VANTAGE HEALTH PLAN
RE-CREDENTIALING PRACTITIONER APPLICATION

VANTAGE HEALTH PLAN

GENERAL INFORM ATION

Name: _____ ☐ M ☐ F
Last First Middle Maiden

Degree: ☐ DPM ☐ DC ☐ DDS ☐ MD Other: _____

Languages spoken other than English? Language(s): _____ _____ ☐ Provider ☐ Other

Accepting New Patients: ☐ Yes ☐ No

SPECIALTY & CERTIFICATIONS

Type of Provider: ☐ Primary Care Physician ☐ Physician Specialist ☐ Both ☐ Other: _____

Primary Specialty: _____ Specialty Board-Certified by: _____

Secondary Specialty: _____ Specialty Board-Certified by: _____

PROFESSIONAL LICENSES

State Lic. #: _____ DEA Lic. #: _____ CDS Lic. #: _____

PRIMARY PRACTICE LOCATION

Legal Business Name (As reported to the IRS): _____

Physical Address: _____
Street City State Zip

Office Hours	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.
	_____–_____	_____–_____	_____–_____	_____–_____	_____–_____	_____–_____	_____–_____

Tax Identification #: (TIN) _____ Appointment Phone #: _____ Fax #: _____

Office Website: _____

Remittance Address: (for payments) _____
Street City State Zip

SECONDARY PRACTICE LOCATION

Legal Business Name (As reported to the IRS): _____

Physical Address: _____
Street City State Zip

Office Hours	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.
	_____–_____	_____–_____	_____–_____	_____–_____	_____–_____	_____–_____	_____–_____

Tax Identification #: (TIN) _____ Appointment Phone #: _____ Fax #: _____

Office Website: _____

Remittance Address: (for payments) _____
Street City State Zip

THIRD PRACTICE LOCATION

Legal Business Name (As reported to the IRS): _____

Physical Address: _____
Street City State Zip

Office Hours	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.
	_____–_____	_____–_____	_____–_____	_____–_____	_____–_____	_____–_____	_____–_____

Tax Identification #: (TIN) _____ Appointment Phone #: _____ Fax #: _____

Office Website: _____

Remittance Address: (for payments) _____
Street City State Zip

MEDICAID / CLIA

Are you currently seeing Medicaid patients? ☐ **Yes** ☐ **No**

Are laboratory testing procedures (as covered by the Clinical Improvement Act – CLIA) currently being performed at your office site where members are seen? If yes, a current copy of your CLIA Registration must accompany this application. ☐ **Yes** ☐ **No**

CURRENT HOSPITAL AFFILIATION

List the hospital to which you primarily admit your patients: _____

List in chronological order from oldest to most current all hospitals at which you currently have privileges:

Hospital	Location/Address	Types of Privileges	Effective Date (MO/YR)

If you DO NOT HAVE ADMITTING PRIVILEGES, who admits for you and to what hospital? Please list provider's name, specialty and hospital.

_____

GENERAL QUESTIONS

Please check the appropriate response to the following questions. If you answered YES to any of the questions below, please attach a full explanation on a separate page.

1. Has any disciplinary action ever been instituted against your license to practice your profession in any state or country, or is any such action currently pending against you? ☐ **Yes** ☐ **No** ☐ **N/A**
2. Has any disciplinary action ever been instituted against your DEA registration or CDS license, or have you voluntarily surrendered or limited your registration, or is any such action pending? ☐ **Yes** ☐ **No** ☐ **N/A**
3. Have you ever been convicted of, or pleaded *nolo contendere* to, or are you currently under investigation for any federal or state felony or other criminal charge or have you ever served a prison sentence? ☐ **Yes** ☐ **No** ☐ **N/A**
4. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified? ☐ **Yes** ☐ **No** ☐ **N/A**
5. Have your clinical privileges at any hospital or health care institutions been voluntarily or involuntarily revoked, not renewed, or subjected to probationary or other disciplinary conditions, or has any disciplinary proceeding been instituted against you by a hospital administration, medical staff committee, or governing board? ☐ **Yes** ☐ **No** ☐ **N/A**
6. Have you ever received a sanction from any regulatory agency (e.g. CLIA, OSHA, etc.)? ☐ **Yes** ☐ **No** ☐ **N/A**
7. Have you engaged in the illegal use of drugs within the past two years or are you currently engaged in the illegal use of drugs? "Illegal use of drugs" means the use of controlled substances obtained illegally, not obtained pursuant to a valid prescription, or not taken in accordance with the direction of a licensed health care practitioner. ☐ **Yes** ☐ **No** ☐ **N/A**
8. Do you currently have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a threat to the health and safety of others? ☐ **Yes** ☐ **No** ☐ **N/A**
9. Do you, your business entity, or any family member have an ownership greater than 5% in any medical enterprise or business? If YES, please attach an explanation of who owns what medical enterprise and the percentage of ownership. ☐ **Yes** ☐ **No** ☐ **N/A**
10. Are you presently a named defendant in a pending professional liability lawsuit? If YES, please enter the number of cases _____ and attach a full explanation of each. ☐ **Yes** ☐ **No** ☐ **N/A**

11. During the past five years, has any adverse medical review panel opinion been rendered, has any settlement or judgment been made, or has any payment been made by you or on your behalf in a professional liability action or potential action? If YES, please enter the number of cases _____ and attach a full explanation of each.

☐ Yes ☐ No ☐ N/A

REQUIRED ATTACHMENTS

Please enclose a current copy of the following documents:

- Malpractice Professional Liability Insurance Certificate
- CLIA Certificate if laboratory test procedures are being performed at your office where members are seen
- Signed Collaborative Agreement only if provider is a Nurse Practitioner
- W-9
- Roster of locations if more than one location

STATEMENT TO APPLICANTS

All providers applying for network participation have the right to review the credentialing application and supporting documents. Exceptions may vary as prohibited by law or health plan policy.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have the opportunity to submit additional information to correct the discrepancy or provide clarification that might positively impact the credentialing decision.

All information and documentation submitted by me in this application is correct and complete to my best knowledge and belief.

PROVIDER STATEMENT TO RELEASE INFORMATION

All information and documentation submitted by me in this re-credentialing application is correct and complete to my best knowledge and belief.

I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for continued network participation.

I consent to the release of all information that may be relevant to an evaluation of my credentials, including information about disciplinary actions or other confidential or privileged information, to Vantage Health Plan or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which I am a Plan provider. I release Vantage Health Plan, its affiliates, and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials.

Printed Name	Signature	Attestation Date