



**MICHIGAN ASSOCIATION OF HEALTH PLANS
Standard Practitioner Application**

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PLEASE:

- 1. COMPLETE THIS ENTIRE APPLICATION.**
- 2. SUBMIT A COPY AND RETAIN THE ORIGINAL FOR YOUR RECORDS.**
- 3. CURRICULUM VITAE WILL NOT BE ACCEPTED AS REPLACEMENT FOR A PART OF THIS APPLICATION.**
- 4. SIGN AND DATE: ATTESTATION ON PAGE 9 AND/OR 10.**
- 5. SIGN AND DATE: RELEASE OF INFORMATION ON PAGE 11.**

I A. PERSONAL INFORMATION

- _____ 2. _____
Name (Last, First, Middle) Degree/Professional Title
- _____ 4. Gender: Male Female
Other Names You May Have Used (Maiden, a.k.a., etc.)
- _____ 6. _____
Home Address/Street City/State/Zip
- (_____) _____ 8. (_____) _____ 9. _____
Home Telephone No. Home Fax No. E-mail Address
- _____ 11. _____
Date of Birth (Month/Day/Year) Citizenship/Place of Birth
- _____ 13. _____
Languages fluently spoken in addition to English Languages written in addition to English
- _____ 15. _____
Social Security No. Ethnicity (Optional)
16. If you are not a US Citizen do you have authorization to work in the US? Yes No

I B. PRACTICE SPECIALTY FOR WHICH YOU ARE SEEKING AFFILIATION

1. Are you applying as a:

Primary Care Physician:

- | | | |
|--|---|---|
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Family Practice with Deliveries | <input type="checkbox"/> Internal Medicine/Pediatrics | <input type="checkbox"/> General Practice |
| <input type="checkbox"/> OB/Gyn | <input type="checkbox"/> Other _____ | |

Specialist:

- Specialty _____
 Sub-Specialty _____

Allied Health Practitioner:

- | | | |
|--|--|--|
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Clinical Nurse Specialist | <input type="checkbox"/> Nurse Midwife | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Optometrist | <input type="checkbox"/> Other _____ | |

2. Other medical interests in practice, research, etc: _____

II B. CROSS COVERAGE [Please list covering practitioners. If additional information, please attach.]

1. _____ (_____) _____
Name of Practitioner Specialty Telephone No.

Address Suite City State Zip

Hospital Affiliations

2. _____ (_____) _____
Name of Practitioner Specialty Telephone No.

Address Suite City State Zip

Hospital Affiliations

3. _____ (_____) _____
Name of Practitioner Specialty Telephone No.

Address Suite City State Zip

Hospital Affiliations

II C. 24-HOUR COVERAGE AND ADMITTING ARRANGEMENTS N/A

1. Do you have arrangements for 24-hour, 7-days-a-week medical coverage for your patients? Yes No
If no, please explain: _____

2. Do you currently admit and care for your hospitalized patients? Yes No If no, please explain the formal inpatient coverage arrangement(s) for each inpatient facility: _____

II D. RADIOLOGY N/A

1. Do you perform/provide radiology services in your office? Yes No X-ray License No. _____
If yes, at what site(s): _____
2. Do you perform mammograms? Yes No If yes, attach copy of State of Michigan and FDA certificate.

II E. DIAGNOSTICS N/A

1. If you provide direct laboratory services, please indicate the Tax ID No. utilized and provide CLIA or COLA information. Attach a copy of your CLIA or COLA certificate or waiver if you have one:

Tax ID Billing Name: CLIA / COLA Type of Service Provided

2. Do you provide in-house Endoscopy procedures? Yes No

II F. SURGICAL N/A

1. If you have multiple office locations, which one(s) has a surgical suite(s): _____
If yes, is it: (check all that apply) State licensed Medicare Certified ACR/FDA
 MQC Accredited AAAASF Accredited AAAHC Accredited
 Other _____

2. Other Certifications (e.g. Fluoroscopy, Radiography, etc.)

Type Number Expiration

Type Number Expiration

II G. ALLIED HEALTH PRACTITIONER SUPERVISING PHYSICIANS N/A

1. _____
 Name of Supervising Physician Specialty Telephone No. (_____) _____

2. _____
 Address Suite City State Zip

3. _____
 Hospital Affiliations

III A. MEDICAL / PROFESSIONAL SCHOOL

List all Medical Schools/Institutions attended including undergraduate and graduate school for allied health practitioners. Enclose copies of your diplomas and certificates.

