

North Carolina Department of Insurance

Uniform Application To Participate as a Health Care Practitioner

Note: Please send completed applications <u>directly</u> 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:

Include an answer in all spaces. Indicate "N/A", if the question is not applicable.

The provider has signed and dated the last page of the Application.

Before submitting the Application, make sure you have <u>enclosed</u> the following, <u>if applicable:</u>

Copy of the provider's original state(s) license(s) and current registration.

Copy of current DEA certificate. (Must have a valid date and refer to current address.)

Copy of South Carolina Controlled Drug Substance Certificate and DEA information.

Copy of the face sheet of your <u>current</u> professional liability insurance policy, indicating by name, provider(s) covered, coverage amounts, effective date, expiration date, and policy number. Attach previous carrier face sheet.

Proof of professional liability insurance for non-physician providers who care for patients in your practice.

Copy of certificate from the Specialty Board.

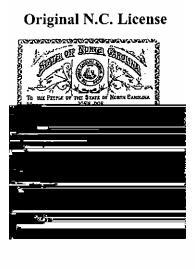
Copy of Educational Commission of Foreign Medical Graduate Certificate- ECFMG.

Letter(s) of reference, recommendation, and/or oversight, if required.

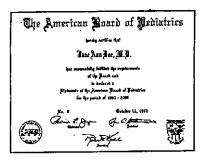
Copy of Curriculum Vitae or work history after graduation from Medical, Dental or other professional school (CV must account for any gaps of 90 days or more).

Copy of CLIA (Clinical Laboratory Improvement Amendments) /ACR (American College of Radiology). Copy of W-9 Form.

Examples of documentation to attach to this application:



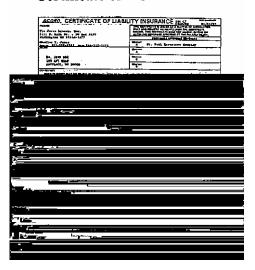
Board Certification



DEA Registration



Certificate of Insurance



Medical Board Registration

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<u> </u>	-	
-		S.

Name of Applicant:			
(Last Name)	(First Name)	(Middle Name)	(Maiden)
	DI ADI A		
Date of Birth: xx/xx/xxxx	Place of Birth	:	
Social Security Number: XXX-XXXXX	Sex: Mal	e	

3. Type of Practice: Primary Care:

A.	DEMOGRAI	PHIC AND P	ERSONAL D	ATA (Conti	inued)		
	Additional Office Address or Billing Address, if different (check one) Billing Office						
	Name:						
	Address:						
	(Street)			(City)	(Cour	nty) (State)	(Zip)
	Handicapped A			Office Phone: xx	x-xxx-xxxx/xxxx	Fax: xxx-xxx-	xxxx/xxxx
	Accepting New	Patients? YES		Restrictions: (Please list or indica	te none)		
	Office Hours:	I	T	I	T =	I a	Ια ,
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
				•			
6.	Name other pro	vider(s) in your p	ractice (if not eno	ugh space, please	attach additional sh	neet):	
7.	patients in your	practice?	YES NO]	rs, or other non-phy loyment for those indivi		ovide care to
8.	Name and addr	ess of provider(s)	who share call wi	th you (if not eno Name:	ugh space, please at	tach additional she	et):
	Name.			Name.			
	Address:			Address:			
				I			
9.	Arrangements f	for 24 hour/7 day	coverage:				
							,
10.	Administrative	Contact: (Name)		ſ	Title)		x-xxx-xxx/xxxx elephone)
		(110110)		((,	G OPTION 109
11.	IRS requires rei	imbursement be n	nade payable to na	ame of practice a	ffiliated with Federa	d Tax ID Number:	
	Federal Tax ID	Number:					
	Name (if differe	nt from practice i	name):				
	Billing Address	(if different from	practice address)	:			
			<u>, </u>				
12.	UPIN Number:			Medicare/Medic	aid Number:	/	
	National Provid	ler Identifier (NPI	():				
	L						
13.	DEA Number:	/Attack		F	Exp. Date:		
		(Attach copy to appli	cation)				

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

COMPLETE ONLY IF LICENSED IN SOUTH CAROLINA

SC Controlled Drug Substance Certificate:

Expiration Date:

(Attach a copy to application)

