PRACTITIONER RE-CREDENTIALING APPLICATION

Notice to applicants: Encore conducts continuous enrollment for practitioners who meet minimum criteria. Minimum criteria for consideration by Encore Credentialing Committee are:
Unrestricted, non-probationary license to practice, current DEA certificate if prescribing controlled substances, adequate professional liability insurance, admitting privileges at Encore participating hospitals for those who normally admit, lack of Medicare/Medicaid sanctions, signed Encore agreement for participation. Providers not meeting the minimum criteria above need not apply.

CHECKLIST

Please ☒ if all items are enclosed:

- ☐ **Attestation and release form is signed and dated with current date.**
- ☐ **Current Copy of State License(s).**
- ☐ **Current Copy of DEA Certificate(s) (if applicable)**
- ☐ **Current Copy of Professional Liability Certificate.**
- ☐ **Completed malpractice detail for all open cases within the past five (5) years.**

If we should have questions about this application, please supply the following contact information:

____________________	____________________	____________________
Name	**Title**	**Phone**

____
Fax

____
Email

____

Return to:
ATTN: **Encore Health Network**
Credentialing Department
8520 Allison Pointe Blvd, #200
Indianapolis, IN 46250-4250

Practitioner Rights: You have the right to review information submitted in support of your application, to correct erroneous information and to receive the status of your application, upon request.

Provider Re-Credentialing Application Form

PLEASE TYPE OR PRINT. FILL IN ALL SECTIONS. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

I. DEMOGRAPHICS

Name (Last, First, Middle)

Title

List Other Names Used (Last, First, Middle)

Date of Birth (for Data Bank Query)

Sex: Male Female

Do You Have the Legal Right to Work in the US? Y N

Corporate Name (if different from name above)

II. OFFICE/PRACTICE INFORMATION

(Please Include All Offices/Practices, Using the Attached Additional Sheets if Necessary)

Primary Care Specialty Care Specialty: ______ Subspecialty: ______

PRIMARY OFFICE ADDRESS/STREET

City/State/Zip

Office Phone

Office Fax

Office Manager

Federal Tax ID#

Billing Address/Street (if different from above)

Billing City/State/Zip

Type of Practice: Solo Single Specialty Group Multispecialty Group Other

Office E-Mail address, if any: ______

Do You Currently: *(CIRCLE ONE)*

Accept New Patients Into Your Practice? Y N

Accept New Patients From Physician Referral Only? Y N

Have Medicare Certification? Y N

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SECONDARY OFFICE ADDRESS/STREET

City/State/Zip

Office Phone

Office Fax

Office Manager

Federal Tax ID#

Billing Address/Street (if different from above)

Billing City/State/Zip

Type of Practice: Solo Single Specialty Group Multispecialty Group Other

Do You Currently: *(CIRCLE ONE)*

Accept New Patients Into Your Practice? Y N

Have Medicare Certification? Y N

Accept New Patients From Physician Referral Only? Y N

PRACTICE SPECIALTY

PRIMARY SPECIALTY

National Board Certification

Certification Number

Name of Board

Date of Certification

Expiration Date

Date of Recertification

SECONDARY SPECIALTY

Board Certification

Certification Number

Name of Board

Date of Certification

Expiration Date

Date of Recertification

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PROFESSIONAL CERTIFICATES/LICENSES/NUMBERS

State License Number/State of License

Expiration Date

Other State License Number/State of License

Expiration Date

Other State License Number/State of License

Expiration Date

Federal DEA Number/State of License

Expiration Date

State Medicare Number/State of License

State Medicaid Number/State of License

State Certification Number (CSR)

Expiration Date

CDS Certification

Individual National Provider Identifier/NPI#

ECFMG Number

Organizational NPI#

PROFESSIONAL LIABILITY INSURANCE

CURRENT CARRIER NAME

Address/Street

City/State/Zip

Dates of Coverage

Policy Number

Coverage Amount Per Occurrence/Aggregate

Policy Type

Occurrence(s)

Claim(s) Paid

Length of Time with Current Carrier

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ADDITIONAL QUESTIONS

(PLEASE PROVIDE AN EXPLANATION FOR ANY "YES" RESPONSES ON A SEPARATE PAGE)

Question	Y	N
1. Have any of your board certifications ever been suspended, revoked, or voluntarily surrendered?	Y	N
2. Have you ever been named as a defendant in any criminal or civil case or convicted of a felony?	Y	N
3. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified?	Y	N
4. Has your malpractice insurance ever been cancelled, suspended, not renewed, restricted, or special-rated?	Y	N
5. Has your license to practice medicine in any state been suspended, restricted, revoked, voluntarily surrendered, been subject to a consent order, or has probation ever been invoked?	Y	N
6. Has your federal or state controlled substance license ever been suspended, revoked, or voluntarily surrendered, or has probation ever been invoked?	Y	N
7. Have your privileges at any hospital or other health care setting ever been suspended, revoked, voluntarily surrendered, reduced, or restricted, or not renewed, or has probation ever been invoked?	Y	N
8. Within the last five years, have you ever been a participating provider of another HMO, PPO, PHO, or MSO, etc. with which you are not affiliated at this time?	Y	N
9. Have you ever received sanctions from a regulatory agency (e.g., CLIA, OSHA, etc.)?	Y	N
10. Has any information on you ever been reported to the National Practitioner Data Bank?	Y	N
11. Have you any inability to perform the essential functions of the position, with or without accommodation?	Y	N
12. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application. Rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)	Y	N
13. Within the last five years, have you ever been reprimanded or disciplined in any manner by any state licensing authority or other professional board or peer review committee for conduct related to the use of alcohol or the use of any drug?	Y	N
14. Number of Continuing Medical Education (CME's) in Category 1 for the previous 24 months.	____ hrs	
15. Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital, ambulatory surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies? If so, please provide the following information:	Y	N

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Name of Organization ______________________ Type of Organization ______________________

Address/Street ______________________

City/State/Zip ______________________

Telephone Number ______________________ Tax Identification Number ______________________

Percent of Business Owned/Invested by Applicant ______________________ Nature of Business Interest (owner, partner, investor) ______________________

AFFIRMATION OF INFORMATION

I, the undersigned, hereby attest that the information given in or attached to this Application is correct and complete and fairly represents the current level of my training, experience, capability and competence to practice at the level requested. I specifically authorize Encore Health Network and its authorized representatives to consult with any third party who, may have information bearing on the subject matter addressed by this Application and to inspect or obtain any reports, records, recommendations or other documents or disclosures of third parties that may be material to the questions in this Application. I also specifically authorize any third parties to release information to Encore Health Network and its authorized representatives upon request. I hereby release Encore Health Network and its authorized representatives and any third parties, from any liability for any such reports, records, recommendation or any other documents of disclosures involving me that are made, requested or received by Encore Health Network, and/or your authorized representatives to, from or by any third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter addressed by this Application. I understand that falsification or omission of information can result in rejection of this Application.

Applicant Signature ____

Print Name ____

Print Degree ___________ Date ______________________

ADDITIONAL DOCUMENTATION

PLEASE ATTACH COPIES OF THE FOLLOWING DOCUMENTS (IF APPLICABLE):

Current State Licenses
Board Certification Certificate
Current Professional Liability Insurance Face Sheet
ECFMG Certificate
State Controlled Substance Registration Certificate
Current Federal DEA Registration