New Jersey Physician Recredentialing Application

(Please type or print)

All sections must be completed fully or clearly marked as "not applicable."
No area should be left blank.

SECTION 1

Personal Information

Physician Name (Last) (First) (MI) (Jr., Sr., etc.)	UPIN	Social Security Number

Corporate Name (if different from name above)	Professional Degree(s)

Practice Location Information - Primary Office

Primary Office Address	City	State	Zip Code

Telephone No.	Fax No.

Tax ID Number and Associated Individual Group Number and Name for This Location

Non-English Languages Spoken (Health Care Provider)	Non-English Languages Spoken (Office Staff)	Handicap Access ☐ Yes ☐ No

Continuing Education

Please list all continuing education for the past two years.

Course Name	Location	Date Taken	Number of CME/CEUs

Professional/Medical Specialty Information

Primary Specialty	Board Certified? ☐ Yes ☐ No

Professional Certificates, Licenses, Identification Numbers

Are you a Member of your State Medical Society? ☐ Yes ☐ No	Primary State License Number	State	Expiration Date

List any additional licenses (current or expired) within the last 15 years:

License Number	State	Expiration Date

Federal DEA Number	Expiration Date

CDS Number	Expiration Date

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Hospital Affiliations

Primary Admitting Facility	From:	To:

Type of Appointment (Active, Courtesy, etc.)	Specialty

Additional Facilities:

Name	Specialty	From/To	Restrictions

Professional Liability Insurance Coverage

Name of Current Malpractice Insurance Carrier			
Address	**City**	**State**	**Zip Code**

Policy Number	Period of Coverage	Amount of Coverage per Occurrence	Amount of Coverage Aggregate
		$	**$**

Additional Office Information

Address	City	State	Zip Code

Telephone No.	Fax No.
E-mail Address	Does this office have capability for electronic billing? ☐ Yes ☐ No

SECTION 2 - DISCLOSURE QUESTIONS

Please answer each question. If you respond "Yes" to any of the questions listed below, please provide an explanation on a separate sheet of paper. If question does not apply, please write in "N/A."

Licensure			
1.	Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?	☐ Yes	☐ No
2.	Has your federal or state narcotics license ever been suspended, limited, revoked, voluntarily suspended or not renewed, or has probation ever been invoked?	☐ Yes	☐ No
3.	Have you ever received a reprimand or been fined by any state licensing board?	☐ Yes	☐ No
Hospital Privileges and Other Affiliations			
4.	Have your clinical privileges at any hospital or healthcare institution 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 records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?	☐ Yes	☐ No
5.	Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?	☐ Yes	☐ No
6.	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 organizations (including HMOs, PPOs, or provider organizations such as IPAs or PHOs)?	☐ Yes	☐ No
Education, Training and Board Certification			
7.	Have you ever been placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, fellowship, preceptorship or other clinical education program?	☐ Yes	☐ No
8.	If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program?	☐ Yes	☐ No
9.	Have you ever, while under 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
10.	Have any of your board certifications or eligibility ever been revoked?	☐ Yes	☐ No
11.	Have you ever chosen not to re-certify or voluntarily suspended your board certification(s) while under investigation?	☐ Yes	☐ No
DEA or CDS Certification/Authorization			
12.	Have your Federal and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?	☐ Yes	☐ No
Medicare, Medicaid and Other Governmental Program Participation			
13.	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 any other private, federal or state health program?	☐ Yes	☐ No

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Other Sanctions or Investigations

14. Are you currently or have you ever been 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? ☐ Yes ☐ No

15. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? ☐ Yes ☐ No

16. Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? ☐ Yes ☐ No

17. Has a patient, employee, or co-worker ever accused you of sexual harassment or other illegal misconduct that resulted in an investigation, sanction or other formal action? ☐ Yes ☐ No

18. During your military career, if applicable, have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, voluntarily terminated or resigned while under investigation by a hospital/healthcare facility of any military agency? ☐ Yes ☐ No

Professional Liability Insurance Information

19. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? ☐ Yes ☐ No

20. 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

21. Have you ever had any malpractice actions (pending, settled, dropped, dismissed, arbitrated, mediated or litigated)? If yes, please provide information for each case (list each action separately). ☐ Yes ☐ No

- Date of occurrence
- Claim/case status
- Date claim was filed
- Professional liability insurance carrier involved (include name, address, phone number and policy number)
- Amount of award or settlement and amount paid:
- Method of Resolution:
  - ☐ Dismissed
  - ☐ Judgment for plaintiff(s)
  - ☐ Mediation/Arbitration
  - ☐ Settled (with prejudice)
  - ☐ Judgment for defendant(s)
  - ☐ Settled (without prejudice)
- Description of allegations
- Indicate whether you were primary defendant or co-defendant
- Number of other co-defendants
- Indicate your involvement in the case (attending, consulting, etc.)
- Description of alleged injury to the patient

Criminal/Civil History
(Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be based upon all relevant circumstances, including the nature of the crime.)

22. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony in the last ten years or been found liable or responsible for or named as a defendant in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional? ☐ Yes ☐ No

23. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony in the last ten years or been found liable or responsible for or been named as a defendant in any civil offense that alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? ☐ Yes ☐ No

24. Have you ever been indicted in any civil or criminal suit? ☐ Yes ☐ No

25. Have you ever been court-martialed for actions related to your duties as a medical professional? ☐ Yes ☐ No

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Ability to Perform Job

26. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? ☐ Yes ☐ No

27. 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

28. 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

29. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients? ☐ Yes ☐ No

30. Do you have Professional Liability (Malpractice) Insurance coverage in force? (If "No," please explain below.) ☐ Yes ☐ No

SECTION 3 - AUTHORIZATION, ATTESTATION AND RELEASE

I understand and agree that, as part of the recredentialing process for participation and/or clinical privileges at or with the above referenced managed care company (hereinafter referred to as the "Entity") and any of the Entity's affiliates, I am required to provide sufficient and accurate information for proper evaluation of my current licensure, relevant training and experience, clinical competence, health status, moral character and any other criteria used by the Entity for determining initial and ongoing eligibility for participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for participation is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorizations

Investigation Concerning Application for Participation: I hereby authorize the following individuals, including the Entity, its representatives, employees, designated agent(s); the Entity's affiliates and their representatives, employees, or agent(s); the Entity's designated professional credentials verification organization (hereinafter collectively referred to as "Agents"), to investigate information, including oral and written statements, records, and documents, concerning my application for participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Third-Party Sources to Release Information Concerning Application for Participation: I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance and managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental and physical condition, alcohol or chemical dependency, diagnosis and treatment, ethics, or any other matter reasonably bearing on my qualifications for participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Release and Exchange of Disciplinary Information: I authorize any third party at which I currently have Participation or had Participation and/or the third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities with which I have Participation, as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Provider Initials: _____ Date: _____

Releases

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information to any person, entity or governmental agency that executes an appropriate confidentiality agreement or has a legal right to know under any state or federal Law. I understand and agree that this Authorization, Attestation and Release is irrevocable for as long as this application is pending and, if accepted for Participation, for so long as the participating provider agreement remains in force and effect. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

Attestation

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (by a written or electronic signature). I further understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s).

Provider Initials: _____ Date: _____

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Name (Print or Type)	Social Security Number
Signature	Date