Belk & Associates, Inc.

Physician Credentialing Checklist for ________________________________

Please submit the following documents. These items will be used in our credentialing process. These copies must be received prior to securing an assignment.

Completed B&A Application & Form W-9 DOB:____________ __________

Signed Independent Contractor Agreement (ICA) __________

Curriculum Vitae in B&A format __________

State License(s) wallet size - # ___________ Exp.____________ __________

State Controlled Substance Cert. #____________ Exp.____________ __________

DEA Certificate - #______________________ Exp.____________ __________

Diplomas: Medical School - ____________________________ __________
Internship/Residency - ________________________ __________
Fellowship - ________________________________ __________

ECFMG Certificate (if applicable) - #_____________________ __________

Board Certification Letter or Verification - ______________________ __________

BCLS (required)_________ __________

ACLS_____ ATLS _____ PALS_____ EMS ________ __________

Copy of Drivers License and Social Security Card __________

Copy of Current Insurance Certificate __________

Copy of UPIN Confirmation Letter (if applicable) __________

Copy of NPI Confirmation Letter/Memo from NPPES with Taxonomy Codes **(if you do not have an NPI, you may apply at https://nppes.cms.hhs.gov.)** __________

Current Provider #'s:_______________________________________ __________

We will query the National Practitioner Data Bank; however, if you have a self-query, please attach a copy __________

References: __________

492 Pinegrove Drive, Muscle Shoals, AL 35661
Toll:888.892.4377/Office:256.389.1341/Fax:256.389.9000/ KBelk@BelkStaffing.com/web: www.BelkStaffing.com

Belk & Associates, Inc.

PHYSICIAN APPLICATION

Identifying Information:

NAME: ______________________________ Social Security #:______________________
Other Names Known By (maiden):____
ADDRESS:______________________________ Birthdate:______________________________
______________________________ Place of Birth: ______________________________
SPOUSE'S NAME______________________ Tax ID # (if applicable):____________________
PHONE:(HOME)______________________ (WORK)______________________________
(FAX) ____________________ (PAGER)____________________ (MOBILE)________________
(E-MAIL)______________________________ (For Office Use Only to expedite communication and send documentation. Email addresses are not sold, purchased, or traded.)
Name to be paid on paychecks: ____
Are you a U.S. Citizen? ______Yes ______No; If No, indicate status and entry into the U.S.A. on a separate sheet and attach.

LICENSES: (If more than 4 licenses, identify on a separate page)

Federal DEA # ____________________ Expiration________________ NPI ____________________
UPIN # __________ Medicaid # ______________ Medicare#______________ BCBS#__________________

State	Number	Date Expired	Controlled Substance (if applicable)	Date Expired
_______	_______________	________________	____________________________	_______________
_______	_______________	________________	____________________________	_______________
_______	_______________	________________	____________________________	_______________
_______	_______________	________________	____________________________	_______________

CERTIFICATION(S):

Board Status:
Specialty: __________________ Eligible________ Certified__________ Expiration_____________
Specialty #2:________________ Eligible________ Certified__________ Expiration_____________
Neither Board Certified or Board Eligible ______

BCLS_________Expiration Date__________ ATLS_________Expiration Date____________
ACLS_________Expiration Date__________ PALS_________Expiration Date____________
NRP __________Expiration Date__________ EMS__________Control Number___________
ECFMG # (if applicable)___________________

EDUCATION:

Medical School: ____
City:__________________________ State:____________________
Date Graduated:__________________ Degree:__________________

Internship:____
City:______________________________State:____________________
Date Graduated:__________________

Residency:____
City:______________________________State:___________Specialty:______________________
Dates Attended: (From)______________________________(To)______________________________
Residency (2):____
City______________________________ State:___________Specialty:______________________
Dates Attended: (From)______________________________(To)______________________________

Fellowship:____
City:______________________________State:___________Specialty:______________________
Dates Attended: (From)______________________________(To)______________________________

Initial____________

EXPERIENCE:

Facility: ____
City: ______________________________ State: ______________________
Dates (From): __________ (To) __________ Specialty Practiced: ______________________

Facility: ____
City: ______________________________ State: ______________________
Dates (From): __________ (To) __________ Specialty Practiced: ______________________

Facility: ____
City: ______________________________ State: ______________________
Dates (From): __________ (To) __________ Specialty Practiced: ______________________

Facility: ____
City: ______________________________ State: ______________________
Dates (From): __________ (To) __________ Specialty Practiced: ______________________

A. List any additional hospitals at which you have privileges and show % of work at each hospital.
1. ____ ______%
2. ____ ______%
3. ____ ______%

B. Briefly describe type and extent of your hospital privileges: ______________________________

C. Indicate membership in professional societies: ______________________________

____

REFERENCES: (please give complete information in order to expedite the credentialing process). List professional references that you have worked with in the last 24 months.

