LOCUM TENENS CREDENTIALING APPLICATION

Provider Information

This form is only valid for Locum Tenens providing coverage for up to 60 days.

Provider Name:	NPI #:
Dates of coverage From: To:	*(must be less than 60 days for locum credentialing)*

A. MEDICARE OPT-OUT - § 1128 of the Social Security Act

Have you ever voluntarily opted-out of Medicare?	❑ Yes ❑ No	Opt out Start Date: _____ Opt out End Date: _____

Practice Setting: *Check all that apply*
❑ Clinic/Group ❑ Solo Practice ❑ Primary Care Site ❑ Urgent Care ❑ Other _____

Provider Profile: *Check all that apply*
❑ PCP ❑ Specialist ❑ Urgent Care ❑ Mental Health ❑ Other _____

Medical School:	Graduation Date (MM/YYYY):
Residency:	Completion Date (MM/YYYY):
Internship:	Completion Date (MM/YYYY):

B. PRIMARY ADDRESS INFORMATION:

Name of Practice or Clinic:

Street: _____ Suite #: _____ City: _____ ST: _____ Zip: _____ Phone: _____ Fax: _____	Tax ID #: Tax ID Name: *If Applicable* Medicare #: Medicaid #:

Primary Contact Name:	Contact Title:	
Phone:	Fax:	E-mail:

Please list languages fluently spoken by office personnel:

Practice Limitations (e.g. age, gender, etc.) ❑ Yes ❑ No If Yes, please explain:

Are you accepting new patients?	❑ Yes ❑ No	Is the office wheelchair accessible?	❑ Yes ❑ No

Office Hours (Open to Close)
Mon: _____ Tue: _____ Wed: _____ Thur: _____ Fri: _____ Sat: _____ Sun: _____

Do you provide 24 hour coverage? ❑ Yes ❑ No If no, please explain how your patients obtain advice and care after hours:

Providers the locum tenens is covering for:	Current Hospital Affiliations and Status (active, courtesy, temporary, etc.)
1.	1.
2.	2.
3.	3.
4.	4.

C. ADDITIONAL ADDRESS INFORMATION:

Mailing Address: (If different)	Billing Address: (If Different)
Name:_____	Name:_____
Address:_____	Address:_____
Suite #: _____	Suite #: _____
City:_____ ST:____ Zip:_____	City:_____ ST:____ Zip:_____
Phone:_____ Fax:_____	Phone:_____ Fax:_____
Email:_____	Email:_____

D. BOARD CERTIFICATION:

Board certification is not proof of your degree, licensure or association membership but is, as a rule, acquired subsequent to your completed specialty education and evidenced by a certificate(s) which may or may not be time limited.

Are you Board Certified:	❑ Yes ❑ No ❑ NA	Are you Board Eligible:	❑ Yes ❑ No ❑ NA

Issuing Board or Entity	Certification Number:	Specialty:	Date Certified:	Expiration Date: (if any)

E. LICENSURE *(Attach a copy of all licenses)*

State of Licensure:	License Number:	Issue Date:	Expiration Date:

F. CERTIFICATES (Attach a copy of all certificates)

DEA (Please include all States where provider is contracted and practicing)

State:	Number:	Issue Date:	Expiration Date:

G. INSURANCE (Attach a copy of Policy or Face Sheet)

Malpractice insurance requirements of $1,000,000 per occurrence and $3,000,000 aggregate

❑ Please check here if you are exempt from meeting requirements and attach explanation.

Current Carrier Name:	Policy #:
Effective Date:	Expiration Date:
Per Incident: $	Aggregate: $

