State of West Virginia
Credentialing Form

Responses must be legible. Any response, which cannot be completed in the space provided, may be included on

2. Office Practice Information

If you have more than one office site or more than one billing address or entity, please make a photocopy of this section before completing it and provide information for each site or billing entity (i.e., multiple tax identifiers), as needed. Indicate below whether the office is the primary or an additional site. (NOTE: Only one primary site should be designated.)

☐ Primary Office Site # 1	☐ Additional Office Site #

Group/Practice Name		
Type of Practice	☐ Individual ☐ Partnership ☐ Group ☐ Corporation	☐ Hospital Based ☐ Teaching or Research ☐ Other (specify):

Address (Building, Street, Suite #)	City

State	Zip Code	County
Telephone Number	**Fax Number**	**Answering Service/After-Hours Number**
( ) -	( ) -	( ) -
Alternate Telephone Number	**Cell Phone Number**	**Beeper/Pager Number**
( ) -	( ) -	( ) -
E-Mail Address		**Long Range Beeper Number**
		( ) -
Medicare Number	**UPIN Number**	**Medicaid Number**

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Patient Population	
Do you limit the age of patients you treat?	**If yes, what ages do you treat?**
☐ Yes ☐ No	Minimum: Maximum:

Remittance/Billing Information (NOTE: Must match box 33 on HCFA/CMS 1500)			
Are all services payable to one practice or group name/address?	☐ Yes ☐ No		
Group/Practice Name (Check Payable To):			
Address (Building, Street, Suite #)	**City**	**State**	**Zip Code**

Billing Office Phone Number	**Billing Manager's Name**
( ) -	
Tax ID Number (must match W-9)	**Name affiliated with Tax ID Number (must match W-9)**

Business Interests	
Do you or your business entity own, operate, have an interest in, or participate in any medical enterprise or business?	☐ Yes ☐ No If yes, provide details on separate sheet.
Do you have a financial relationship with a hospital, clinical lab, nursing home, pharmacy, radiology lab, emergency room, or any other medical related organization?	☐ Yes ☐ No If yes, provide details on separate sheet.

Practice Classification

☐ Primary Care Physician (Family Practitioners, Internists, or Pediatricians who deliver primary health care services)

☐ Specialist Physician (Physicians other than primary care physicians in their designated clinical practice)

☐ Allied Health Professional (Licensed, certified, or registered non-physician Practitioners of direct patient care services)

☐ Dual Role (Serve as both a Primary Care Physician as well as a Specialist)

Directory Listing	
Should this office be listed in the directory?	**Should this office receive correspondence?**

☐

3. Medical/Professional Education:

(Attach copy of diploma. If international graduate, submit ECFMG Certificate.) If additional space is needed, please photocopy this page and attach. All time gaps greater than three (3) months must be accounted for in Section 11.

Name of School	Degree Received	Dates of Attendance (List Mo/Yr)	
		From:	To:
Street Address	**Phone # (if known)**	**Fax # (if known)**	**Graduation Date**
	( ) -	( ) -	
City	**State**	**Country**	**Zip Code**
Name of School	**Degree Received**	**Dates of Attendance (List Mo/Yr)**	
		From:	To:
Street Address	**Telephone # (if known)**	**Fax # (if known)**	**Graduation Date**
	( ) -	( ) -	
City	**State**	**Country**	**Zip Code**

4. Professional Training - Internship/Residency/Fellowship/Preceptorship/Other

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Training Institution	**Program**		
	☐ Internship ☐ Residency	☐ Fellowship ☐ Preceptorship	☐ Other:

Street Address	**City**

State	**Country**	**Zip Code**

Telephone # (if known)	**Fax # (if known)**

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8. Professional Peer References

Please list three (3) professional peer references who have personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others, and who will provide specific written comments on these and other relevant matters upon request. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you. These individuals must have acquired the requisite knowledge through observation of your professional practice over a reasonable period of time. At least one reference must be from the same specialty area, not formerly, currently or about to become associated with you in practice. At least one must be from an individual who has had organizational responsibility in a medical setting (e.g., Department Chair, Medical Director). If your training was completed

9. Hospital/Health Care Entity Affiliations (list current affiliation first)

☐ **Check here if entire section is not applicable to applicant.**

List **ALL** health care facilities at which you currently have, or have had, privileges. **Explain gaps greater than three (3) months in Section 11.**