1. _____
 Medical/Professional School Degree Awarded Date of Graduation (mm/yy)

 Address City State Zip

2. _____
 Medical/Professional School Degree Awarded Date of Graduation (mm/yy)

 Address City State Zip

III B. POST GRADUATE TRAINING

List all training attended. Enclose copies of your certificates. Explain any 30-day or greater gap in your training on a separate sheet.

1. INTERNSHIP

Program successfully completed? Yes No

 Institution/Hospital Dates From (mm/yy) Dates To (mm/yy)

 Address City State Zip

 Program Specialty Program Director Telephone No. (_____) _____

2. RESIDENCY

Program successfully completed? Yes No

 Institution/Hospital Dates From (mm/yy) Dates To (mm/yy)

 Address City State Zip

 Program Specialty Program Director Telephone No. (_____) _____

3. FELLOWSHIP

Program successfully completed? Yes No

 Institution/Hospital Dates From (mm/yy) Dates To (mm/yy)

 Address City State Zip

 Program Specialty Program Director Telephone No. (_____) _____

4. OTHER

Program successfully completed? Yes No

 Institution/Hospital Dates From (mm/yy) Dates To (mm/yy)

 Address City State Zip

 Program Specialty Program Director Telephone No. (_____) _____

Directions for Sections IV & V: List in chronological order (with the current affiliation first) all institutions where you have current affiliations and have had previous hospital privileges. This includes hospitals, residential treatment and rehabilitation centers, surgery centers, institutions, corporations, military assignments, or government agencies. Work history should include self-employment. If more space is needed, attach additional sheet(s). **A curriculum vitae (CV) is not sufficient as replacement for these sections.**

IV. HOSPITAL / FACILITY HISTORY

1. _____
CURRENT Primary Admitting Facility _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
 Address _____ Suite _____ City _____ State _____ Zip _____
 Department/Specialty _____ Staff Category _____ Chairperson _____ Telephone No. _____

2. _____
Admitting Facility _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
 Address _____ Suite _____ City _____ State _____ Zip _____
 Department/Specialty _____ Staff Category _____ Chairperson _____ Telephone No. _____

3. _____
Admitting Facility _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
 Address _____ Suite _____ City _____ State _____ Zip _____
 Department/Specialty _____ Staff Category _____ Chairperson _____ Telephone No. _____

4. _____
Admitting Facility _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
 Address _____ Suite _____ City _____ State _____ Zip _____
 Department/Specialty _____ Staff Category _____ Chairperson _____ Telephone No. _____

V. WORK HISTORY [Add additional sheets if more space required.]

Chronologically list all work history activities since completion of postgraduate training. Explain any gaps of more than thirty days.

1. _____
Current Practice _____ Contact Name _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
 Address _____ Suite _____ City _____ State _____ Zip _____ Telephone No. _____

2. _____
Previous Practice/Employer _____ Contact Name _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
 Address _____ Suite _____ City _____ State _____ Zip _____ Telephone No. _____

3. _____
Previous Practice/Employer _____ Contact Name _____ Dates From (mm/yy) _____ Dates To (mm/yy) _____
 Address _____ Suite _____ City _____ State _____ Zip _____ Telephone No. _____

VI. TIME INTERVALS [Explain any time intervals not accounted for in application.]

Suspended from Practice _____ From _____ To _____
 Loss of License _____ From _____ To _____
 Served in Military _____ From _____ To _____
 Personal Leave _____ From _____ To _____
 Other (Please describe) _____ From _____ To _____

VII. MEDICAL / PROFESSIONAL LICENSURE

1. _____
Michigan State Medical / Professional License No. _____ Date First Issued _____ Expiration Date _____

2. _____
Michigan State Controlled Substance No. _____ Expiration Date _____

3. _____
Drug Enforcement Administration Certification No. (DEA) _____ Expiration Date _____

4. ALL OTHER STATE MEDICAL/PROFESSIONAL LICENSES:

State: _____ License No.: _____ Expiration Date: _____

State: _____ License No.: _____ Expiration Date: _____

5. _____
Medicare ID No.

6. _____ or N/A
ECFMG No.

7. _____
UPIN

8. _____
National Provider Identification No.

9. _____
HIPAA Taxonomy Codes

VIII. BOARD CERTIFICATION/CERTIFYING ENTITY

Name of Board/Certifying Entity	Certificate No.	Date Certified / Re-certified	Expiration Date	Specialty
1.				
2.				
3.				

Have you applied for board certification other than those indicated above? Yes No

If yes, list board(s) and date(s): _____

If not certified, do you intend to apply? Yes Specify timeframe: _____

No Specify reason: _____

Have you ever taken and not passed a medical board examination? Yes No If yes, will you re-take? Yes No

IX. REFERENCES

List three professional references, preferably from your specialty area, not including relatives, and no more than one current partner or associate. NOTE: References must be from individuals who are directly familiar with your work, either clinical observation or close working relations.

