New Jersey Universal Physician Application

(Please type or print)

SECTION 1

Personal Information

Physician Name (Last) (First) (MI) (Jr., Sr., etc.)	Professional Degree(s) *(MD, DO, DDS, DMD, DPM, DC)*	Social Security Number

Home Mailing Address	City	

Group/Corporate Name *(as it appears on W-9)*, if different from Group

Tax ID Number and Associated Individual Group Number and Name for This Location			
Are you currently practicing at the above location? ☐ Yes ☐ No	If No, what is your expected start date?		
Other Office Street Address	City	State	Zip Code
Telephone No.	Fax No.	E-mail Address	
Do you want this site listed in the Directory? ☐ Yes ☐ No	Tax ID Number and Associated Individual Group Number and Name for This Location		
Other Office Street Address	City	State	Zip Code
Telephone No.	Fax No.	E-mail Address	
Do you want this site listed in the Directory? ☐ Yes ☐ No	Tax ID Number and Associated Individual Group Number and Name for This Location		
Correspondence Office Street Address	City	State	Zip Code
Telephone No.	Fax No.	E-mail Address	

If you have additional offices, please submit an attachment containing the above information and check this box: ☐

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

License and Other Identification Numbers

(License Information - Include all license(s) and certifications in all States where you are currently or have previously been licensed.)

Type	State(s) of Registration	Do You Currently Practice In This State?	License/Certificate Number	Expiration Date	N/A
License		☐ Yes ☐ No			
License		☐ Yes ☐ No			
DEA Registration Certificate		☐ Yes ☐ No			
CDS Registration Certificate		☐ Yes ☐ No			
Other (CDS/DEA) (Specify)		☐ Yes ☐ No			

UPIN	National Provider ID (when available)	Are you a participating Medicare Provider?	Medicare Provider No.	Are you a participating Medicaid Provider?	Medicaid Provider No.

International Medical Graduates: Are you certified by the Educational Council for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No	If yes, ECFMG Number	ECFMG Issue Date

Medical Education

School Issuing Professional Degree (Medical, Dental, Chiropractic)	Degree	Attendance Dates	
Address	City	State/Country	Zip Code

If you have attended additional schools, please submit an attachment containing the above information and check this box: ☐

Post-Graduate Education ☐ Internship ☐ Fellowship ☐ Residency ☐ Teaching Appointment	Institution Name		
Address	City	State	Zip Code
Specialty	Start Date (Month/Year)	End Date (Month/Year)	

Post-Graduate Education ☐ Internship ☐ Fellowship ☐ Residency ☐ Teaching Appointment	Institution Name		
Address	City	State	Zip Code
Specialty	Start Date (Month/Year)	End Date (Month/Year)	

Post-Graduate Education ☐ Internship ☐ Fellowship ☐ Residency ☐ Teaching Appointment	Institution Name		
Address	City	State	Zip Code
Specialty	Start Date (Month/Year)	End Date (Month/Year)	

If you completed additional training, please submit an attachment containing the above information and check this box: ☐

Other Graduate Level Education for Which a Degree Was Obtained - Type of Program (Psychology, Public Health, MBA, etc.)	Institution Name		
Address	City	State	Zip Code
Degree Obtained	Date of Graduation (Month/Year)		

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Professional/Medical Specialty Information		
Primary Specialty	Board Certified? ☐ Yes ☐ No	Name of Certifying Board
Initial Certification Date	Recertification Date (s) *(if applicable)*	Expiration Date *(if applicable)*

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Professional Liability Insurance Coverage

Are you self-insured? ☐ Yes ☐ No

Name of Current Malpractice Insurance Carrier or Self-Insured Entity		Telephone Number	Effective Date		Expiration Date
Address		City		State	Zip Code
Policy Number	Amount of Coverage per Occurrence	Amount of Coverage Aggregate	Type of Coverage ☐ Individual ☐ Shared		Length of Time with Carrier
Name of Previous Malpractice Insurance Carrier or Self-Insured Entity		Telephone Number	Effective Date		Expiration Date
Address		City		State	Zip Code
Policy Number	Amount of Coverage per Occurrence	Amount of Coverage Aggregate	Type of Coverage ☐ Individual ☐ Shared		Length of Time with Carrier

Status/Role in Practice

☐ Owner ☐ Partner ☐ Employee ☐ Officer ☐ Shareholder

Interests in Outside Clinical Lab(s)

If you own/co-own, or have interests in any other outside clinical lab, please fill in below:

Legal Billing Name	TIN (Attach copy of W-9)	Clinical Description

Please provide a summary pattern for this business:

Office Coverage

List names of colleague(s) providing regular coverage and his/her specialty(ies).

