

## Physician Re-Credentialing Application

Dear Provider:

The Teachers Health Trust (Trust) is currently updating its records. Enclosed you will find a re-credentialing application. Please promptly submit the required documents listed below along with the re-credentialing application to the Trust.

Required Documents: (If any of the documents requested do not apply to your practice, please indicate below.)

- Current Arizona/Nevada/Utah Medical License
- Current Federal DEA License
- Current State Pharmacy License
- Current Professional Liability Insurance
- Current copy of CLIA Certificate (if applicable)

If any of the documents requested do not apply to your practice, please indicate so above.

The Trust has provided a copy of its credentialing update application. Copies of the form can be made as needed for each physician and/or provider rendering services in the practice. An updated credentialing application **must** be completed and returned for "ENTER PHYSICIAN NAME HERE" to remain in the Trust Network at this time. You may choose to update all providers at once or wait to update each provider as requested.

Completed applications and documents should be sent to the following address within 30 days of this notice to avoid a delay in payment or termination of your in-network status:

**Teachers Health Trust**  
**Attention: Provider Relations Department**  
**P.O. Box 96238**  
**Las Vegas, Nevada 89193-6238**

If you have any questions regarding how to complete the forms, please contact the Provider Relations Department via email at [providerrelations@teachershealthtrust.org](mailto:providerrelations@teachershealthtrust.org) or at 702-866-6120. You will receive written notice once your application is completed. Please allow 60 days to process your re-credentialing information.

Thank you for your participation in the Trust Provider Network.

Sincerely,

Provider Relations Department  
Teachers Health Trust

Provider Name (Please print legibly)	Provider Specialty
Tax ID Number	Practice Name (if different than physician name)
Name and Title (of person completing form)	Contact Information

**If the answer to any of the following questions is YES, please provide legal documents and full details (date of occurrence, description of events, and current status, etc.) on a separate sheet of paper. Sign and date all information provided.**

**All questions are to be completed for the time period of the last 3 years to present day.**

- A. *Has your license to practice medicine in any jurisdiction been denied, revoked, terminated, relinquished, suspended, otherwise limited or restricted, or been made subject to a program of probation; or have you been issued a citation or letter of reprimand by a licensing agency; or have formal or informal proceedings or investigations toward any of those ends ever been commenced?*  Yes  No
- B. *Has your medical staff membership or medical staff status at any hospital, comparable acute care facility, ambulatory surgery center, or other comparable facility been denied, revoked, terminated, relinquished, suspended, restricted, or limited based on patient care or professional conduct reasons; or have formal or informal proceedings or investigations toward any of those ends ever been commenced?*  Yes  No
- C. *Have your admitting or clinical privilege(s) at any other hospital, comparable acute care facility, ambulatory surgery center, or other comparable facility been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, restricted, or limited based on patient care or professional conduct reasons; or have formal or informal proceedings or investigations toward any of those ends been commenced?*  Yes  No
- D. *Have you voluntarily or involuntarily relinquished medical staff membership or status, relinquished admitting or clinical privileges, or withdrawn an application for membership or privileges at any hospital, comparable acute care facility, ambulatory surgery center, or other comparable facility after notification of the actual or imminent commencement of a formal or informal review or investigation of your practice, credentials, or professional conduct?*  Yes  No
- E. *Has your membership, participation, privileges, contractual affiliation, or other 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 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 been commenced?*  Yes  No
- F. *Have you 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 practice or professional conduct?*  Yes  No

- G. *Has your membership or status in any state or local professional society or other comparable medical organization 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
- H. *Has your status as a participating provider in the Medicare, Medicaid, or Tricare (formerly Champus) programs been sanctioned, denied, suspended, voluntarily or involuntarily terminated, limited, or revoked; or have formal or informal proceedings or investigations toward any of those ends been commenced? If so, provide copies of letters and if reinstated provide copy of reinstatement letter.*  Yes  No
- I. *Has a letter of concern or reprimand been issued to you? If so, provide copy of initial reprimand, outcome of reprimand and/or proof of any stipulations agreed to.*  Yes  No
- J. *Have you been denied professional liability insurance, or has your policy been canceled?*  Yes  No
- K. *Have you been named in a complaint filed with a state medical board or society based on allegations of professional negligence or professional misconduct, or have you received notice of an intent to commence litigation of that type? With regard to any such complaint or suit, has it resulted in a judgment, settlement, or other final disposition, or is it still pending? **Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case (including all legal/court documentation ie. court dismissal documents, settlement documents).***  Yes  No
- L. *Does your professional liability (malpractice) coverage exclude you from performing any specific procedure(s) or practicing portions of your specialty for which you are requesting privileges?*  Yes  No
- M. *Has your specialty board certification or eligibility been denied, revoked, voluntarily or involuntarily terminated, or suspended; or have formal or informal proceedings or investigations toward any of those ends been commenced?*  Yes  No
- N. *Has your Drug Enforcement Agency or other controlled substances authorization been denied, revoked, voluntarily or involuntarily terminated, suspended, or restricted; or have formal or informal proceedings or investigations toward any of those ends been commenced?*  Yes  No
- O. *Have you been convicted of a criminal offense other than a minor traffic violation? If so, submit court documents, proof of fines paid and current status.*  Yes  No
- P. *Have you been addicted to a controlled substance or alcohol? **If the answer to this question is yes, please provide the name, address, and a full description of any rehabilitation program in which you are now participating or in which you have participated as well as the name and title of the individual who can describe your care and participation in that program. Provide a current status letter from rehab program if currently participating.***  Yes  No
- Q. *Do you currently use illegal drugs?*  Yes  No
- R. *Do you have any mental or physical condition that may significantly affect your ability to practice medicine or to exercise the particular privileges that you have requested? If so, do you believe that, with reasonable accommodation, you will be able to provide care that meets the standards controlling the award of privileges and status that you seek?*  Yes  No

## 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 I am qualified and remain qualified for the award of membership in accordance 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 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 the responsibilities of 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 as well as 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 centers, 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, 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 as well as 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 accordance with applicable bylaws, and specifically, 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 related to my profession 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 of any significant change or any formally recommended change in licensure status; any actual or formally recommended denial, suspension, or revocation of privileges, membership, or status by another healthcare entity; or any cancellation or interruption of my 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, complete, and furnished in good faith.

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Signature of Applicant

Printed Name

Date

## MALPRACTICE CLAIM INFORMATION WORKSHEET

**Please provide complete information from past 3 years to current day.**


*Please duplicate this form and complete for EACH case in which you were named as a defendant. Also, for each case that has been settled or dismissed, please supply court documentation. All additional information provided must be signed and dated.*

Practitioner name:		
Patient name:		
Diagnosis:		
Your involvement in the case (attending, consulting, etc.):		
Allegations:		
Clinical case summary (Include additional pages or inserts if necessary):		
Patient outcome:		
Other pertinent details:		
Date of incident:	Date filed:	Date closed:
Current status of case <b><u>must be noted</u></b> (dismissed, settled out of court, pending, other). NOTE: All cases litigated must include documentation:		
Settlement amount paid on your behalf, if any ( <b>if no settlement please indicate none or zero</b> ):		
Professional liability insurer involved:		
Name of insurer:		
Address of insurer:		
Policy number:		

- I have no malpractice issues to disclose.
- I certify that I have disclosed all malpractice issues.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

 \_\_\_\_\_  
Signature (**Regardless of whether you have had any claims, this form must be signed and dated.**)