

Application

Physician Name: _____ Gender: _____
Home Address: _____
Home Phone: _____ (only if you want placed on applications)
Date of Birth: _____ Place of Birth: _____
Degree: _____ Social Security Number: _____
Primary Specialty: _____ Choose One Listing: ___ PCP ___ Specialist
Second. Specialty: _____ Citizenship: _____
Subspecialty: _____
CAQH Number: _____ CAQH Login: _____ CAQH Password: _____
NPI Number: _____ NPI Login: _____ NPI Password: _____

EDUCATION AND TRAINING

Premedical Education

Name of College or University: _____ Degree: _____
City and State _____ Year of Grad _____

Medical Education

Name of College or University: _____ Degree: _____
City and State _____ Year of Grad _____
E.C.F.M.G. Number (if foreign Medical graduate): _____

Internship

Name of Hospital _____ Specialty: _____
City and State _____ Dates _____

Residency

Name of Hospital _____ Specialty: _____
City and State _____ Dates _____
Department Chair _____

Fellowship

Name of Hospital _____ Specialty: _____
City and State _____ Dates _____
Department Chair _____

Board Certification (please provide copy)

Specialty _____ Date _____
Board Name: _____
Certificate Number: _____ Expiration: _____
Specialty _____ Date _____
Board Name: _____
Certificate Number: _____ Expiration: _____
Board Eligibility
Specialty _____ Date _____

PRACTICE INFORMATION Please duplicate this page and complete the information for each additional office site.

Primary Office: Type of practice: Group _____ Solo _____
Physician Start Date: _____ Group Start Date: _____
Practice Name _____
Office Address _____
City _____ State _____ Zip _____
County _____ Contact _____
Telephone _____ Fax # _____ Email Address: _____
Billing Name _____
Billing Address _____
Billing Mgr Name _____ Billing Phone: _____ Fax: _____
City _____ State _____ Zip _____
Tax ID Number _____ Medicare # _____
Medicaid # _____ UPIN # _____
Blue Shield # _____ Practice Age Limits _____ to _____
Lab work done at this location? Yes _____ No _____ If yes, CLIA # _____
X-Rays done at this location ?Yes _____ No _____ Is the office handicapped accessible? Yes _____ No _____
Office Hours: Mon. Tue. Wed. Thur. Fri. Sat. Sun.

Languages spoken by Physician _____ Languages spoken by Office Staff _____
Number of Additional Staff:
____ RN _____ Nurse Practitioner _____ Medical Assistant
____ LPN _____ Physical Therapist _____ Receptionist
____ Secretary _____ Physician Assistant _____ Other: _____

Secondary Office: Type of practice: Group _____ Solo _____
Practice Name _____
Office Address _____
City _____ State _____ Zip _____
County _____ Contact _____
Telephone _____ Fax # _____ Email Address: _____
Billing Name _____
Billing Address _____
Billing Mgr Name _____ Billing Phone: _____ Fax: _____
City _____ State _____ Zip _____
Tax ID Number _____ Medicare # _____
Medicaid # _____ UPIN # _____
Blue Shield # _____ Lab work done at this location? Yes _____ No _____
Practice Age Limits _____ to _____ If yes, CLIA # _____
X-Rays done at this location ?Yes _____ No _____ Is the office handicapped accessible? Yes _____ No _____
Office Hours: Mon. Tue. Wed. Thur. Fri. Sat. Sun.

Languages spoken by Physician _____ Languages spoken by Office Staff _____
Number of Additional Staff:
____ RN _____ Nurse Practitioner _____ Medical Assistant
____ LPN _____ Physical Therapist _____ Receptionist
____ Secretary _____ Physician Assistant _____ Other: _____

PRACTICE INFORMATION (continued)

Workman's Compensation Experience? Yes _____ No _____ Years experience _____
 Percent of practice _____

Do you have 24 hour/day, 7 days/week answering service coverage of your practice? Yes ___ No ___
 Name of Service _____

Please list all covering physicians, their phone numbers, addresses and their hospital affiliations:

For the purpose of utilization and quality review, will you and all members of your group agree to periodic review of patient records? (Subject to proper confidentiality restrictions and authorizations) Yes _____ No _____

Within how many hours/days will a patient receive an appointment in your office?
 Elective Visit _____ Urgent Problem _____ Routine _____

Approximately how many patients per day do you see? _____
 Approximately how many patients are you scheduled to see in an hour? _____

Are you currently eligible to receive payments under the Medical Assistance/Medicare Programs?
 Yes _____ No _____ If no, please provide details below:

Practice Associates Indicate all physicians associated with practice.

