



Teachers Health Trust Credentialing Application - Entity

Please complete the enclosed credentialing application or provide an application that you have used previously that contains the information requested. Please ensure that any copies used include an updated signature and date. This application must be typed or legibly printed. If more space is needed than provided, attach additional sheets.

PLEASE MAINTAIN A COPY OF YOUR COMPLETED APPLICATION FOR YOUR FILES.

Attach copies of the following documents:

- Business License (Clark County Business License, if applicable)
- Division of Health Certificate
- Certificate of Liability Insurance
- Medicare number or confirmation of Medicare certification/approval
- Records of licensing complaints or negligent actions, if any
- Accreditation currently held or in planning stages
- Copy of W9 or EIN

Please allow at least sixty (60) days to process your application.



BUSINESS DATA

Name:	Tax ID:
Other Business Name(s) Previously Used:	NPI:
Type of Business:	Business Start Date:

Contact Information for Your Business

Billing Address:	
Phone Number:	Fax Number:
Primary Contact:	
Primary Contact/Cell Number:	Answering Service Number:

Credentialing Address:	
Phone Number:	Fax Number:
Primary Contact:	E-Mail:



Physical Locations and Phone Numbers of all Business locations

(If additional space is needed, you may copy this form or submit on a separate sheet of paper)

1.	Address:	
	Phone:	Fax:

2.	Address:	
	Phone:	Fax:

3.	Address:	
	Phone:	Fax:

4.	Address:	
	Phone:	Fax:

GENERAL/PROFESSIONAL LIABILITY INSURANCE

*(Attach copy of present policy face sheet and ALL insurance carriers for the **past 5 years.***

Attach additional sheets if necessary)

Present Carrier for Nevada Business:		
Mailing Address:		
Telephone Number:		Fax Number:
Policy#:	Effective Date:	Expiration Date:
Amounts of Coverage – Minimum 1 Million/3 Million Malpractice if applicable Minimum 2 Million Public Liability		



STATEMENT OF UNDERSTANDING, AUTHORIZATION, CONSENT AND RELEASE

I understand that any misrepresentation or significant omission in this application constitutes cause for denial or for subsequent revocation of membership in the Teachers Health Trust's provider network. I also have had an opportunity to review the information submitted in support of this application. If during the process of credentialing, the Teachers Health Trust's provider network receives information that varies substantially from information I have provided, I will be notified of this and will have an opportunity to correct erroneous information.

I recognize that as the applicant I bear the burden of demonstrating that my business qualifies and remains qualified for the award of membership in accord with the criteria and standards required by the Teachers Health Trust's provider network, and I recognize that I have the burden of resolving any reasonable doubts about my business qualifications for membership, participation and privileges.

In order to facilitate the evaluation of this application, I agree to meet and cooperate with the various officers, representatives and committees charged with responsibility for credentialing and peer review activities. Moreover, I consent to the communication and release of information and documents (including medical staff records and patient care records) among the specified medical centers, medical staffs and other entities which I have disclosed in this application and any and all other hospitals, medical staffs, medical schools, training programs, medical societies, professional associations, professional liability insurers, licensing authorities, specialty boards, health maintenance organizations, medical groups, ambulatory or outpatient care center, clinics, independent practice associations and any and all other sources that may be available for the purpose of evaluating my professional education, training, experience, character, conduct and judgment. In this regard, care shall be taken to safeguard the privacy of medical information and the confidentiality of medical staff information and medical records. I understand that the evaluation of credentials shall be accomplished in a professional manner, and that I will be afforded an appropriate review in the event that action on this application is adverse in accordance with the bylaws or rules pertaining to each organization.

I specifically authorize the transmission of this application and all supporting documentation, and all information collected during the credentialing process, to each employee of the Teachers Health Trust responsible for reviewing my application.