Name	Provider Specialty

Partners

List full names of all partners in your practice (attach list for large group).

Name (Last, First, MI)	Name (Last, First, MI)

Office Manager or Business Office Staff Contact: Name: Telephone No.:	Office Manager or Business Office Staff Contact: Name: Telephone No.:	

Other Practice Information (specify for each site)

(Continued from previous page.)

Site 1, Continued			Site 2, Continued		
Do you accept new patients into the practice?	☐Yes	☐No	Do you accept new patients into the practice?	☐Yes	☐No
-All new patients?.....	☐Yes	☐No	-All new patients?.....	☐Yes	☐No
-Existing patients with change of payor?.....	☐Yes	☐No	-Existing patients with change of payor?.....	☐Yes	☐No
-New patients from physician referral?.....	☐Yes	☐No	-New patients from physician referral?.....	☐Yes	☐No
-New Medicare patients?	☐Yes	☐No	-New Medicare patients?	☐Yes	☐No
-New Medicaid patients?.....	☐Yes	☐No	-New Medicaid patients?.....	☐Yes	☐No
If this information varies by health plan, provide explanation:			If this information varies by health plan, provide explanation:		
			No		

Other Practice Information (specify for each site)

Patient Scheduling

What is patient wait time for emergency care? .....
What is patient wait time for urgent care? .....
What is patient wait time for symptomatic care? .....
What is patient wait time for scheduling routine visits? .....
What is patient wait time for scheduling routine care? .....
What is average wait time for patients between waiting room and examination?
What is average wait time in minutes for returning a patient's call? .....

Required Attachments or Supplemental Information

Please attach hard copy or scanned documents of the following:

- Copy(ies) of DEA registration certificate(s)
- Copy of state Controlled Dangerous Substance (CDS) registration certificate(s)
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and provider's name
- Copy(ies) of W-9(s) for verification of each tax identification number used
- Copy of workers compensation certificate of coverage, if applicable

SECTION 2 - DISCLOSURE QUESTIONS

Please answer each question and include an explanation for any question answered "Yes."

Licensure

1. Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation or have you ever been subject to a consent order, probation or any conditions?

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Ability to Perform Job

23. 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.) ☐ Yes ☐ No

24. 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? ☐ Yes ☐ No

25. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients? ☐ Yes ☐ No

26. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? ☐ Yes ☐ No

Please provide information below for Malpractice Actions indicated for Disclosure Question #19.

Date of occurrence: _____

Date claim was filed: _____

Claim/case status: _____

_____

Professional liability carrier involved: _____

Address: _____

Telephone Number: _____

Policy Number: _____

Amount of award or settlement and amount paid: _____

Method of resolution: ☐Dismissed ☐Settled (with prejudice) ☐Settled (without prejudice)
☐Judgment for defendant(s) ☐Judgment for plaintiff(s) ☐Mediation or arbitration

Description of allegations: _____

_____

_____

_____

Were you primary defendant or co-defendant? _____

Number of other co-defendants: _____

Your involvement in case (attending, consulting, etc.): _____

Description of alleged injury to the patient: _____

_____

_____

_____

To the best of your knowledge, is this case included in the National Practitioner Data Bank (NPDB)? ☐Yes ☐No

NEW JERSEY UNIVERSAL PHYSICIAN APPLICATION (Continued)

Please provide information below for any Disclosure Questions in Section II answered "Yes."	
Question No.	Explanation

Provider Initials: _____ Date: _____

SECTION 3 - AUTHORIZATION,