1. _____
Name _____ Title/Relationship _____ Telephone No. _____
Address _____ City _____ State _____ Zip _____ Fax No _____
Email Address: _____

2. _____
Name _____ Title/Relationship _____ Telephone No. _____
Address _____ City _____ State _____ Zip _____ Fax No _____
Email Address: _____

3. _____
Name _____ Title/Relationship _____ Telephone No. _____
Address _____ City _____ State _____ Zip _____ Fax No _____
Email Address: _____

X. PROFESSIONAL LIABILITY CARRIER INFORMATION

Please list all of your professional liability carriers for the **past ten years**:

Does your current professional liability insurance cover you in all of your practice locations? Yes No

1. _____
Current Insurance Carrier Policy No. _____

Address City State Zip Telephone No. (_____) _____

Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

Initial Date of Coverage Retroactive Date of Coverage Expiration Date

2. _____
Insurance Carrier Policy No. _____

Address City State Zip Telephone No. (_____) _____

Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

Initial Date of Coverage Retroactive Date of Coverage Expiration Date

3. _____
Insurance Carrier Policy No. _____

Address City State Zip Telephone No. (_____) _____

Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

Initial Date of Coverage Retroactive Date of Coverage Expiration Date

4. _____
Insurance Carrier Policy No. _____

Address City State Zip Telephone No. (_____) _____

Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

Initial Date of Coverage Retroactive Date of Coverage Expiration Date

5. _____
Insurance Carrier Policy No. _____

Address City State Zip Telephone No. (_____) _____

Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

Initial Date of Coverage Retroactive Date of Coverage Expiration Date

XI. CLAIM / LAWSUIT HISTORY - 10 YR. HISTORY

If you answer "YES" to any of the following questions, please provide details per the attached claims information sheet. Please explain any surcharge to your professional liability coverage on a separate sheet.	YES	NO
Have you ever been a defendant in a malpractice suit?		
Have any judgments been made against you or settlements been agreed to in any professional liability cases?		
Are there any professional liability lawsuits pending against you at the present time?		
Has your professional liability insurance ever been terminated or restricted or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?		

XII. HEALTH STATUS

If the answer to any question is "YES", reference the question on a separate sheet. Please provide a full explanation and attach.	YES	NO
Are you currently using any chemical substance(s), which in any way may impair or limit your ability to practice medicine with reasonable skill and safety?		
Are you currently engaged in the illegal use of controlled substances?		
Do you have a mental or physical condition, which in any way may impair or limit your ability to practice medicine with reasonable skill and safety with or without reasonable accommodation?		

XIII. PROFESSIONAL PRACTICE

Have any of the following been or are currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, reviewed, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state, territory or country? If "YES", provide full explanation and attach.	YES	NO
Medical or professional license		
DEA Registration or Controlled Substance license		
Hospital medical staff membership		
Clinical privileges or other rights on any hospital medical staff		
Employment by any hospital, institution or the military		
Professional society membership		
Participation in any private, federal, or state health insurance program (i.e. Medicare, CHAMPUS, Medicaid)		
Participation in an HMO, PPO, or any other managed care organization		
Board Certification		

XIV. OTHER DISCLOSURES

At any time have you ever been:	YES	NO
Convicted of any criminal offense in any jurisdiction		
Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of trial, or an accelerated rehabilitation disposition of felony charges in any state, territory or country		
Have you ever, at any time, or are you currently:	YES	NO
Under audit by a Health Care Agency (i.e. Medicare, Medicaid, MDCH, or any insurance)		
Under indictment for any crime		
The subject of an investigation by any private, federal or state health insurance program or state, territory or country licensing board		
The subject of any adverse action reports to a state or federal agency		
Sanctioned by a government program or agency for any reason		
Have you ever, at any time, either voluntarily or involuntarily:	YES	NO
Withdrawn your application for medical staff membership at any facility		
Withdrawn your request for any clinical privileges at any facility		

XV. ATTESTATION STATEMENT

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature: _____

Date: _____

Go To Next Page To Update Attestations

XVI. UPDATE ATTESTATION STATEMENT

One signature block below is to be signed if a previously completed application is being reviewed and updated for submission to an additional organization.

The application was designed so that a practitioner need complete it in its entirety only once. If application is then made to another organization which accepts this Standard Application and it has been more than 60 days since the practitioner completed or updated the application, the practitioner may review the application, make any needed modifications and then sign one of the attestation statement blocks below, reconfirming that the application is complete, true and accurate. It is particularly important that the Disclosure Questions be reviewed and any changes made with appropriate documentation included.

