Commission of Foreign Medical Graduate Certificate- ECFMG.

Letter(s) of reference, recommendation, and/or oversight, *if required*.

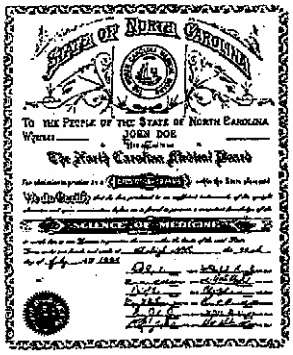
Copy of Curriculum Vitae or work history after graduation from Medical, Dental or other professional school **(CV must account for any gaps of 90 days or more).**

Copy of CLIA (Clinical Laboratory Improvement Amendments) /ACR (American College of Radiology).

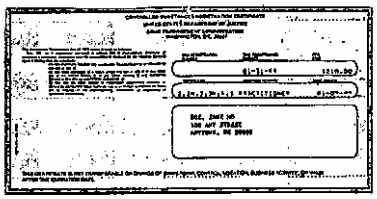
Copy of W-9 Form.

Examples of documentation to attach to this application:

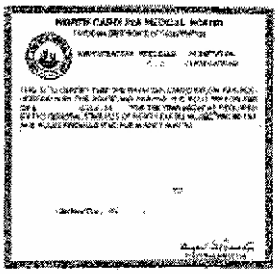
Original N.C. License



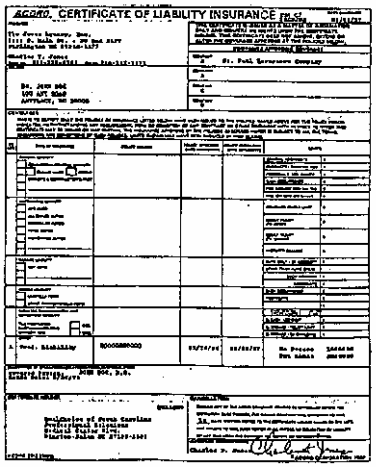
DEA Registration



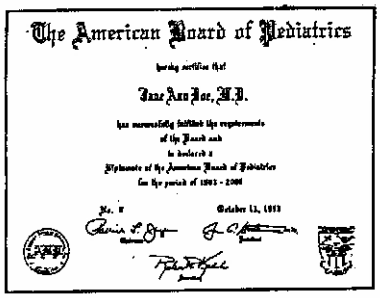
Medical Board Registration



Certificate of Insurance



Board Certification



A. DEMOGRAPHIC AND PERSONAL DATA:

1. Name of Applicant:
(Last Name) (First Name) (Middle Name) (Maiden)

2.

Date of Birth:	Place of Birth:
Social Security Number:	Sex: Male ☐ Female ☐

3.

Type of Practice: Primary Care: ☐	Specialist: ☐
(Primary Specialty)	(Secondary Specialty)
Please Identify Areas of Clinical Expertise:	
What population(s) do you treat (e.g. geriatric, all ages):	

4. Name of Practice:

5. Primary Office Address (If you maintain more than one office, list each office, address, and hours of operation)

Practice Name:

Address:
(Street) (City) (County) (State) (Zip)

Handicapped Accessible? YES ☐ NO ☐ Office Phone: Fax:

E-mail address:

Accepting New Patients? YES ☐ NO ☐ Restrictions:
(Please list or indicate none)

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Secondary Office Address

Practice Name:

Address:
(Street) (City) (County) (State) (Zip)

Handicapped Accessible? YES ☐ NO ☐ Office Phone: Fax:

E-mail address:

Accepting New Patients? YES ☐ NO ☐ Restrictions:
(Please list or indicate none)

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

Additional Office Address or Billing Address, if different (check one) ☐ Billing ☐ Office

Name:

Address:
(Street) (City) (County) (State) (Zip)

Handicapped Accessible? YES ☐ NO☐ Office Phone: Fax:

Accepting New Patients? YES ☐ NO☐ Restrictions:
(Please list or indicate none)

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

6. Name other provider(s) in your practice (if not enough space, please attach additional sheet):

7. Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? YES☐ NO ☐
(If yes, please attach proof of professional liability insurance and proof of employment for those individuals)

8. Name and address of provider(s) who share call with you (if not enough space, please attach additional sheet):

Name: Name:	
Address:	Address:

9. Arrangements for 24 hour/7 day coverage:

10. Administrative Contact:
(Name) (Title) (Telephone)

11. IRS requires reimbursement be made payable to name of practice affiliated with Federal Tax ID Number:

Federal Tax ID Number:

Name (if different from practice name):

Billing Address (if different from practice address):

12.