H. ACTION HISTORY			
	PLEASE PLACE A CHECK MARK IN THE APPROPRIATE COLUMN	YES	NO
1	*Subsequent* to your latest application for credentialing/recredentialing with IPN, is there anything that would prevent you, with or without reasonable accommodation, from practicing safely and in accordance with the standard of care and performing the essential functions of a physician under the IPN Participating Provider Agreement?	○	○
2	*Subsequent* to your latest application for credentialing/recredentialing with IPN, has your license to practice in any jurisdiction been denied, limited, suspended, revoked, not renewed or made subject to any stipulation, action or probation?	○	○
3	*Subsequent* to your latest application for credentialing/recredentialing with IPN, has your narcotics registration or certificate been suspended, revoked, limited or restricted?	○	○
4	Have you ever been arrested or convicted of a criminal offense not involving drugs or alcohol?	○	○
5	Have you ever been arrested or convicted of a drug or alcohol-related offense?	○	○
6	Are you currently engaged in illegal drug use?	○	○
7	Are you presently taking medications or other substances that could impair your ability to provide patient care services?	○	○
8	*Subsequent* to completion of your latest application for credentialing/recredentialing with IPN, has your professional liability insurance (or application therefore) been denied, limited, cancelled or not renewed or is any such action pending?	○	○
9	*Subsequent* to your latest application for credentialing/recredentialing with IPN, have you been or are you now a defendant or subject of a professional liability claims, settlement, judgment, pre-litigation proceeding, suit or other judicial or administrative adjudication?	○	○
10	*Subsequent* to completion of your latest application for credentialing/recredentialing with IPN, has your staff membership (or your application for membership) at any hospital or health care facility been denied, limited, suspended, revoked, not renewed or made subject to probation?	○	○
11	*Subsequent* to completion of your latest application for credentialing/recredentialing with IPN, have any of your clinic privileges (or application for any privileges) at any institution been denied, limited, suspended, revoked, not renewed or made subject to probation?	○	○
12	*Subsequent* to completion of your latest application for credentialing/recredentialing with IPN, have you been disciplined or sanctioned in any way by any hospital, clinic, health maintenance organization, professional licensing board, professional society or organization, health care payor (including Medicare or Medicaid) or other health care organization?	○	○
13	*Subsequent* to completion of your latest application for credentialing/recredentialing with IPN, has your membership or participation in any professional organization or managed care organization ever been denied, limited, suspended, revoked, not renewed or made subject to probation?	○	○
14	*Subsequent* to completion of your latest application for credentialing/recredentialing with IPN, have you resigned membership privileges or participation (or withdrawn an application therefore) in any health care organization while an investigation or charge that could lead to an adverse action or discipline against you was open or pending, or is any investigation or charge currently open or pending that could lead to any discipline or sanction by any health care organization?	○	○

FOR ANY "YES" ANSWERS, PLEASE EXPLAIN ON FOLLOWING PAGES

PROVIDER SIGNATURE	DATE

I. EXPLANATION FROM ACTION HISTORY *For multiple explanations, add additional copies of this page as needed*			
All information will be kept confidential			
Date of Incident:		State of Incident:	
Clinical Details:			
Your specific responsibilities in the incident:			
Subsequent events, including patient's clinical outcome:			
Date suit or claim was filed:		Your Role:	❑ Defendant ❑ Co Defendant ❑ Other
Status:	❑ Pre-Litigation ❑ Discovery ❑ Pending ❑ Closed		
Settlement amount: *(If applicable)*		Settlement Date:	
If case was settled out-of-court, or with a judgment, settlement amount attributed to you:			
Insurance Carrier:			

J. ATTESTATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize IPN and its representatives to consult with others who have information bearing on our professional competence, character, professional practice or ethical qualifications. I authorize all malpractice carriers to release coverage and/or claims history information which may exclude direct patient identification including name, address or telephone numbers to IPN and its representatives. I hereby further consent to the inspection by IPN and/or its representatives, of all documents, including medical records, which may be relevant to evaluation of our professional, practice, competence or moral and ethical qualifications. *IPN complies with the Health Insurance Portability and Accountability Act of 1996 "HIPAA" (as defined in 45 CFR § 160 et seq.) as well as other state and federal statutes, rules and regulations relating to confidentiality and privacy.* We understand that we have the right to review any information submitted in support of this credentialing application.

I hereby release from liability any and all individuals and organizations that provide information to IPN concerning my professional competence, practices, ethics, character or other qualifications for participating Practitioner's status and hereby consent to the release of such information. I further agree to release and hold harmless, from any liability, IPN, Inc. and any and all persons who participate within the scope of their duties at IPN in review of or any action or recommendations relating to my professional competence, practice, ethics, character or other qualifications. I understand and agree that I, as an applicant to IPN, Inc., have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I also understand that to participate as an IPN practitioner, this application must be verified and approved and I must be notified in writing by IPN that my application has been accepted. I hereby certify that the information contained herein is true, accurate and is completed in good faith. Any information found herein which subsequently is found to be false, could result in my immediate termination from participation or employment with IPN. In the event that any information contained herein ceases to be accurate at any future time, I agree to immediately notify IPN, Inc. in accordance with executed Participating Physician Agreement, of such change.

Failure to notify IPN of changes in the information contained in this Application may result in immediate termination from participation with IPN.
A copy of this release is to be treated as an original and remains in effect from the date of this document until revoked.

PROVIDER SIGNATURE	DATE

Return Completed application to:

IPN Credentialing
PO Box 5406
Boise ID 83705
Fax: (208) 433-4604