Health Alliance℠
3310 Fields South Drive
Champaign, IL 61822
HealthAlliance.org

PARTICIPATING PROVIDER APPLICATION

Please note: Applications must be **complete, signed and dated**. Failure to complete this application in full and include all requested information will affect our ability to complete the credentialing process in a timely manner.

I. PERSONAL IDENTIFICATION DATA

Full Name _____ Maiden Name _____
Last First Middle

Any Other Name(s) You Have Used or Been Known By _____
Last First Middle

Social Security # _____ Tax ID # _____

NPI # _____ UPIN # _____

Birthdate _____ Birthplace _____

II. PRACTICE DATA

PROFESSIONAL DESIGNATION ❑ M.D. ❑ D.O. ❑ Ph.D. ❑ D.P.M. ❑ Other _____

Type of Practice: ❑ Solo ❑ Hospital-Based ❑ PHO/IPO ❑ Single-Specialty Group Practice
❑ Multi-Specialty Group Practice

SPECIALTY _____
(Your choice should reflect your primary practice and will determine how you are listed in our directory.)

LANGUAGE Please indicate whether you or a member of your staff is fluent in a foreign language.

Please specify language _____ ❑ Provider and/or ❑ Staff

Please specify language _____ ❑ Provider and/or ❑ Staff

PRIMARY OFFICE ADDRESS

Organization Name _____

Street _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ Office Hours _____

Office Contact _____

Names and Classification of Medical Employees _____

_____

OTHER OFFICE ADDRESS

Organization Name _____

Street _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____

III. PROFESSIONAL LIABILITY DATA*

NAME OF PRESENT INSURANCE CARRIER _____

Policy Number _____ Amount of Coverage Per Occurrence _____, Aggregate _____

Expiration Date _____ Limitations on Coverage, if any _____

*Any changes in malpractice limits or malpractice actions must be communicated to Health Alliance Medical Plans immediately.

IV. PRESENT INSTITUTIONAL AFFILIATIONS

List all current hospital affiliations.

Institution	Location	Dates	Active Staff	Courtesy Staff
Primary			[ ]	[ ]
Secondary			[ ]	[ ]
1.			[ ]	[ ]
2.			[ ]	[ ]
3.			[ ]	[ ]

V. WORK HISTORY

List, in chronological order, all clinic practice sites since completion of postgraduate education. Include all hospitals, corporations, military assignments or government agencies. Please explain any gaps in work history that exceed 6 months. List additional sites on separate sheet.

Institution and Address	Department	Dates (Mo/Yr) From	To
NAME _____		_____	_____
Address _____			
City, State, Zip _____			
NAME _____		_____	_____
Address _____			
City, State, Zip _____			
NAME _____		_____	_____
Address _____			
City, State, Zip _____			

VI. LICENSURE/CERTIFICATION DATA

A. APPLICABLE LICENSES TO PRACTICE

	Profession	State	License Number	Expiration Date	Currently practicing in the state(s) you hold licensure in? Yes	No
Medical					❑	❑
					❑	❑
Controlled Substance					❑	❑
					❑	❑

B. DRUG ENFORCEMENT ADMINISTRATION (DEA) # _____ Expiration Date _____

C. BOARD CERTIFICATION

Primary Specialty _____ Board Certified ❑ Date _____

Name of Board _____ Expiration _____

Sub-Specialty _____ Board Certified ❑ Date _____

Name of Board _____ Expiration _____

Attach copies of current license(s) and DEA registration to this application.

VII. EDUCATION

A. SCHOOLS (please provide country if outside of U.S.)

Professional/Medical School — Degree — Date of Graduation

_____
Name of Institution

_____
City, State, Country

B. INTERNSHIPS/RESIDENCIES/FELLOWSHIPS (please list all programs attended)

Served Internship — Dates (From/To) — Type — Completed Yes ❑ No ❑

_____
Name of Institution

_____
City, State, Country

Served Residency — Dates (From/To) — Type — Completed Yes ❑ No ❑

_____
Name of Institution

_____
City, State, Country

Served Fellowship — Dates (From/To) — Type — Completed Yes ❑ No ❑

_____
Name of Institution

_____
City, State, Country

Use additional paper if necessary.

If you completed your medical education and training outside of the United States, please provide your ECFMG number:

_____

VIII. PRACTICE AND HEALTH HISTORY

(For each question check the appropriate Yes or No response.)

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, PLEASE GIVE A DETAILED EXPLANATION REGARDING THE CIRCUMSTANCES.