Medical, Dental, or other Professional	School Attended:		
Institution:			
Address:			
(Street)	(City)		(State) (Zip)
Degree:		From: xx/xx/xxxx	To: xx/xx/xxx
Please attach Educational Commission	n of Foreign Medical Graduate Ce	rtificate – (ECFMG), if applic	cable.
Tatama Pa			
<u>Internship</u>			
Institution:			
Address:			
(Street)	(City)		State) (Zip)
Specialty:		From: xx/xx/xxxx	To: xx/xx/xxx
Residency			
Institution:			
Address:			
(Street)	(City)	(:	State) (Zip)
Specialty:		From: xx/xx/xxxx	To: xx/xx/xxx
Other Residency / Fellowship – (specif	<u>fy)</u>		
Institution:			
Institution: Address:			
	(City)	((State) (Zip)

xx 1.6 6 61.636w(8()36wwwjn3.5()75 119.940195.48 B.w[EDUCATION AND PRACTI6 775(CE HISTORY()-7.54436w().4())0.70

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 <u>please sign and date this application</u>. If this application does not have <u>the provider's signature</u>, it cannot be accepted.

1.	Has your license to practice in any jurisdiction ever been limited, restricted, reduced, suspended, voluntarily surrendered, revoked, denied or not renewed; have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license; are you under investigation by any licensing or regulatory agency? (If yes, please complete Supplemental Question No. 1.)	Y 🗆	N 🗆
2.	Has your professional employment or membership in a professional organization ever been subject to disciplinary proceedings, denied, limited, restricted, reduced, suspended, revoked, not renewed, or voluntarily relinquished during or under threat of termination for any reason? (<i>If yes, please complete Supplemental Question No.2.</i>)	Y	N 🗆
3.	Has your Drug Enforcement Agency registration or other controlled substance authorization ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your registration during or under the threat of an investigation or are any such actions pending? (If yes, please complete Supplemental Question No.3.)	Y	N 🗆
4.	Have you ever been sanctioned or suspended by Medicare or Medicaid? (If yes, please complete Supplemental Question No.4.)	Y 🗆	N 🗆
5.	To your knowledge, have you ever been reported to the National Practitioner Data Bank or the North/South Carolina Board of Medical Examiners? (If yes, please complete Supplemental Question No.5.)	Y 🗆	N 🗆
6.	Have you ever been convicted of a felony or misdemeanor, or are you under investigation with respect to such conduct? (If yes, please complete Supplemental Question No.6.)	Y 🗆	N 🗆
7.	Has a professional liability claim been assessed against you in the past five years, or are there any professional liability cases pending against you? (If yes, please complete Supplemental Question No.7.)	Y 🗌	N 🗆

Provider Name:	Provider ID#
	(if applicable)
1. License Limited, Reprimanded, etc.	
List Ctata(s) where action took places	
List State(s) where action took place:	
Date(s) License revoked, suspended, etc. From xx/xx/xxxx To xx/xx	/xxxx
Disconnection	
Please explain:	
2. Employment/Membership Suspended, Limited, etc.	
List State(a) where action took place:	
List State(s) where action took place:	
List Professional Organization:	
Please explain:	
3. Drug Enforcement Agency (DEA) Explanation.	
List State(s) where action took place:	
List state(s) where action took place.	
Please explain:	

Provider Name:	Provider ID#
	(if applicable)
A M. J. m. /M. J. mid Constion Disciplinam, Action(a)	
4. Medicare/Medicaid Sanction Disciplinary Action(s)	
Disciplined Action(s):	
List State(s):	
Date(s) of action. From xx/xx/xxxx To xx/xx/xxxx	
Please explain:	
Hease explain:	
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5. National Practitioner Data Bank Report(s)	
Please explain the NPDB report (if you have a copy please attach):	
	l
	l
6. Felony or Misdemeanor	
Did you serve a sentence: Y ☐ N ☐ If YES, check how many years: 1 ☐	2 3 4 5 6 Other:
List State(s):	
Please explain charge and verdict:	

Provider Name:	Provider ID#
	(if applicable)
7. Named in Professional Liability Judg	gment, Settlement, etc.
Please explain, include dates & amounts:	
8. Cancelled, Refused Coverage, etc.	
Please list Insurance Carrier(s):	
Please explain:	
9. Practiced Without Liability Coverage	?
Please explain:	

Provider Name:		Provider ID#	
		(if applicable)	
10. Medical, Chemical Dependen	ncy, or Psychiatric (Conditions	
Please explain in detail:			
11. Hospital or Clinic Privileges	Revoked, Restricted	l, etc.	
List Hospital(s):			
Date privileges revoked, suspended, etc.	From xx/xx/xxxx	To xx/xx/xxxx	
Please explain:			

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

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below.