UPIN Number:	Medicare/Medicaid Number: /
National Provider Identifier (NPI):	

13. DEA Number: Exp. Date:
(Attach copy to application)

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

COMPLETE ONLY IF LICENSED IN SOUTH CAROLINA

SC Controlled Drug Substance Certificate: Expiration Date:
(Attach a copy to application)

14. Provide the following information for each state in which you are currently or were previously licensed to Practice (If not enough space please attach additional sheet)

STATE	DATE OF LICENSE	LICENSE NUMBER	STATUS Active, Inactive, Suspended	EXPIRATION DATE

PLEASE ATTACH A COPY OF EACH STATE LICENSE CERTIFICATE

15. Certification of Specialty Boards as applicable:

a. If you are certified by a specialty board, indicate name of board and date of certificate.

(Primary Specialty Board)	Date Certified:	Exp. Date:
(Secondary Specialty Board)	Date Certified:	Exp. Date:

b.. Are you listed in the American Board of Medical specialists? YES ☐ NO ☐

c. If you have applied to a specialty board for examination, give the name of board and the date of scheduled examination.

	Date:

d. If you have not applied to a specialty board, please explain:

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

16. List the dates of all current professional memberships in societies, including state and county societies:

	FROM	TO

17. List all hospitals where you currently have privileges and indicate the type and status of those privileges:
(Type: active, admitting, associate, consulting, courtesy. Status: pending, provisional, suspended, temporary, visiting)

Hospital	Privilege and Status of Privilege	Estimated % of Admission
(primary admitting facility)		

18. If you do not have admitting privileges, who admits for you?

Name:	Name:
Address:	Address:
Phone:	Phone:

B. EDUCATION AND PRACTICE HISTORY

1.

Medical, Dental, or other Professional School Attended:		
Institution:		
Address: (Street) (City) (State) (Zip)		
Degree:	From:	To:

Please attach Educational Commission of Foreign Medical Graduate Certificate – (ECFMG), if applicable.

2.

Internship		
Institution:		
Address: (Street) (City) (State) (Zip)		
Specialty:	From:	To:

3.

Residency		
Institution:		
Address: (Street) (City) (State) (Zip)		
Specialty:	From:	To:

4.

Other Residency / Fellowship – (specify)		
Institution:		
Address: (Street) (City) (State) (Zip)		
Specialty:	From:	To:

B. EDUCATION AND PRACTICE HISTORY (Continued)

5. List work history since beginning of medical, dental, or other professional school; please be specific.
(If not enough space, please attach additional sheet)

	FROM (mm/yyyy)	TO (mm/yyyy)
(Current Practice)		
(Previous Practice)		
(Previous Practice)		
(Previous Practice)		
(Previous Practice)		

6. List other training and/or education (including CME) within the last three years, if applicable.

7. Have you involuntarily or voluntarily withdrawn or been suspended from any internship, residency or fellowship training program? Please explain:

8. Please explain any incident(s) in which you have involuntarily or voluntarily withdrawn your application for appointment, clinical privileges or reappointment before a decision was made by a hospital or healthcare facility's governing board.

C. PROFESSIONAL INFORMATION

Please check yes or no for the following questions. Please complete the attached Supplemental Form for any questions to which you answer "yes". Also please sign and date this application If this application does not have the provider's signature, it cannot be accepted.