	Yes	No
A. Have any disciplinary actions been taken or are any pending against you by any state licensure boards?	❑	❑
B. Has your license to practice in any state ever been limited, suspended, or revoked?	❑	❑
C. Have you ever been suspended or otherwise restricted from practicing in any private, federal, or state insurance program (e.g. Medicare, Medicaid)?	❑	❑
D. To your knowledge, have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state insurance program?	❑	❑
E. Has your DEA number ever been limited, suspended, or revoked?	❑	❑
F. Has your professional liability insurance coverage ever been terminated by action of the insurance company?	❑	❑
G. Have any professional liability suits ever been filed against you?	❑	❑
H. Are any professional liability suits filed against you presently pending?	❑	❑
I. Have any judgments or settlements been made against you in professional liability cases?	❑	❑
J. Has your employment, appointment, or privilege to practice ever been suspended, diminished, revoked, or refused at any hospital, medical practice, group medical practice, or other institution?	❑	❑
K. Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings in any professional organization?	❑	❑
L. Do you currently have any physical or mental health problems that could affect your practice?	❑	❑
M. Are you currently under any limitations in terms of activity or work load due to disability or medication?	❑	❑
N. Have you taken or used any illegal substance, including marijuana, cocaine or other recreational drugs within the past five years?	❑	❑
O. Has a physician or counselor ever advised you that you have a problem with alcohol or substance abuse?	❑	❑
P. Do you have any impairment due to chemical dependency or alcohol or substance abuse?	❑	❑
Q. Have you ever been convicted of a felony?	❑	❑
R. Have you been convicted within the past five years of driving under the influence of alcohol or any illegal substance?	❑	❑

IX. PROFESSIONAL LIABILITY ACTION EXPLANATION

Please complete this form for each dismissed, pending or settled professional liability action and any payment made on behalf of the physician reported on your application. If additional sheets are required, please photocopy this page prior to completing. Please provide us a separate sheet for each malpractice action.

Please Print

Date _____ Date Suit Filed _____

Patient Name _____

Claim Status:

- ❑ OPEN - If open, amount being sought _____
- ❑ CLOSED - If closed, indicate method of closing:
  - ❑ Dismissal
  - ❑ Settlement
  - ❑ Judgement - If judgement, indicate type of judgement and amount of settlement, if applicable:

    _____

Please summarize the case in your own words _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

X. REFERENCES

Please provide names/addresses of two practitioners (peers) who are familiar with your clinical ability, ability to work with others and who will provide specific written comments upon request. References provided should not be related to the applicant or associated with the applicant in practice.

1. Name _____

   Address _____

   City, State and Zip _____

   Phone Number _____ Fax Number _____

   Email Address _____

2. Name _____

   Address _____

   City, State and Zip _____

   Phone Number _____ Fax Number _____

   Email Address _____

XI. INSTRUCTIONS

A. To complete this application, please attach the following:
- Copy of current license to practice
- Copy of Controlled Substance license
- Copy of DEA certificate
- Current certificate of professional liability insurance
- Copy of residency certification and medical school degree
- Copy of curriculum vitae
- **Two peer references (if you do not have hospital privileges)**

B. **Applications must be complete, dated and signed. Failure to complete this application in full and indicate all requested information will affect our ability to complete the credentialing process in a timely manner.**

C. Mail completed application to:

Attn: _____, PNM

Health Alliance Medical Plans

3310 Fields South Drive

Champaign, IL 61822

XII. AUTHORIZATION AND CERTIFICATION

Statement of Application (please read carefully before signing)

I specifically authorize Health Alliance Medical Plans and its authorized representatives to consult with any third party who may have information bearing on my professional qualifications, licensure, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter, as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties. I specifically authorize said third parties to release said information to Health Alliance Medical Plans and its authorized representatives upon request.

I also authorize Health Alliance Medical Plans and its authorized representatives to provide to hospitals, medical associations, licensing boards, governmental agencies, health plans and other organizations concerned with provider performance and quality and efficiency of patient care any information relevant to such matters that Health Alliance Medical Plans may have concerning me, and release from any liability for so doing all representatives of Health Alliance Medical Plans, providing such information is furnished in good faith and without malice.

To the fullest extent permitted by law, I extend absolute immunity to, and release and hold harmless from any and all liability, Health Alliance Medical Plans and its authorized representatives and any third party for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, performed, made, requested, or received by Health Alliance Medical Plans and its authorized representatives to, from, or by any third party, including otherwise privileged or confidential information made or given in good faith. This indemnification and hold harmless is given with the understanding that Health Alliance will act in good faith with respect to each matter addressed and that it will use its best efforts to maintain the confidentiality of the information and records received by it from third parties.

I also certify that the information given in or attached to this application is complete, accurate, and fairly represents the current level of my training, experience, capability and competence to practice. I further understand that any further misrepresentations, misstatement in, or omission from this application whether intentional or not, shall, of itself alone, constitute cause for automatic and immediate rejection of this application. In the event this application is approved prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may result in termination for cause of any agreement made as a result of this application by and between Health Alliance Medical Plans and myself.

I agree to notify Health Alliance Medical Plans immediately with respect to any of the following involving myself or any individual provider of health care services employed or retained under contract by myself: (i) any inquiry, investigation, action or proceeding with respect to licenses, Drug Enforcement Act registration or any change in certification or accreditation by any association or organization; (ii) any claim, notice of claim or legal action filed or threatened in connection with the rendering of health care services; (iii) any adverse malpractice judgments; and (iv) any inquiry, investigation, action or proceeding with respect to participation in any government program as a provider of Health Care Services, including but not limited to Medicare, Medicaid, Maternal and Child Health Services Block Grant and Block Grants to States for Social Services programs.

_____

Print Name

_____

Signature Date