

MedCost+

Recredentialing Form

Applicant's Name: _____
Last First Middle

Name of Practice: _____

Address: _____

Phone: _____ Fax: _____ E-Mail: _____

Federal Tax ID Number: _____ NPI: _____

Office Hours: _____

Arrangements for 24 hour/7 Day coverage: _____

Name and address of provider(s) who share call with you:

Name: _____ Address: _____

Name: _____ Address: _____

Credentialing Contact: _____

Name

E-mail Address

Phone

Fax

A. PERSONAL DATA

1. DOB: _____ SS#: _____ MedSchool/Year: _____

2. State Medical License #: _____ Federal DEA #: _____

3. Type of Practice: Primary Care Specialist

What is your Primary Specialty? _____ Secondary Specialty? _____

4. Are you **BOARD CERTIFIED**?

Yes _____
Board Name Year Certified/Recertified

Secondary Specialty Board Name (if any) Year Certified/Recertified

No Are you **BOARD ELIGIBLE**? Yes No
If YES, what specialty? _____ Date of Examination: _____

5. List **all** Hospitals where you currently have privileges:

Hospital _____ Privileges _____

6. If you do not have admitting privileges, who admits for you? Include Name, Address and phone number

Please complete ALL sections on this application. Include "N/A" if not applicable.

B. PROFESSIONAL INFORMATION *SINCE LAST CREDENTIALING*

If the answer to any of the following questions is yes, please attach explanation.

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?	Y <input type="checkbox"/>	N <input type="checkbox"/>
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?	Y <input type="checkbox"/>	N <input type="checkbox"/>
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?	Y <input type="checkbox"/>	N <input type="checkbox"/>
4.	Have you ever been sanctioned or suspended by Medicare or Medicaid?	Y <input type="checkbox"/>	N <input type="checkbox"/>
5.	To your knowledge, have you ever been reported to the National Practitioner Data Bank or the North/South Carolina Board of Medical Examiners?	Y <input type="checkbox"/>	N <input type="checkbox"/>
6.	Have you ever been convicted of a felony or misdemeanor, or are you under investigation with respect to such conduct?	Y <input type="checkbox"/>	N <input type="checkbox"/>
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?	Y <input type="checkbox"/>	N <input type="checkbox"/>
8.	Has any liability insurance carrier canceled, refused coverage, or rated up because of unusual risk or have any procedures been excluded from your coverage?	Y <input type="checkbox"/>	N <input type="checkbox"/>
9.	Have you ever practiced without liability coverage?	Y <input type="checkbox"/>	N <input type="checkbox"/>
10.	Do you currently have any medical, chemical dependency or psychiatric conditions that might adversely affect your ability to practice medicine or surgery or to perform the essential functions of your position?	Y <input type="checkbox"/>	N <input type="checkbox"/>
11.	Have your Hospital and/or Clinic privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of an investigation or are any such actions pending?	Y <input type="checkbox"/>	N <input type="checkbox"/>

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 are supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in the application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in MedCost, I signify my willingness to appear for interview in regard to my application. I authorize MedCost to consult with administrators and members of medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to MedCost materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension or action to curtail my medical-surgical privileges. I further consent to the inspection by representative of MedCost of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of MedCost for the acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications and I release from any liability, all individuals and organizations that provide information to MedCost in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to MedCost.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, MedCost, may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in MedCost, I hereby consent to MedCost for inspection of my patient records relating to MedCost enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify MedCost in a timely manner (not to exceed 30 days) of any changes to the information on the initial application.

Print Name of Provider

Signature of Provider

Date

Please sign this completed application and return with items listed below to:

1. Copy of *Current Board of Medical Examiners Physician Certificate of Registration & Active State License*
2. Copy of *Current Liability Information Sheet*
3. Copy of *Specialty Board Certificate*
4. Copy of Curriculum Vitae if changes or updates in work history/education in last three years
5. Copy of *Current DEA certificate (Must have a current date and refer to a current address.)*