CREDENTIALING APPLICATION CHECKLIST

PRACTITIONER

Please use this checklist to complete the Credentialing requirements to become a Participating Provider with NetCare Life & Health and our affiliated networks.

For questions, please contact NetCare Provider Relations Department at (671)472-3610.

Please submit completed application and documents to: providerrelations@netcarelifeandhealth.com

To facilitate review of your application, please return all documents together.

- ☐ Completed Credentialing Application with Current Curriculum Vitae
- ☐ Current Guam/CNMI/State Medical/Allied Health/ State License
- ☐ Current Guam Business License
- ☐ Medical Degree/Undergraduate Degree/Diploma/Certificates
- ☐ Current Federal DEA Certificate *
- ☐ Current Local CSR Certificate*
- ☐ Board Certificate (if applicable)
- ☐ Professional Liability Insurance/Malpractice
- ☐ W - 9 Tax Payer and Certificate Form for Billing Entity
- ☐ ECFMG Certificate (Foreign graduates only)
- ☐ ANCC certificate (Nurses)
- ☐ ACNM certificate (Nurse Midwife)
- ☐ NCCPA certificate (Physician Assistant)
- ☐ AANA certificate (Nurse Anesthetist)

*Must list current practice location.
If DEA/CSR is in process, you may submit a Prescribing Letter from a NetCare Credentialed Provider if they are prescribing on your behalf.

PROVIDER CREDENTIALING APPLICATION

Provider Information

Provider Name _____ ☐ New ☐ Provisional ☐ Recredential

Effective Date(s) _____ Clinic _____ NPI _____

Social Security Number_____ Date of Birth _____ Gender _____

Degree/Specialty _____ Board Certified/Eligible? _____

Sub-Specialty _____ Board Certified /Eligible? _____

Email address _____ Language(s) Spoken other than English _____

Licensure

	Issuing State/Territory	License/Certificate Number	Date of Issue	Date of Expiration
Medical/Allied Health License				
DEA				
CSR				

Please list any practice restrictions for the Provider _____

Does the provider participate in and meet the conditions of participation in Medicare? _____

Does the provider have a current, valid and active Medicare participating PTAN number? _____

If yes, please indicate participating individual PTAN number: _____

Hospital Privileges

Hospital _____

Appointment Date _____ Staff Category _____

PROVIDER CREDENTIALING APPLICATION

Education and Work History – Submit all applicable certificates and diplomas.

Please attach your Curriculum Vitae with Education details and work history in Month/Year format addressing all gaps in leading to the time of this application submission.

Professional Liability Insurance – Submit copy with coverage amounts

Carrier _____ Policy Number _____ Coverage End Date _____

Practice Information

Group Name _____ Phone _____

Tax ID_____ Group NPI _____

Physical Address _____

Mailing Address (if different) _____

Billing Address (if different) _____

Primary Practice Contact _____ Phone _____ Email _____

Fax Referral Number_____

Billing Contact _____ Phone _____ Email_____

Email address for Provider Notices/Additional info _____

_____

Practitioner Rights Notification

Providers have the right to review information submitted on this form and to correct or update information. Please contact the Provider Relations Department at providerrelations@netcarelifeandhealth.com.

Additional Documents to Submit: Please see *Credentialing Application Checklist* attached to this application. This is also available under Provider Resources at netcarelifeandheath.com.

PROVIDER CREDENTIALING APPLICATION

A written explanation is required for any question(s) answered "YES." Please provide the explanation on a separate sheet. If you do not provide the information, your application may be denied for non-compliance.