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Signature:

Date:

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

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Signature:

Date:

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Signature:

Date:

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Signature:

Date:

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CONSENT TO RELEASE OF INFORMATION FORM

I understand that this Consent to Release Information is made in connection with Physician/Practitioner contracting, credentialing, recredentialing or reappointment activity of the Plan. I further understand that the Plan is responsible for the evaluation of my professional training, experience, professional conduct and judgment. All information submitted by me or on my behalf pursuant to this Consent to Release Information is true and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission related thereto may constitute cause for the summary dismissal/denial of such participation in the Plan. I understand and agree that as an applicant for participation with the Plan, I 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 hereby authorize the Plan and its representative to contact and/or consult with any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and professional liability carriers) which I have been affiliated, have used for liability insurance or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as references by me. I consent to the release and communication of information and documents between the Plan and persons, entities or institutions in jurisdictions in which I have trained, resided, practiced, or applied for professional licensure, privileges or membership in plans for the purpose of evaluation of my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice insurance claims history.

I also authorize and direct persons contacted by the Plan to provide such information regarding my character and/or professional competence and qualifications, my professional liability insurance and/or malpractice insurance claims history to representatives of the Plan and I understand in doing so, I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, or institutions who, in good faith and without malice for acts performed in gathering or exchanging information in this credentialing or recredentialing process. This release and hold harmless provision applies to all persons, entities and institutions who will provide and/or receive, as part of the Plan's credentialing or recredentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency and mental health information.

I further authorize the release of the above information or any other information obtained from the application by a credentialing verification organization (CVO) to any health care organization designated by me or one that has entered into an agreement with the CVO where I currently have, am currently applying, or in the future will be applying for participation. I also authorize the CVO or the Plan to allow my file to be reviewed by the organizations' state or national accrediting and licensing bodies.

I further affirm that I currently do not have any physical and/or mental conditions and/or impairments, such as substance abuse, alcohol dependency and/or mental health concerns which interfere with my ability to practice medicine. I agree to notify representatives of the Plan of any changes in my professional licensure, scope of hospital privileges, participating Plan status, status of my malpractice insurance, malpractice claims history information and practice locations. I understand that this application shall not be deemed complete until an on-site medical practice office review is completed, if applicable, as well as receipt of all information required by this application process. I further agree to appear before the Plan for interviews, if requested, or inquiries regarding evaluations of my professional qualifications at reasonable times and places.

A photocopy of this consent shall be as effective as an original when presented.

Practitioner's Printed Name: _____

Practitioner's Signature: _____

Date: _____

Updated Signature: _____

Date: _____

Updated Signature: _____

Date: _____

Updated Signature: _____

Date: _____

Updated Signature: _____

Date: _____

Updated Signature: _____

Date: _____

(PLEASE COMPLETE A SEPARATE FORM FOR EACH CLAIM)

Claim Number or Patient Initials: _____ Age: _____ Gender: _____

Incident Is: Pending Closed Date: _____
 Dismissed Date _____
 Settlement Date _____ \$ _____
 Judgment Date _____ \$ _____

You Are: Solo Defendant
 Co-Defendant With _____
 Other _____

Were the Settlement Terms Confidential? Yes No

Settlement/Judgment Details: _____

Amount Paid on Your Behalf: _____

Date of Incident: _____ Date Suit Filed: _____

Court: _____ Case No.: _____

Name and Address of Insurance Carrier at Time of Incident: _____

Name of Additional Defendant(s): _____

Explain in Detail the Plaintiff's Allegations: _____

Explain in Detail your Defenses to These Allegations: _____

Patient's Condition Post-Incident: _____

Whom may we consult for further legal information about the suit: _____

Signature of Applicant _____ Date _____

Print Name _____

Please enclose the following copies with your application:

- Signed Authorization For Release of Information/Liability (Page 11)
- For updating of the MAHP application ONLY please sign Page 10 and 11
- Current Licensure
 - Michigan License to Practice
 - Michigan Drug Control License (if applicable)
 - Michigan Controlled Substance (if applicable)
 - Federal Controlled Substance Registration Certificate (DEA) (if applicable)
- Board Certification Certificate(s)
- Medical School, Internship, Residency, Fellowship certificates
- ECFMG Certificate for International Medical Graduates
- Current Professional Liability Coverage
- Completed Supplemental Claims Information Form indicating involvement in any suits or judgments (pending, settled or otherwise)
- CLIA/COLA Registration
- Mammography Certification (ACR & FDA)
- W-9
- Federal Tax Deposit Coupon
- Curriculum Vitae (with work history)
- X-ray License