Name of Current Primary Hospital Affiliation	Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number**		
( ) -	( ) -		
Department/Service	**Department Chair's Name**		
Staff Status	**# Admits/Month**	**Percent of time spent at facility**	
Restricted?	**Dates of Affiliation (Mo/Yr)**		
☐ Yes ☐ No If yes, explain:	From: To:		
Reason for leaving, if applicable			

Name of Affiliation/Hospital/Healthcare Entity	Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number**		
( ) -	( ) -		
Department/Service	**Department Chair's Name**		
Staff Status	**# Admits/Month**	**Percent of time spent at facility**	
Restricted?	**Dates of Affiliation (Mo/Yr)**		
☐ Yes ☐ No If yes, explain:	From: To:		
Reason for leaving, if applicable			

Staff Status	# Admits/Month	Percent of time spent at facility
Restricted?	**Dates of Affiliation (Mo/Yr)**	
☐ Yes ☐ No If yes, explain:	From: To:	
Reason for leaving, if applicable		

9. Additional Affiliations:

(Photocopy this page for additional affiliations)

Name of Affiliation/Hospital/Healthcare Entity	Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number**		
( ) -	( ) -		
Department/Service	**Department Chair's Name**		
Staff Status	**# Admits/Month**	**Percent of time spent at facility**	

Telephone Number	**Fax Number**		
( ) -	( ) -		
Department/Service	**Department Chair's Name**		
Staff Status	**# Admits/Month**	**Percent of time spent at facility**	
Restricted?	**Dates of Affiliation (Mo/Yr)**		
☐ Yes ☐ No If yes, explain:	From: To:		
Reason for leaving, if applicable			

10. Work History/Experience:

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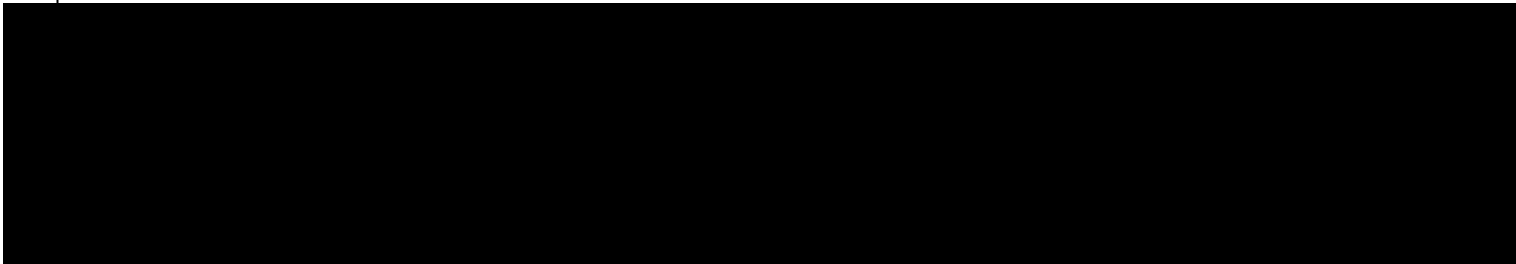
From: To:			
Reason for leaving, if applicable			
Practice/Employer	**Contact Name**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number (if known)**		
( ) -	( ) -		
Dates of Employment (Month/Year)	**Job Title or Type of Work Performed**		
From: To:			
Reason for leaving, if applicable			



Medical/Professional Education	From: To:	
	From: To:	
	From: To:	
	From: To:	
	From: To:	

14. Professional Liability Insurance Coverage:

Submit a copy of your current professional liability insurance coverage face sheet showing coverage in your practice specialty. Please list current and previous insurance carriers for the last ten (10) years in chronological order beginning with most current. (If additional space is needed, please photocopy this page and attach.)

Current Insurance Carrier	Telephone Number		
	( ) -		
Address	**City**	**State**	**Zip**

Coverage Effective Date	Coverage Termination Date	Amount of Coverage

15. Professional Liability Insurance Coverage Disclosure:

If the answer to any of these questions is yes, please provide a full explanation of the details of each and every matter on the attached Professional Liability Information Addendum. The explanation must include the name of the court in which the suit was filed, the caption and docket number of the case, and the name and address of the attorney defending you, and all other relevant details. Include suits TJ20.45ud3.7(e)8de suits TJt3age 16

16. Practice Disclosure Information

If the answer to any question below is yes, please provide a full explanation of the details on a separate sheet and attach.