1. Has your license to practice medicine in any jurisdiction been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, otherwise limited or restricted, or been made subject to a program of probation, or have you been issued a citation or letter of reprimand by the licensing agency, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced in the last three years?	☐Y ☐N
2. Has your medical staff membership or medical status at any hospital or comparable facility, been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care of professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced in the last three years?	☐Y ☐N
3. Have your admitting or clinical privilege(s) at any other hospital, or at any comparable acute or long term care facility, or ambulatory surgery center or comparable facility, been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care of professional conduct reasons, or have formal or informal proceedings, or investigations toward any of those ends ever been commenced in the last three years?	☐Y ☐N
4. Have you voluntarily or involuntarily relinquished medical staff membership or status, admitting or clinical privileges, withdrawn an application for membership or privileges at any hospital or comparable acute or long term care facility, or ambulatory surgery center or comparable facility, after notification of the acute or imminent commencement of a formal or informal review, or investigations of your practice, credentials or professional conduct in the last three years?	☐Y ☐N
5. Has your membership, participation, privileges, contractual affiliation or other status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization or any other comparable health care entity been denied, revoked, voluntarily or involuntarily terminated, suspended, restricted or limited based upon patient care of professional conduct grounds, or have formal or informal proceedings, or investigations toward any of those ends been commenced in the last three years?	☐Y ☐N
6. Have you voluntarily or involuntarily relinquished membership, participation, privileges, a contractual affiliation or other comparable status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization or any other comparable health care entity after notification of the actual or imminent commencement of a formal or informal review or investigation, of your practice or professional conduct in the last three years?	☐Y ☐N

PROVIDER CREDENTIALING APPLICATION

7. Has your membership or status in any state or local professional society or other comparable medical organization been denied, revoked, voluntarily or involuntarily terminated, suspended or restricted based upon patient care of professional conduct concerns, or have formal or informal proceedings, or investigations toward any of those ends been commenced in the last three years?	☐Y ☐N
8. Has your status as a participating provider in the Medicare, Medicaid, or TRICARE programs been sanctioned, denied, suspended, voluntarily or involuntarily terminated, limited or revoked, or have formal or informal proceedings, or investigations toward any of those ends been commenced in the last three years?	☐Y ☐N
9. Has a letter of concern or reprimand been issued to you?	☐Y ☐N
10. Have you been denied professional liability insurance or has your policy been canceled in the last three years?	☐Y ☐N
11. (a) Have you been named in a complaint based on allegations of professional negligence or professional misconduct or have your received notice of intent to commence litigation of that type in the last three years?	☐Y ☐N
(b) With regard to any suit, has it resulted in judgment, settlement or other final disposition, or is it still pending?	☐Y ☐N
12. Does your professional liability coverage exclude you from performing any specific procedure(s) or practicing portions of your specialty for which you are requesting privileges?	☐Y ☐N
13. Has your specialty board certification or eligibility been denied, revoked voluntarily involuntarily terminated, suspended, or have formal or informal proceedings or investigations toward any of these ends been commenced in the last three years?	☐Y ☐N
14. Has your drug enforcement agency or other controlled substances authorization been denied, revoked, voluntarily or involuntarily terminated, suspended or restricted or have formal or informal proceedings, or investigations toward any of those ends been commenced in the last three years?	☐Y ☐N
15. Have you been convicted of a criminal offense (other than a minor traffic violation, felony, fraud, narcotics offense, moral or any type of ethical crime in the last three years?	☐Y ☐N

PROVIDER CREDENTIALING APPLICATION

16. Are you now or have been addicted to a controlled substance of alcohol in the past three years? If the answer is yes, please provide the name, address, and full description of any rehabilitation program in which you are now participating or in which you have participated as well as the name and title of the individual who can describe your care and participation in that program.	☐Y ☐N
17. Do you have any mental or physical impairment or disability that could, without reasonable accommodation, that may significantly affect your ability to practice medicine or provide care to accepted standards of professional performance or poses a threat to the health or safety of your patients?	☐Y ☐N

ATTESTATION & RELEASE

I attest to the fact that all the information submitted by me in this application is true and accurate to the best of my knowledge and belief.

I authorize NetCare Life and Health Insurance Co., it's professional staff and legal representatives for the purpose of evaluating my professional competence, character, criminal history and ethical conduct, to contact and consult with administrators and members institution, professional society, school, employer, law enforcement agency, or practice with which I have been associated. In addition, I consent to the inspection by NetCare Life and Health Insurance Co., it's professional staff and legal representatives of all records and documents, including health records and documents, including health records at other treatment facilities that may be material for evaluation of my professional qualifications. I also release from liability all individuals or organizations for their acts performed in good faith and without malice that initiate and respond to the inquires authorized for use by NetCare Life and Health Insurance Co. I agree that a photocopy of this authorization be accepted with the same authority as the original.

Signature _____ Date _____