Name & Title: ______________________

Specialty: ______________________

Address: ______________________

City: ________ ST: ______ Zip: ________

Phone: __________ Fax: __________

Email address: ______________________

Name & Title: ______________________

Specialty: ______________________

Address: ______________________

City: ________ ST: ______ Zip: ________

Phone: __________ Fax: __________

Email address: ______________________

Name & Title: ______________________

Specialty: ______________________

Address: ______________________

City: ________ ST: ______ Zip: ________

Phone: __________ Fax: __________

Email address: ______________________

Name & Title: ______________________

Specialty: ______________________

Address: ______________________

City: ________ ST: ______ Zip: ________

Phone: __________ Fax: __________

Email address: ______________________

Initial __________

QUESTIONS:

1.a. Have <u>any</u> claims involving allegations of medical malpractice been made against you? ______Yes ______No _______#
b. Did any result in any monetary settlement or judgment against you? ______Yes ______No _________#
c. Are there any pending? ______Yes _____ No ______#
d. Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer?
_____Yes _____No ______#
e. Are you aware of any acts, errors, omissions or circumstances that may result in a malpractice claim or suit being made against you? ____Yes _____No
f. List malpractice insurance carriers for the <u>past 5 years</u>: ____
____
Attach <u>current</u> Certificate of Insurance

If yes to any of the above questions, please attach a Supplemental Claim Form (pg. 7) for <u>each</u> medical malpractice case.

2. Have you ever had any professional liability insurance canceled, declined, refused to renew or accepted only on special terms?
_____Yes _____No

3. Have there been, or are there currently pending, investigations of any unusual occurrences or arbitration proceedings involving alleged malpractice related to your professional practice? _______Yes _______No

If yes, please list each one on a separate sheet(s) and provide a brief clinical summary in your own words of the alleged occurrence, including the outcome.

4. Has your license to practice medicine in any jurisdiction ever been denied, limited, suspended, revoked, or voluntarily surrendered? ______ Yes _______ No

5. Have any disciplinary actions been initiated or are pending against you by any state licensure board?
______ Yes _______ No

6. Have you ever been refused membership on a hospital medical staff?
______ Yes _______ No

7. Has your request for any specific clinical privilege ever been denied or granted with stated limitations?
______ Yes _______ No

8. Have your privileges or membership at any hospital ever been suspended, revoked, not renewed, or surrendered?
______ Yes _______ No

9. Has your narcotics registration or DEA ever been suspended, revoked, limited, or surrendered?
______ Yes _______ No

10. Have you ever been denied membership, or renewal thereof, or been subject to disciplinary action in any medical organization? ______Yes ______ No

11. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics, or any other substance abuse, sexual addiction/abuse/harassment, anger management or any other mental/behavioral illness, including but not limited to depression and/or chronic fatigue? _____ Yes ______ No

If yes, please attach a written explanation

12. Have you ever been arrested for, convicted of, pled guilty to or entered into a plea agreement for a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol or any other substance?
______ Yes _______ No

If yes, please attach a written explanation

13. Have you ever been investigated by, suspended from, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (for example, Medicare, Medicaid)? ______ Yes _______ No

Initial___________

		Yes	No
14. Do you perform one or more of the following:			
A. Endoscopic Procedures (other than sigmoidoscopy or proctoscopy)? If "Yes", describe:____	A.	___	___
B. Catheterization (other than swan-ganz, umbilical cord or uretheral, or arterial line in a peripheral vessel)? Describe:___________________________	B.	___	___
C. Arteriography/lymphangiography/myelography/phenmoencephalography ?	C.	___	___
D. Interventional radiology-percutaneous transluminal angioplasty or embolization?	D.	___	___
E. Radiation therapy – deep (includes radium transplants)?	E.	___	___
F. Chemobrasion/dermabrasion/hair transplants or suturing of hairpieces?	F.	___	___
G. Mohs micrographic surgery? Describe:_______________________	G.	___	___
H. Acupuncture (for analgesia) or acupuncture anesthesia?	H.	___	___
I. Prenatal care and normal deliveries? If "Yes" do you perform home deliveries? Yes___No___ Do you supervise nurse midwives? Yes___No___ ; Refer:______wks. gestation	I.	___	___
J. Dilation and curettage?	J.	___	___
K. Needle biopsies? Describe:__________________________________	K.	___	___
L. Electroshock therapy or hypnosis? Describe:____________________	L.	___	___
M. Radial keratotomy? Location: ___Hospital ___Office ___Surgicenter	M.	___	___
N. Hexagonal keratotomy? Location: ___Hospital ___Office ___ Surgicenter	N.	___	___
15. Do you perform one or more of the following:			
A. Surgery other than incision of boils and superficial abcesses or suturing skin and superficial fascia?	A.	___	___
B. Non-spontaneous, induced abortions? __1st Trimester (not exceeding 14 weeks gestation) __2nd Trimester – location: ____Hospital ____Office ____Surgicenter	B.	___	___
C. Sterilization procedures? Describe:____________________________	C.	___	___
D. Cosmetic plastic surgery, cosmetic body contouring (suction lipectomy), implantations, injections and/or blepharopigmentation? Describe:_____________	D.	___	___
E. Spinal Surgery. If you also perform chemonucleolysis, check here___ and/or percutaneous lumbar discectomy, check here___	E.	___	___
F. Open reduction of fractures? Describe:__________________________	F.	___	___
G. Administration of general spinal or caudal block anesthesia?	G.	___	___
H. Hysterectomies? Laparoscopically? ___Yes ___No	H.	___	___
I. Cholecystectmies? Laparoscopically? ___Yes __ No	I.	___	___
J. Tonsillectomies and/or Adenoidectomies?	J.	___	___
K. Caesarian sections?	K.	___	___
L. Organ transplantations? Describe:________________________________	L.	___	___
M. Weight reduction surgery?	M.	___	___
N. Sex change operations? Describe:________________________________	N.	___	___
O. Experimental or surgical research, or experimental therapy in human patients?	O.	___	___
P. Other surgery? Describe:_______________________________________	P.	___	___