Question			
A. Have any investigations been initiated or are any pending against you by any state licensure board, registration board, or regulatory agency?	☐ No	☐ Yes	
B. Has your license to practice in any state ever been voluntarily or involuntarily relinquished, restricted, denied, reduced, limited, suspended, placed on probation, revoked, or subject to any disciplinary action including reprimand?	☐ No	☐ Yes	
C. Have you ever been suspended, sanctioned, or otherwise restricted from participating or been the subject of an investigation in any private, federal, or state health insurance program (e.g., Medicare, Medicaid)?	☐ No	☐ Yes	
D. Has your narcotics (DEA) registration certificate (federal or state) ever been voluntarily or involuntarily relinquished, limited, suspended, not renewed, placed on probation, revoked, or challenged?	☐ No	☐ Yes	☐ NA
E. Have you ever been convicted of or plead no contest to any criminal (felony or misdemeanor) charges including a drug or alcohol-related offense or motor vehicle offenses, but not including minor traffic or parking violations? Are any such proceedings currently pending?	☐ No	☐ Yes	
F. Have you ever had an academic appointment denied, limited, revoked, suspended, reduced, placed on probation, not renewed, or other adverse action taken?	☐ No	☐ Yes	☐ NA
G. Have you ever been refused membership on the medical or allied health staff of any hospital or institution or been denied advancement in staff status?	☐ No	☐ Yes	☐ NA
H. Has your employment, medical staff status, appointment, reappointment, or clinical privileges, or scope of practice ever been voluntarily or involuntarily suspended, restricted, reduced, revoked, denied, relinquished, not been renewed or subjected to probationary conditions or limited at any hospital, managed care organization or other health care entity?	☐ No	☐ Yes	
I. Have you ever been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation, or otherwise sanctioned by any health care organization, including but not limited to, hospitals, HMOs, PPOs, IPAs, PHOs, professional associations or societies, professional standards review organization or peer review organizations, or any other health care facilities, based on professional competence?	☐ No	☐ Yes	
J. Have your ever withdrawn your application for appointment, reappointment or request for clinical privileges or resigned from the medical or allied health staff of a hospital, managed care organization, or other health care entity while under investigation or before a decision about your appointment or reappointment or clinical privileges was rendered by the governing board of any hospital, managed care organization or any other health care entity?	☐ No	☐ Yes	
K. Have you ever been allowed to resign your position or voluntarily relinquish specific clinical privileges rather than face any charge or investigation on the part of the medical staff of a hospital, managed care organization, or other health care entity?	☐ No	☐ Yes	
L. Are there currently pending adverse actions on your employment, medical staff appointment, reappointment, clinical privileges or scope of practice at any hospital, managed care organization, or other health care entity?	☐ No	☐ Yes	
M. Has any investigation (other than normal performance improvement reviews) involving your clinical practice, competence or professional conduct ever been initiated by any hospital, managed care organization, governmental agency, other health care entity, or branch of the armed forces?	☐ No	☐ Yes	
N. Has your request for any specific clinical privileges or scope of practice ever been denied (as a result of disciplinary action) or granted with stated limitations or conditions (aside from ordinary initial probationary requirements of proctorship)? Are such proceedings currently pending?	☐ No	☐ Yes	

ADDENDUM

VERIFICATION OF PROFESSIONAL LIABILITY

I, the undersigned, authorize my CURRENT professional liability insurance carrier,

____
(Enter Current Professional Liability Insurance Carrier Name)

____
(Enter Street Address) (City) (State & Zip)

to send verification of my professional liability coverage, to include dates of coverage, amounts of coverage, and any limitations in coverage, to ____ .
(Entity Specific)

____ is to hereinafter be
(Entity Specific)

a Certificate Holder and is to be notified of the amount of my coverage and any future changes in my insurance status, to include all information regarding claims history (but not necessarily limited to judgments entered, claims settled, cases and lawsuits pending), and any restriction regarding specific privileges which may be excluded from coverage.

I will notify ____ of any
(Entity Specific)

changes in Professional Liability carriers so that another Verification of Professional Liability form can be completed.

______________________________________ ______________________________
Practitioner's Signature Date

____
Printed Name

____
Policy Number

(Instructions: Please complete, sign, date and return to entity named above with your initial application.)