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 sub

INSTRUCTIONS

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

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

_____

_____

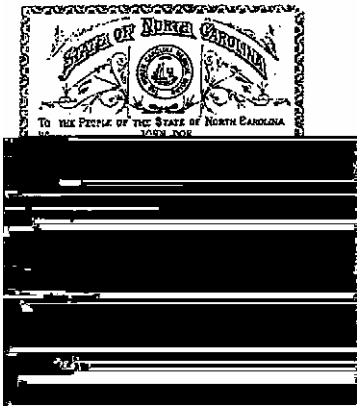
_____

if required.

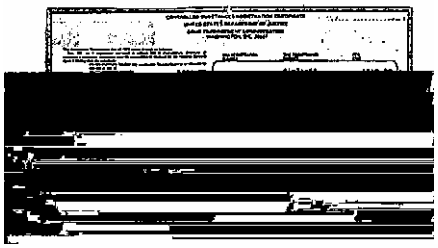
(CV must account for any gaps of 90 days or more).

Examples of documentation to attach to this application:

Original N.C. License

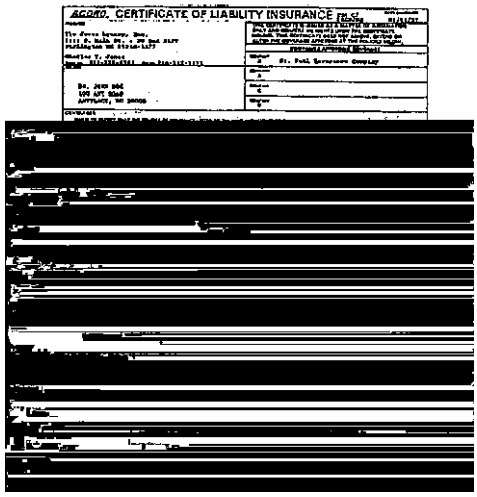


DEA Registration

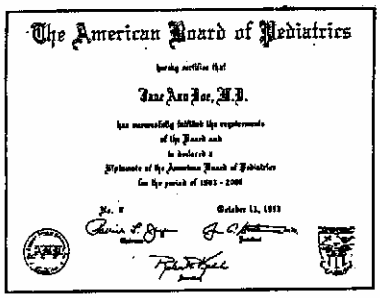


Medical Board Registration

Certificate of Insurance



Board Certification



A. DEMOGRAPHIC AND PERSONAL DATA:

1.	**Name of Applicant:**

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

3. **Type of Practice:** **Primary Care:**

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

Additional Office Address or Billing Address, if different (check one) ☐ **Billing** ☐ **Office**						
Name:						
Address:						
Handicapped Accessible? YES ☐ **NO** ☐ **Office Phone:** **Fax:**						
Accepting New Patients? YES ☐ **NO** ☐ **Restrictions:**						
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:**

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:**

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

COMPLETE ONLY IF LICENSED IN SOUTH CAROLINA

1. **Medical, Dental, or other Professional School Attended:**

:		

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

2. **Internship**

:		

3. **Residency**

:		

4. **Other Residency / Fellowship – (specify)**

:		

B. EDUCATION AND PRACTICE HISTORY (Continued)

5. List work history since beginning

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.

	If yes, please complete Supplemental Question No. 1	**Y** ☐	**N** ☐
	If yes, please complete Supplemental Question No.2	**Y** ☐	**N** ☐
	If yes, please complete Supplemental Question No.3	**Y** ☐	**N** ☐
	If yes, please complete Supplemental Question No.4	**Y** ☐	**N** ☐
	(If yes, please complete Supplemental Question No.5	**Y** ☐	**N** ☐
	If yes, please complete Supplemental Question No.6	**Y** ☐	**N** ☐
	If yes, please complete Supplemental Question No.7	**Y** ☐	**N** ☐

SUPPLEMENTAL FORM

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

1. License Limited, Reprimanded, etc.

2. Employment/Membership Suspended, Limited, etc.

3. Drug Enforcement Agency (DEA) Explanation.

SUPPLEMENTAL FORM

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

4. Medicare/Medicaid Sanction Disciplinary Action(s)

5. National Practitioner Data Bank Report(s)

if you have a copy please attach):

6. Felony or Misdemeanor

☐ ☐	☐ ☐ ☐ ☐ ☐ ☐

SUPPLEMENTAL FORM

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

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

8. Cancelled, Refused Coverage, etc.

9. Practiced Without Liability Coverage

SUPPLEMENTAL FORM

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

10. Medical, Chemical Dependency, or Psychiatric Conditions

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

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