

**RECREDEntIALING VERIFICATION FORM
(Confidential)**

INSTRUCTIONS: Please complete all sections below. Responses may be submitted to ConnectiCare’s Credentialing Department via the following methods:

Fax: 866-561-9260

E-mail: CCICredentialing@ConnectiCare.com

Mail: ConnectiCare Credentialing Department, 175 Scott Swamp Road, P.O. Box 4050, Farmington, CT 06032

Date:

DEMOGRAPHIC INFORMATION:

FIRST Name:	M.I.	LAST Name:
Date of Birth:	Individual’s NPI #:	
Licensed State:	License #:	
Federal DEA #:		
List all foreign languages spoken by you (NOT OFFICE STAFF):		

PROVIDER DIRECTORY INFORMATION: Please list all the groups that you participate with and their addresses if you would like them listed in the ConnectiCare Provider Directory.

	Primary Practice / Directory Address	Second Practice / Directory Address	Third Practice / Directory Address
Group Name			
Street			
City			
State			
Zip Code			
Telephone Number			
Fax Number			
Wheelchair Accessible?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you offer extended office hours?	<input type="checkbox"/> Before 9 AM <input type="checkbox"/> After 5 PM <input type="checkbox"/> Weekends <input type="checkbox"/> None	<input type="checkbox"/> Before 9 AM <input type="checkbox"/> After 5 PM <input type="checkbox"/> Weekends <input type="checkbox"/> None	<input type="checkbox"/> Before 9 AM <input type="checkbox"/> After 5 PM <input type="checkbox"/> Weekends <input type="checkbox"/> None

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BOARD CERTIFICATION STATUS: List all current board certifications and please submit the supporting documentation. Most recent information is listed. If you have recently become Board Certified or renewed your expired certification, please submit supporting documentation.

Board Certification Specialty	Year Certified	Certification Expires

HOSPITAL PRIVILEGES: List all hospitals where you have an affiliation or maintain privileges along with the type of privileges.

HOSPITAL including State	ADMITTING PRIVILEGE STATUS (e.g. None, Full Unrestricted, Provisional, Temporary)

PRACTITIONER USE OF INTERNET TECHNOLOGY:

NOTE: The information below will be listed in ConnectiCare’s Provider Directory

1. Does your office use e-mail for the following non-clinical services:

- Prescription refills? Yes No
- Referral requests? Yes No
- Making appointments? Yes No

2. Do you allow patients to use e-mail for simple clinical questions? Yes No

3. Do you do online consultations? Yes No

4. Do you use e-prescribing? Yes No

5. Do you send patients reminder notices, educational messages or compliance messages via e-mail? Yes No

6. Do you have an office website? Yes No

GROUP / PRACTICE CREDENTIALING CONTACT INFORMATION:

Credentialing Contact Name:	
Direct Telephone #:	E-mail Address:

LIABILITY INSURANCE INFORMATION: Please complete attestation below or provide a copy of your current liability insurance coverage face sheet.

By signing this application, I attest that I maintain Professional Liability coverage as follows:

Coverage Amounts: _____ / _____
Incident *Aggregate*

Policy Period: _____ : _____
From (mm/dd/yyyy) *To (mm/dd/yyyy)*

DISCLOSURE QUESTIONS: Please answer questions below. If you answer “YES” to any of the following questions, please include a detailed explanation of each situation on a separate piece of paper. If a question does not apply, please select “N/A”.

Licensure

1. Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, or restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitation by any state or professional licensing, registration or certification board? * Yes No
2. Has there been any challenge to your licensure, registration or certification? * Yes No

Hospital Privileges and Other Affiliations

3. Have your clinical privileges or medical staff membership at any hospital or health care institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or having proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee or governing board? * Yes No N/A
4. Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? * Yes No N/A

5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organization (including HMOs, PPOs, or provider organizations such as IPAs or PHOs)? * Yes No

Education, Training and Board Certification

6. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? * Yes No
7. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? * Yes No
8. Have any of your board certifications or eligibility ever been revoked? * Yes No N/A
9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? * Yes No N/A

DEA or State Controlled Substance Registration

10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished? * Yes No N/A

Medicare, Medicaid or Other Governmental Program Participation

11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs? * Yes No

Other Sanctions and Investigations

12. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or sexual offense or sexual misconduct? * Yes No
13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank? * Yes No
14. Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? * Yes No
15. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last 10 years for sexual harassment or other illegal misconduct? * Yes No

16. Are you currently being investigated or have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or health care facility of any military agency? * Yes No

Professional Liability Insurance Information and Claims History

17. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? * Yes No
18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history? * Yes No

Malpractice Claims History

19. Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? * Yes No

Criminal / Civil History

20. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony? * Yes No
21. In the past 10 years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? * Yes No
22. Have you ever been court-martialed for actions related to your duties as a medical professional? * Yes No

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 an 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. section 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 unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation? * Yes No

NOTE: A detailed explanation of all * “Yes” responses is enclosed: See Attachment(s)

AUTHORIZATION, ATTESTATION AND RELEASE OF INFORMATION:

By applying to be a participating/continuing practitioner with ConnectiCare, either directly or through my IPA and/or my PHO which has entered into an agreement with ConnectiCare, I certify that the information I have provided and responses I have given are true, correct and complete to the best of my knowledge and belief. I understand and agree that if this form contains either (i) any material omissions or misrepresentations, or (ii) false or misleading information, my application to participate may be denied and/or my participation with ConnectiCare may be terminated. I agree to notify ConnectiCare immediately in the event there are any changes to any of the information I have provided on this application.

I understand that in accordance with applicable laws and the requirements of accreditation organizations, ConnectiCare will credential practitioners and every three years will recredential practitioners. To facilitate compliance with those requirements, as well as the credentialing standards of other regulatory and accrediting agencies or organizations, I hereby authorize ConnectiCare or its designee to receive and to inspect all records and documents and to verify with individuals, organizations, and other health practitioners all information, including information described in this form, that may be appropriate to an evaluation of my personal and professional qualifications, and my ability to perform my professional and medical duties. I agree to cooperate with scheduled on-site visits including reviews of record documentation and agree, when requested, to submit copies of medical records for audit purposes to the extent permitted by applicable laws.

I hereby authorize and request all individuals and institutions to promptly reply to all requests from ConnectiCare for information or verification of information as described above. I agree to hold harmless and release from any and all liability all individuals and institutions furnishing such information to ConnectiCare, their respective agents, employees, and representatives, provided the information is given in good faith and without malice.

I hereby authorize ConnectiCare to use the information provided in their selection, credentialing and recredentialing process and to verify such information as appropriate. Notwithstanding, I understand and agree that I have the responsibility of producing all information required or requested by ConnectiCare in accordance with this application. ConnectiCare is under no obligation to complete the processing of this application until such information is provided by me.

I agree that a photocopy of my signature below may be relied upon by any person or entity receiving a copy of this authorization.

Practitioner Name: _____
(Please Print)

Practitioner Signature*: _____
*(*Required) Note: a stamped signature is not acceptable*

*Date: _____
*(*Required)*