 (Last, First, Middle, Degree)

 (Last, First, Middle, Degree)

 (Last, First, Middle, Degree)

Other HMO, PPO Affiliations: •Please indicate Affiliations with other insurers by checking below:

<input type="checkbox"/> Administar	<input type="checkbox"/> HIP	<input type="checkbox"/> Personal Choice
<input type="checkbox"/> Aetna/USHealthCare	<input type="checkbox"/> HMO Blue/Mercy	<input type="checkbox"/> PHCS
<input type="checkbox"/> Americare	<input type="checkbox"/> MagnaCare	<input type="checkbox"/> Premier Blue/PABS
<input type="checkbox"/> AmeriHealth	<input type="checkbox"/> MHS	<input type="checkbox"/> Prudential
<input type="checkbox"/> AtlantiCare	<input type="checkbox"/> NYL Care	<input type="checkbox"/> United Health Care
<input type="checkbox"/> Blue Cross/Blue Shield	<input type="checkbox"/> Medicare	<input type="checkbox"/> UHP
<input type="checkbox"/> Cigna	<input type="checkbox"/> Oxford	<input type="checkbox"/> UNISYS/Medicaid
<input type="checkbox"/> First Option	<input type="checkbox"/> XACT Medicare	
Other:		

HOSPITAL AFFILIATIONS

Primary Hospital

Name _____ Date(s) Initiated _____
Privileges _____ Department _____
(Full, Courtesy, etc.)
Admissions per year _____

Hospital #2

Name _____ Date(s) Initiated _____
Privileges _____ Department _____
(Full, Courtesy, etc.)
Admissions per year _____

Hospital #3

Name _____ Date(s) Initiated _____
Privileges _____ Department _____
(Full, Courtesy, etc.)
Admissions per year _____

Hospital #4

Name _____ Date(s) Initiated _____
Privileges _____ Department _____
(Full, Courtesy, etc.)
Admissions per year _____

OPTIONAL

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___
Do you have children? Yes ___ No ___

CME HOURS

Please list on a separate sheet of paper the total number of postgraduate CME hours/credits attended over the past three years with areas of concentration; include copies of all documents pertaining to same.

WORK EXPERIENCE

Please provide a current copy of your curriculum vitae in **month/day/year** format and account for any gaps greater than three (3) months since graduation from medical school.

MEDICAL LICENSES

Please list ALL licenses (active, expired, inactive, etc. Attach additional page(s) if necessary)

State & License Number: _____ Date of Expiration: _____
Original Date of License: _____

Other State & License Number _____ Date of Expiration: _____
Original Date of License: _____

Federal DEA Number _____ Date of Expiration _____
Controlled Substances (CDS) # _____ Date of Expiration _____

PROFESSIONAL LIABILITY INSURANCE INFORMATION

Professional Liability Carrier: _____

Address of Carrier: _____

Amount of Coverage: _____ Policy Number: _____

Specialties Covered: _____ Policy of Coverage: _____

Length of time with Current Carrier: _____

Previous Carriers for past ten (10) years – include policy number & years of coverage:

General Liability Carrier (for office): _____

Address of Carrier: _____

Amount of Coverage: _____ Policy Number: _____

Length of time with Current Carrier: _____ Previous Carrier: _____

If your answer to any of the following questions is "yes", please give full details on a separate sheet of paper.