I therefore fully release from liability any person or entity, including any and all representatives of the Teachers Health Trust and any representative, agent or component thereof, that requests or provides information in connection with the evaluation of my application, credentials and practice, to the fullest extent allowed by applicable statutes, regulations and judicial decisions. Moreover, I fully release from liability the Teachers Health Trust and any representative, agent or component thereof, and all other persons or entities participating in the evaluation of my credentials and practice from any and all liability for their actions and decisions, to the fullest extent allowed by applicable statutes, regulations and judicial decisions. As part of this application, I pledge that if I am granted the requested membership, I will maintain an ethical practice in accord with applicable bylaws, and specifically that I will:

- A. Refrain from fee splitting or other inducements relating to patient referral
- B. Provide for the continuous care and supervision of my patients;
- C. Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a medical practitioner who is not qualified to undertake this responsibility and who is not adequately supervised;
- D. Abide by all applicable and generally recognized ethical principals applicable to my business and to each and every healthcare entity to which I am applying; and,
- E. Maintain the confidentiality of patient information received by both paper and electronic means.

During the time that this application is being processed, I agree to update the application should there be any material change in the information provided which may affect the application or its outcome, and I specifically agree to notify the Teachers Health Trust immediately upon notification upon any significant change or any formally recommended change in licensure status, or any actual or formally recommended denial, suspension or revocation of privileges or membership or status by another healthcare entity, or cancellation or interruption of my general or professional liability insurance coverage.

I present this application and arrange for the submission of other information as part of this credentialing process in the expectation that the confidentiality and privacy of this information will be preserved and that this information and these materials will only be released and disclosed as part of current and future credentialing, peer review and quality assurance processes as described above.

I affirm that all information submitted by me in this application is true, current and complete and is furnished in good faith.

Signature of Applicant

Printed Name

Date



INSURANCE CLAIM INFORMATION WORKSHEET

Please provide complete information since the date your business first became licensed.

Please duplicate this form and complete for EACH case in which you or your business was named as a defendant.
Also, for each case that has been settled or dismissed, supply court documentation.

Business Name:

Claimant Name:

Complaint or Injury:

Allegations:

Patient Outcome:

Other pertinent details:

Date of Incident:

Date filed:

Date closed:

Current Status of Case **must be noted** (dismissed, settled out of court, pending, other) NOTE: All Cases must include legal documentation:

Settlement amount paid on your behalf, if any:

Liability Insurer involved:

Name of Insurer:

Address of Insurer:

Policy Number:

Name

Date

Signature **Note: This form must be signed and dated whether or not you have any items to disclose.**



PRACTITIONER QUESTIONNAIRE

If the answer to any of the following questions is YES, please give full details on a separate sheet of paper. (Date of occurrence, description of events, and current status)

- A. *Has your business license in any jurisdiction ever been denied, revoked, terminated, relinquished, suspended, otherwise limited or restricted, or been made subject to a program of probation, or have you ever been issued a citation or letter of reprimand by the licensing agency, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced?* Yes No
- B. *Has your membership, participation, contractual affiliation or other status with any health maintenance organization, medical group, preferred provider organization, or any other comparable health care entity ever been denied, revoked, voluntarily or involuntarily terminated, suspended, restricted or limited based upon patient care or professional conduct grounds, or have formal or informal proceedings, or investigations toward any of those ends ever been commenced?* Yes No
- C. *Have you ever relinquished membership, participation, privileges, a contractual affiliation or other comparable status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity after notification of the actual or imminent commencement of a formal or informal review or investigation, of your business?* Yes No
- D. *Has your membership or status in any state or local professional society or other comparable medical organization ever been denied, revoked, voluntarily or involuntarily terminated, suspended or restricted based upon patient care or professional conduct concerns, or have formal or informal proceedings, or investigations toward any of those ends ever been commenced?* Yes No
- E. *Has your status as a participating provider in the Medicare, Medicaid, or Tricare (formerly Champus) programs ever been sanctioned, denied, suspended voluntarily or involuntarily terminated, limited or revoked, or have formal or informal proceedings or investigations toward any of those ends ever been commenced?* Yes No
- F. *Has a letter of concern or reprimand ever been issued to you? If Yes, provide copies.* Yes No
- G. *Have you ever been denied general or professional liability insurance or has your policy ever been canceled?* Yes No
- H. *Have you ever received notice of intent to commence litigation based on allegations of negligence or misconduct? With regard to any such complaint or suit, has it resulted in a judgment, a settlement, or other final disposition, or is it still pending? **Note: Make copies of the attached Insurance Claim Information Worksheet and complete for each case including all legal documentation.*** Yes No