16. A. Do you perform surgery in your office? __Yes__No. If "Yes", list procedures:_________________________________
____
B. Do you perform surgery in any other non-hospital facilities? __Yes__No If "Yes", list facilities and procedures:
____
C. During surgery (described in A or B) is general anesthesia administered by you? __Yes __No; by others? __Yes __No

17. Indicate number of <u>hours per month</u> devoted to hospital emergency room care: ____hours per month; ____ hours per year

18. Do you assist in surgery: ___Yes ___No

19. Do you practice weight reduction or control (other than by diet-exercise)? __Yes __No _____ % of patients
Do you dispense (as opposed to prescribe) any weight control drugs? __Yes __No.
If "Yes", list drugs dispensed:____
Do you use injections for weight control? __Yes __ No If "Yes", list drugs injected:______________________________

20. Do you participate in any activity, e.g., newspaper columns, broadcasts, etc., whereby professional advice is offered to the public? __Yes __No. If "Yes", please attach detailed explanation of this activity.

Initial____________

RELEASE OF INFORMATION

I certify that the information submitted is true to the best of my knowledge, that I have not suppressed nor misstated material facts. I understand and agree that said information forms the basis of my application with Belk & Associates, Inc. for the purpose of providing clinical medical services. I further understand that any misrepresentation or concealment in this application will render the application and any contracts or arrangements with Belk & Associates, Inc. null and void.

I authorize Belk & Associates, Inc. to verify my personal and professional information through any medical school, hospital, clinic, physician, legal counsel, state medical board, Federation of State Medical Boards (FSMB), American Medical Association (AMA), professional and personal associates, background check, and all government agencies for the sole purpose of aiding in the credentialing process. I release Belk & Associates, Inc. and any entity or person to whom the inquiry is made from any and all claims or liability as a result of such inquiries. All information is confidential and will be used only for the above purpose.

____
Applicant's Signature (required)

____
Date

____
Print Name

SUPPLEMENTAL CLAIM INFORMATION

Answer all questions completely.

(PLEASE TYPE OR PRINT)

1. Full name of Applicant: ______________________________

2. Full name of individual(s) of firm involved in the claim: ______________________________

3. Full name of Claimant: ______________________ Sex: _____ Age: _____

4. Was claim or suit
   - ❑ merely threatened, or
   - ❑ limited to claimant's attorney contact (e.g., request of medical records),or
   - ❑ actually filed against you?
5. Date of alleged error: ____________________
6. Date of claim: ____________________
7. Additional defendants: ______________________________
8. Disposition of claim:
   - ❑ DISMISSED (Action dropped without any payment to claimant or Statute of Limitations has expired)
   - ❑ ABANDONED (no activity from claimant for over 3 years)
   - ❑ WON by defense
   - ❑ WON by claimant Total paid $______________ Amount paid on your behalf $__________________
     Indicate whether______Court Judgment, or _______Out of Court Settlement
   - ❑ OPEN (Provide the following):
     Claimant's settlement demand? $__________________
     Defendant's offer for settlement? $__________________
     Insurer's loss reserve? ______________________

9. Name of Insurer:______________________________

10. Description of claim (Provide enough information to allow evaluation)
    A. Alleged act, error or omission upon which Claimant bases claim: ______________________________
    ____
    ____

    B. Description of case and events:______________________________
    Diagnosis:______________________________
    ____
    Prognosis:______________________________
    C. Type of injury claimed:

Injury:	❑ Emotional only	❑ Temporary Disability	❑ Death
	❑ Cosmetic	❑ Permanent Disability	❑ Other (describe)__________________

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same warranty and conditions.

Signature of Applicant:______________________________Date:____________________

PHOTOCOPY THIS FORM AND SUPPLY SEPARATE INFORMATION FOR EACH CLAIM, SUIT OR INCIDENT.