1. Has your license to practice medicine in any jurisdiction ever been voluntarily limited, suspended or revoked?
Yes _____ No _____
2. Have your DEA number to prescribe controlled substances ever been voluntarily or involuntarily limited, suspended or revoked? Yes _____ No _____
3. Have your privileges at any hospital ever been voluntarily or involuntarily suspended, diminished, revoked or not renewed? Yes _____ No _____
4. Has your specialty board status ever been voluntarily or involuntarily suspended, diminished, revoked or not renewed? Yes _____ No _____
5. Have you ever been denied appointment or renewal thereof, or been subject to disciplinary action by any medical/hospital organization? Yes _____ No _____
6. Are there any medical malpractice judgments, awards or out of court settlements that have been made in the past 10 years, or are currently pending against you? Yes _____ No _____
7. Has your faculty membership in any medical or other professional school ever not been renewed or either voluntarily or involuntarily, subject of disciplinary action? Yes _____ No _____
8. Have you ever been indicted or convicted of fraud? Yes _____ No _____
9. Are you now an active or habitual user of alcoholic beverages or any controlled or illegal substances? Yes _____ No _____
10. Have you ever been convicted of a narcotics offense? Yes _____ No _____
11. Have you ever received counseling and/or treatment for alcohol or substance abuse? Yes _____ No _____
12. Have you ever been convicted of any felony offense? Yes _____ No _____
13. Are you aware of any health impairments which would affect your ability to perform professional and staff duties? Yes _____ No _____
14. Do you have any readily communicable diseases? Yes _____ No _____
15. Have you ever been terminated or suspended, on either a voluntary or involuntary basis, from receiving payments under the Medicaid or Medicare programs? Yes _____ No _____
16. Are you in violation of any order or written agreement to pay child support? Yes _____ No _____

REFERENCES: Please provide three (3) including Name, Address, and Phone

WARRANTY and RELEASE OF INFORMATION

The information contained in this application includes specific details regarding my background, character and competence. I understand that this information will be reviewed and certify that all the information provided is true.

A photocopy of this original warranty and release will be valid.

By signing below, I :

- 1.) Certify that all information provided in this application is true and complete to the best of my knowledge; and,
- 2.) Agree to notify AddVal of any changes to the information provided within thirty (30) days of any such change.

Signature

Date

Print name

Please submit this completed application, a signed agreement and the following documents:

- Curriculum Vitae MUST include month/year and all employment;
- Medical License(s);
- Board Certificate(s);
- Professional Liability Insurance;
- Documents regarding all settled and/or pending malpractice claims;
- NPI number approval letter;
- Copy of social security card (needed for Medicaid application);
- IRS verification of Tax ID & copy of diploma (for Medicare);
- CME certificates;
- Driver's license or passport copy, TB & rubella test results (for hospital applications);
- Letters for all participating hospital privileges; and,
- DEA and state controlled substance certificates(if applicable).

Office Information Addendum

Practice Name: _____
Date Practice Established: _____
Group/Organization NPI Number: _____

Physicians:	Date joined practice:
_____	_____
_____	_____
_____	_____
_____	_____

Narrative Description of Practice:

Is Public Transportation Available? ___ Yes ___ No (If yes, please indicate route information):

Directions to Office:

Do any of the physicians listed or their family members have an ownership interest in a medically related organization? ___ Yes ___ No
If yes, please specify below:

Please provide the percent of the practice that is:
___ Office Based
___ Hospital Care
___ Other: (Please define:) _____
100% Total

Please provide patient mix information:
___ Medicare
___ Medicaid
___ Commercial
___ Workers' Compensation
100% Total

The approximate count of active patients for the last two (2) years: _____

Office Information Addendum (cont'd)

In your office, do you perform?

Service:	Yes	No	Service	Yes	No
EKG			Asthma Treatments		
Office gynecology			Allergy Skin Testing		
Draw blood			Osteopathic manipulation		
Immunizations			Intravenous treatment		
Minor surgery			List Others:		
Audiometry screening					
Flexible sigmoidoscopy					
Laceration repair					
Pulmonary Function Studies					

State License Addendum

The completion of state license applications for the practice of telemedicine requires the following additional information and documents:

PERSONAL INFORMATION:

Height: ____ Weight: _____ Hair: ____ Eyes: ____ Race: _____

Father's Name: _____

Mother's Name (include maiden name): _____

LICENSING INFORMATION:

Licensing Examination Taken (please check and provide date):

- USMLE _____
Date
- FLEX _____
Date
- NBME _____
Date

REASON FOR APPLYING FOR STATE LICENSURE:

ADDITIONAL DOCUMENTS NEEDED:

- Copy of ALL certificates of graduate education (internship, residency, fellowship)
- Copy of medical school diploma
- Copy of ALL court documents for each malpractice claim.

Thank you for completing AddVal's application. Please call if you need any additional information, or, if you have any questions. Thank you.

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Revised: August 1998; September 1999; June 2001; July 2006; March 2007