1.	Has your license to practice in any jurisdiction ever been limited, restricted, reduced, Suspended, voluntarily surrendered, revoked, denied or not renewed; have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license; are you under investigation by any licensing or regulatory agency? *(If yes, please complete Supplemental Question No. 1.)*	Y ☐	N ☐
2.	Has your professional employment or membership in a professional organization ever been subject to disciplinary proceedings, denied, limited, restricted, reduced, suspended, revoked, not renewed, or voluntarily relinquished during or under threat of termination for any reason? *(If yes, please complete Supplemental Question No.2.)*	Y ☐	N ☐
3.	Has your Drug Enforcement Agency registration or other controlled substance authorization Ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your registration during or under the threat of an investigation or are any such actions pending? (*If yes, please complete Supplemental Question No.3.*)	Y ☐ N	☐
4.	Have you ever been sanctioned or suspended by Medicare or Medicaid? *(If yes, please complete Supplemental Question No.4.)*	Y ☐	N ☐
5.	To your knowledge, have you ever been reported to the National Practitioner Data Bank or the North/South Carolina Board of Medical Examiners? *(If yes, please complete Supplemental Question No.5.)*	Y ☐	N ☐
6.	Have you ever been convicted of a felony or misdemeanor, or are you under investigation with respect to such conduct? (*If yes, please complete Supplemental Question No.6.*)	Y ☐	N ☐
7.	Has a professional liability claim been assessed against you in the past five years, or are there any professional liability cases pending against you? *(If yes, please complete Supplemental Question No.7.)*	Y ☐	N ☐
8.	Has any liability insurance carrier canceled, refused coverage, or rated up because of unusual risk or have any procedures been excluded from your coverage? *(If yes, please complete Supplemental Question No. 8.)*	Y ☐	N ☐
9.	Have you ever practiced without liability coverage? *(If yes, please complete Supplemental Question No.9.)*	Y ☐	N ☐
10.	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 position? (*If yes, please complete Supplemental Question No.10.*)	Y ☐	N ☐
11.	Have your Hospital and/or Clinic 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 an investigation or are any such actions pending? *(If yes, please complete Supplemental Question No. 11).*	Y ☐	N ☐

SUPPLEMENTAL FORM

Provider Name:	*Provider ID#* *(if applicable)*

1. License Limited, Reprimanded, etc.

List State(s) where action took place:
Date(s) License revoked, suspended, etc. From To
Please explain:

2. Employment/Membership Suspended, Limited, etc.

List State(s) where action took place:
List Professional Organization:
Please explain:

3. Drug Enforcement Agency (DEA) Explanation.

List State(s) where action took place:
Please explain:

SUPPLEMENTAL FORM

Provider Name:	*Provider ID #* *(if applicable)*

4. Medicare/Medicaid Sanction Disciplinary Action(s)

Disciplined Action(s):
List State(s):
Date(s) of action. From To
Please explain:

5. National Practitioner Data Bank Report(s)

Please explain the NPDB report (*if you have a copy please attach):*

6. Felony or Misdemeanor

Did you serve a sentence: Y☐ N ☐ If YES, check how many years: 1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ Other:
List State(s):
Please explain charge and verdict:

SUPPLEMENTAL FORM

Provider Name:	*Provider ID#* *(if applicable)*

7. Named in Professional Liability Judgment, Settlement, etc.

Please explain, include dates & amounts:

8. Cancelled, Refused Coverage, etc.

Please list Insurance Carrier(s):
Please explain:

9. Practiced Without Liability Coverage

Please explain:

SUPPLEMENTAL FORM

Provider Name:	*Provider ID#* *(if applicable)*

10. Medical, Chemical Dependency, or Psychiatric Conditions

Please explain in detail:

11. Hospital or Clinic Privileges Revoked, Restricted, etc.

List Hospital(s):		
Date privileges revoked, suspended, etc.	From	To
Please explain:		

Attestation Statement

(IMPORTANT: Submit Original Only)

This application is to be signed by each individual provider submitting an application.

Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in _____, I signify my willingness to appear for interview in regard to my application. I authorize _____ to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to _____ materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of _____ of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of _____ for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to _____ in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to _____.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, _____, may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in _____, I hereby consent to _____ for inspection of my patient records relating to _____ enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify _____ in a timely manner (not to exceed 30 days) of any changes to the information on the initial application.

_____

PRINT NAME OF PROVIDER

_____

SIGNATURE OF PROVIDER

_____

DATE

Please Sign and Complete this Application