

## PROVIDER CREDENTIALING APPLICATION

<b>First Name</b>		<b>Initial</b>	<b>Last Name</b>		<b>Suffix</b>
<b>Sex</b>	<b>DOB</b>	<b>Degree</b>	<b>Languages</b>		
<b>Medical License# &amp; State</b>			<b>Expiration Date</b>	<b>TIN #</b>	<b>SS#</b>
<b>DEA#</b>			<b>Expiration Date</b>	<b>CDS #</b>	<b>Expiration Date</b>

**PRIMARY OFFICE**

<b>Group Name</b>					
<b>Address</b>					
<b>City</b>		<b>State</b>	<b>Zip</b>	<b>County</b>	
<b>Phone Number</b>		<b>Extension</b>		<b>Fax Number</b>	<b>Email Address</b>
<b>Billing Name (if different)</b>					
<b>Billing Address</b>					
<b>City</b>		<b>State</b>	<b>ZIP</b>		
<b>Phone Number</b>				<b>Fax Number</b>	

**SECONDARY OFFICE**

<b>Group Name</b>			
<b>Address</b>			
<b>City</b>	<b>State</b>	<b>Zip</b>	<b>County</b>
<b>Phone Number</b>			<b>Fax Number</b>
<b>Billing Name (if different)</b>			
<b>Billing Address</b>			
<b>City</b>	<b>State</b>	<b>ZIP</b>	
<b>Phone Number</b>			<b>Fax Number</b>

**AFFILIATIONS**

<b>Primary Specialty:</b>	
Board Certified <input type="checkbox"/> YES <input type="checkbox"/> NO	Board Eligible <input type="checkbox"/> YES <input type="checkbox"/>
<b>Secondary Specialty:</b>	
Board Certified <input type="checkbox"/> YES <input type="checkbox"/> NO	Board Eligible <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Medicare:</b> <input type="checkbox"/> Participant <input type="checkbox"/> Non-participant <input type="checkbox"/> Opt out	
<b>Place of residency:</b>	<b>Date of attendance:</b>
<b>Hospital Affiliations including status (Full Admitting, Pending, Provisional, Etc.) :</b>	
<b>SurgiCenter Affiliations:</b>	

PLEASE USE ADDITIONAL SHEET IF NECESSARY

## MALPRACTICE INFORMATION

PROVIDER'S NAME \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Please supply the following information for each malpractice action (i.e. pending, settled, dropped, dismissed, litigated) you have had in the past ten (10) years. All information is strictly confidential. Failure to provide sufficient details will prevent your application from being approved. In most cases, full disclosure of the details will result in a prompt action on your application. Please print or type answers to each of the following questions in detail. If more than one (1) case exists, please photocopy this sheet for each case.

1. Date of Occurrence: \_\_\_\_\_ Carrier involved: \_\_\_\_\_

2. If damages were paid, either by settlement or court award, please indicate amount.

- Attributed to your involvement in the case? \$ \_\_\_\_\_
- Paid by all parties? \$ \_\_\_\_\_

3. Please indicate your status in the case?

\_\_\_\_ Primary Defendant      \_\_\_\_ Co-Defendant  
\_\_\_\_ Other

4. Please indicate the status of case?

\_\_\_\_ Dropped      \_\_\_\_ Found for Defendant      \_\_\_\_ Dismissed  
\_\_\_\_ Pending      \_\_\_\_ Found for Plaintiff      \_\_\_\_ Settled out-of-court

If pending, please indicate last contact with Plaintiff's attorney? \_\_\_\_\_  
What is the likely outcome? \_\_\_\_\_

5. Explain, in detail, the circumstances of the case and attach additional pages, if necessary.

- A. What were the circumstances of the patient's illness and the contributing diagnosis? What were your recommendations, evaluations, and/or treatments?
- B. What was the alleged harm to the patient?
- C. What were you alleged to have done incorrectly or failed to have done correctly?
- D. Please list any other details you feel were pertinent to the case:
- E. 1.) Were you the attending physician?      YES              NO  
2.) Were other parties named in the suite? (If Yes, please note)

## PROVIDER CREDENTIALING WARRANTY

I agree that The Health Care Payers Coalition of NJ may use the information that I have provided and this credentialing warranty for credentialing purposes.

**The credentialing information that I have provided, including documents, contains detailed and specific information relating to my character and professional competence. By my signature below, I**

- (a) Warrant that all of the information that I have provided and the responses I have given in those documents are correct and complete to the best of my knowledge and belief, and
- (b) Understand that if this application contains (i) any material omissions, or (ii) false or misleading information, my participation with The Health Care Payers Coalition of NJ may be terminated; and
- (c) Agree to notify The Health Care Payers Coalition of NJ immediately in the event there are any changes to any of the information I have provided on this application.
- (d) Agree that termination of this agreement may be made by either party with 120 days written notice.

I also hereby authorize and request all individuals and institutions to promptly reply to all requests from The Health Care Payers Coalition of NJ for information or verification of information as described above. I release from any and all liability, all individuals and institutions furnishing such information to HCPC, their respective agents, employees, and representatives, provided the information are given in good faith and without malice.

I release HCPC, their respective agents, employees, and representatives of and from any liability for disclosing any such information, which is provided in good faith and without malice.

I authorize HCPC to use this information provided in their selection, credentialing process, and to verify such information as appropriate.

I agree that a copy of my signature below may be relied upon by any person or entity receiving a copy of this authorization, and that for so long as I am a participant, or in the process of applying for participation status with HCPC, this authorization shall be irrevocable and binding upon me, and may be relied upon by any and all persons and institutions receiving a copy hereof. Notwithstanding the foregoing, I will promptly execute at any time upon request of HCPC any authorization and release form provided to me by HCPC to be delivered to such third parties as HCPC deems appropriate as part of the credentialing or peer review process.

Signed \_\_\_\_\_  
Printed Name \_\_\_\_\_  
Date \_\_\_\_\_

## PROVIDER CREDENTIALING APPLICATION

### **Please submit copies of the following documents with your application:**

- All current State Medical Licenses
- Board Certification
- Current State CDS Certificate (if applicable)
- Current Federal DEA Certificate
- Current professional liability coverage face sheet indicating company name, coverage amounts and expiration date
- Curriculum Vitae
- Letter(s) stating your hospital privileges
- W-9 Form
- Two (2) signed Physician Reimbursement Agreements (if applicable)

### **Please send all information to the following address:**

The Health Care Payers Coalition of New Jersey  
Raritan Plaza II  
P.O. Box 6858  
Edison, NJ 08818-6858

**INCOMPLETE APPLICATIONS AND/OR MISSING INFORMATION  
WILL DELAY THE PROCESSING OF YOUR APPLICATION**