MEDEX
PRACTICE SOLUTIONS

Provider Documents needed for Enrollments

Last Name: _____ **First Name:** _____ **DO / MD / Other**_____

- ☐ **Current Medical License – need pocket copy with local address**
- ☐ **Current DEA Registration Certificate – must have local address**
- ☐ **Malpractice Liability Insurance Certificate - current**
- ☐ **Medical School Diploma**
- ☐ **Internship Diploma/Certification (if applicable)**
- ☐ **Residency Diploma/Certification (if applicable)**
- ☐ **Fellowship Diploma/Certification (if applicable)**
- ☐ **Board Certification Certificate**
- ☐ **Driver's License – current**
- ☐ **ECFMG (if applicable)**
- ☐ **Copies of any lawsuit/malpractice claim paperwork**
- ☐ **Updated CV**
  - **Month/Year (for both start dates and end dates) for all employment and education sections. Any gaps of more than 6 months or more must be explained.**

MEDEX
PRACTICE SOLUTIONS

PROVIDER INFORMATION SHEET

Provider Full Name/Title:							
Provider Specialties:							
Provider NPI:							
Provider Start Date:							
Do you see Telemed?		Video and Audio?		Just Audio?			
PERSONAL INFORMATION							
Date of Birth:		Place of Birth: City/State/Country		Gender:			
SSN:		Drivers License#		Drivers License State:			
Home Address:		Home City:		Home State/ZIP:			
Home Phone:		Cell Phone:		Personal Email:			
Any lawsuits pending? If yes, provide documentation		List foreign languages spoken:		Alternate Names:			
LICENSE/CERTIFICATION INFORMATION							
Medical License #		Date Issued:		Date Expires:			
DEA License #		Date Issued:		Date Expires:			
Malpractice Carrier Name:							
Malpractice Policy #		Date Issued:		Date Expires:			
Board Certification Entity:							
Board Certification #		Board Cert Date Issued:		Board Cert Date Expires:			
Board Specialty:		Board Eligible only? (Y/N)		If Y, when is exam?			
Supervising Physician: (midlevels only)		Supervising Physician NPI:		Have collaborating agreement?			
HOSPITAL AFFILIATIONS							
Hospital Name:		Hospital Address:		Hospital Phone/Fax:			
Can you admit here? If not, who admits for you?		Type of Privileges:		Effective date:			
Hospital Name:		Hospital Address:		Hospital Phone/Fax:			
Can you admit here? If not, who admits for you?		Type of Privileges:		Effective date:			
Hospital Name:		Hospital Address:		Hospital Phone/Fax:			
Can you admit here? If not, who admits for you?		Type of Privileges:		Effective date:			
PROFESSIONAL REFERENCES							
Reference Name:		Specialty:		Specialty Degree:			
Address:		Phone:		Email:			
Reference Name:		Specialty:		Specialty Degree:			
Address:		Phone:		Email:			
Reference Name:		Specialty:		Reference Degree:			
Address:		Phone:		Email:			
PORTAL ACCESS INFORMATION							
CAQH User Name:		CAQH Password:		CAQH ID:			
PECOS User Name: (Medicare)		PECOS Password:		PECOS MFA Access Added?:			
PAVE User Name: (Medi-Cal)		PAVE Password:		PAVE Recovery Email Added?:			
Medicaid User Name: (AZ/NV only)		Medicaid Password:		Medicaid ID:			

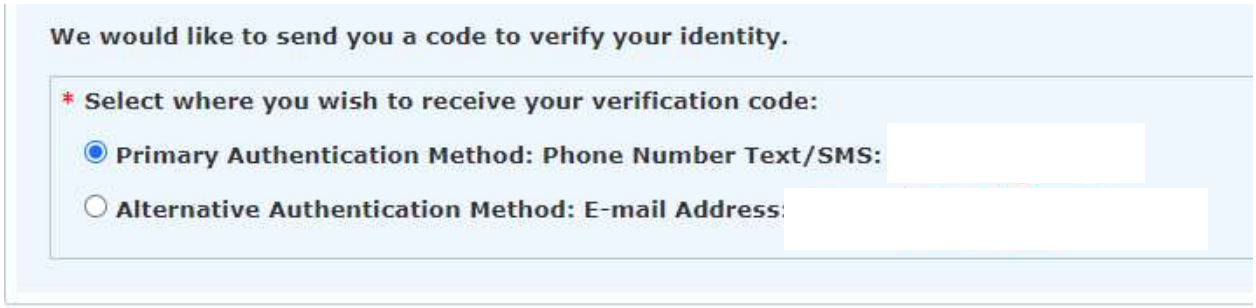
CMS Centers for Medicare & Medicaid Services

Identity & Access Management System

MFA Steps

Step 1 – Login to I&A at https://nppes.cms.hhs.gov/IAWeb/login.do

Step 2 – Click Reset MFA



Step 3 – Complete User Information on the right side

Step 4 – It will send a code to the provider's email or phone. The next screen will allow you to ADD another MFA contact. Choose Email and enter my email aaron.medexps@gmail.com and save it. Once that is done let me know and I will go in and make sure it is done correctly.

Section 8

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

Allied Health Providers

If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".

Disclosure Questions

LICENSURE

1. ◯ YES ◯ NO Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?*

2. ◯ YES ◯ NO Has there been any challenge to your licensure, registration or certification?*

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. ◯ YES ◯ NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*

4. ◯ YES ◯ NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*

5. ◯ YES ◯ NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*

EDUCATION, TRAINING AND BOARD CERTIFICATION

6. ◯ YES ◯ NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*

7. ◯ YES ◯ NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*

8. ◯ YES ◯ NO Have any of your board certifications or eligibility ever been revoked?*

9. ◯ YES ◯ NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

10. ◯ YES ◯ NO Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

11. ◯ YES ◯ NO Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*

OTHER SANCTIONS OR INVESTIGATIONS

12. ◯ YES ◯ NO Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*

13. ◯ YES ◯ NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*

14. ◯ YES ◯ NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CUA, OSHA, etc.)?*

15. ◯ YES ◯ NO Have you ever been convicted of, pied guilty to, pied nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*

16. ◯ YES ◯ NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. ◯ YES ◯ NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*

18. ◯ YES ◯ NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

Disclosure Questions (Continued)

Section 8
Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

IMPORTANT
If you answered "Yes" to **question #19,** you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.

MALPRACTICE CLAIMS HISTORY

19. ◯ YES ◯ NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?* If yes, provide information for each case.

CRIMINAL/CIVIL HISTORY

20. ◯ YES ◯ NO Have you ever been convicted of, pied guilty to, or pied nolo contendere to any felony?*

21. ◯ YES ◯ NO In the past ten years have you been convicted of, pied guilty to, or pied nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*

22. ◯ YES ◯ NO Have you ever been court-martialed for actions related to your duties as a medical professional?*

Note: A criminal record **will** not necessarily be a bar to acceptance. Decisions **will** be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.

ABILITY TO PERFORM JOB

23. ◯ YES ◯ NO Are you currently engaged in the illegal use of drugs?*

("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

24. ◯ YES ◯ NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*

25. ◯ YES ◯ NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*

26. ◯ YES ◯ NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

_____ _____

Signature* Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

CAQH ID:_____

3094 DOB: _____ ST License: _____