State of West Virginia
Recredentialing Form

Please complete each section thoroughly. Information submitted on the application should be representative of activity/information that occurred or changed on or after the Date of Last Credentialing listed below. Attach additional sheets where necessary. *(Indicate clearly the practitioner name and section on each attachment)* Type or print clearly in black ink. Sign and date the application.	
Date of Last Credentialing (may be obtained from Entity if not provided)	
Practitioner's Name	

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Responses must be legible. Any response, which cannot be completed in the space provided, may be included on supplementary sheets of paper and attached. DO NOT LEAVE ANY FIELDS BLANK. If an item is not applicable, indicate N/A. Please note you will be held responsible for all information or omissions in this application, regardless of whether such statements were prepared by you, an employee, agent or representative. For time gaps greater than three (3) months provide information in Section 11. After completion of the application, you may photocopy and then submit with a signed attestation to each entity to which you wish to apply.

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

State of West Virginia Recredentialing Form: Misrepresentation of any statements and information provided by you in support of this application shall be

Patient Population

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Back-up Coverage **(Please list the name, specialty, and telephone number of partner(s) or associate(s) or physician(s) covering your practice in your absence.)**			
Name	**Specialty**	**Partner, Associate, Or Covering**	**Telephone Number**
			( ) -
			( ) -

7. Specialty Board Certification:

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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)**		

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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 SINCE THE LAST CREDENTIALING DATE 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	If Umbrella/Excess coverage, amount of coverage
		$ million/occurrence $ million/aggregate	$

Policy Number	Type of Coverage		Do you have prior acts coverage?	
	☐ Claims Made	☐ Occurrence	☐ No	☐ Yes

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

Coverage Effective Date	Coverage Termination Date	Amount of Coverage	If Umbrella/Excess coverage, amount of coverage
		$ million/occurrence $ million/aggregate	$

Policy Number	Type of Coverage		Do you have prior acts coverage?	
	☐ Claims Made	☐ Occurrence	☐ No	☐ Yes

Previous Insurance Carrier	Telephone Number
	( ) -

15. Professional Liability Insurance Coverage Disclosure: (Respond only for actions since date of last credentialing.)

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 in which a judgment or settlement was made against a professional corporation of which you are/were a member, shareholder, or employee in any matter in which you were involved in the patient's care.

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ADDENDUM