UNM HOSPITALS
TRIWEST PROVIDER NETWORK DEVELOPMENT

INITIAL PRACTITIONER CREDENTIALING CHECKLIST

To expedite processing of your application in the UNMH VAPC3/Choice Network, please complete this application in its entirety and attach the following documentation, as appropriate for your provider type (Physician, Mid-Level or Allied Health):

PHYSICIAN	MID-LEVEL	ALLIED HEALTH	REQUESTED DOCUMENT COPY:
√	√	√	Curriculum Vitae (must be in month/year format)
√	√	√	Current New Mexico State Board License
√	√	√	Current unexpired DEA certificate, if applicable
√	√	√	Current unexpired state controlled substances license, if applicable
√	√	√	Copies Board Certifications, Degrees
√	√	√	Current unexpired malpractice declaration sheet (evidence of professional liability insurance which indicates coverage limits of not less than $200,000 each occurrence and $600,000 Aggregate, expiration dates, name of provider must be on the cover sheet or if in a group on a list of provider's letterhead from the insurance company
√			Copy of Educational Commission for Foreign Medical Graduate (ECFMG) Certificate, if applicable
√	√	√	W-9 form
	√		Behavioral Health Providers: please complete the Provider Capability Form
	√	√	OT, PT, ST, SLP, LMSW, LISW, LMHC, LPCC, LMFT, PhD: enclose diploma
√	√		Hospital and Healthcare Affiliation

Applicants have the right to review the information submitted in support of their credentialing application. Please contact the TriWest Credentialing Department (505-925-7758) if you would like to review your credentialing documentation.

Please type or print legibly, ensure that the attestation and release forms are signed and dated by the practitioner. Please do not use whiteout. If the application is not complete, signed and dated or if whiteout is used, it will not be processed. Please use additional sheets if you need to provide additional information.

PLEASE SUBMIT THE APPLICATION

VIA FAX TO 505.272.3614.

THE UNIVERSITY OF NEW MEXICO ◆ HEALTH SCIENCES CENTER
UNM HOSPITALS

New Mexico VAPC3/Choice Network
Initial Practitioner Credentialing Application

PERSONAL

Name:				
	Legal Last Name	*Legal First Name*	*Legal Middle Name*	*Other Name(s) Used*

Check One →

☐ MD	☐ DO	☐ DMD	☐ DPM	☐ OD	☐ OT	☐ ACUPUNCTURE
☐ PA-C	☐ CNM	☐ CNP	☐ CNS	☐ LMSW	☐ ST	
☐ LISW	☐ LPCC	☐ LMHC	☐ PT	☐ RT		
☐ LMFT	☐ Audiologist	☐ PhD	☐ CRNA	☐ *Other*:_____		

U. S. Citizen: ☐ Yes ☐ No If you are not a U.S. Citizen, are you lawfully authorized to work in the U.S.? ☐ Yes ☐ No

Gender: ☐ M ☐ F

Date of Birth:

Foreign Language(s): **Read** ☐ **Speak** ☐ **Write** ☐

Specialty:

IDENTIFICATION NUMBERS

Social Security:	
UPIN:	
NPI:	
Organizational NPI	
ECFMG*(If applicable)*:	

CURRENT SERVICE/PRACTICE LOCATION

If more than one practice location please attach additional sheet(s) & include Primary, Billing & Mailing address for each location.

PRIMARY PRACTICE LOCATION		
Practice Name:		**Start Date:**
Street Address:		**Tax ID#:**
City:	**State:**	**Zip Code:**
Practice Scheduling Telephone:		**Auth/Referral Fax:**
E-mail Address:		
Claims Payment Address (Billing)		
Billing City:	**State:**	**Zip Code:**
Billing Telephone:		**Billing Fax:**
Mailing Address for Re-Credentialing:		
City:	**State:**	**Zip Code:**
Mailing Telephone:		**Mailing Fax:**

CREDENTIALING CONTACT

*Who can we contact with questions about **this** application?*

Name:	
Telephone:	**Fax:**
E-mail:	

EDUCATION AND TRAINING EXPERIENCE

*In chronological order, list all educational and post-graduate training in **Mo/Yr format**. Attach additional 8 1/2 x 11 sheet(s), if necessary.*

EDUCATION AND TRAINING
(ATTACH ADDITIONAL SHEETS IF NECESSARY)

MEDICAL OR PROFESSIONAL EDUCATION

SCHOOL/INSTITUTION	ADDRESS, CITY, STATE, ZIP	DATES (Month/Year)	DEGREE
		From: To:	
		From: To:	
		From: To:	
		From: To:	

POST GRADUATE TRAINING/SUPERVISED EXPERIENCE INTERNSHIP/RESIDENCIES/FELLOWSHIPS

SCHOOL/INSTITUTION	ADDRESS, CITY, STATE, ZIP	DATES (Month/Year)	SPECIALTY	TYPE
		From: To:		☐ Internship ☐ Residency ☐ Fellowship
		From: To:		☐ Internship ☐ Residency ☐ Fellowship
		From: To:		☐ Internship ☐ Residency ☐ Fellowship
		From: To:		☐ Internship ☐ Residency ☐ Fellowship

PROFESSIONAL EXPERIENCE / WORK HISTORY

PLEASE USE MONTH / YEAR FORMAT. *In chronological order, list professional experience attained since completion of medical school to the present.* ***Explain all breaks, greater than 6 months****. If necessary, attach additional 8-1/2 x 11 sheet(s).*

Location		From:	To:
Street :			
City	ST	Zip:	
Type of Practice:	Contact Person:		
Type of Discharge:	Rank Achieved:		

Location		From:	To:
Street:			
City	ST	Zip:	
Type of Practice:	Contact Person:		
Type of Discharge:	Rank Achieved:		

Location		From:	To:
Street:			
City	ST	Zip:	
Type of Practice:	Contact Person:		
Type of Discharge:	Rank Achieved:		

Location		From:	To:
Street:			
City	ST	Zip:	
Type of Practice:	Contact Person:		
Type of Discharge:	Rank Achieved:		

Location		From:	To:
Street:			
City	ST	Zip:	
Type of Practice:	Contact Person:		
Type of Discharge:	Rank Achieved:		

LICENSURE-REGISTRATION-CERTIFICATION INFORMATION

List all licenses to practice medicine and/or healthcare in any/all state(s).

State License Numbers *(past and present)*				
State, County or Province	**License Number**	**Date License Issued**	**Date License Expires**	**Any Limitations on License?**
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
Federal Drug Enforcement Administration (DEA)				☐ No ☐ Yes
New Mexico/Texas Controlled Substance Registration Number (CSR)				☐ No ☐ Yes

HOSPITAL AND HEALTHCARE AFFILIATIONS *(other than training)* ☐ Not Applicable

*List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five (5) years. If an institution is no longer in existence, please provide an alternative source of verification. (For **locum tenens**, list only those of a 30-day or longer duration.) Attach additional 8 1/2 x 11 sheet(s), if necessary.*

1) Current Primary Admitting Facility: *(Hospital Name)*			
Street:			
City:	ST:	Zip:	
Telephone:		Fax:	
Appointment Dates:			
Type of Appointment:			
Privileges Assigned:			
2) Facility Name:			
Street:			
City:	ST:	Zip :	
Telephone :		Fax :	
Appointment Dates:			
Type of Appointment:			
Privileges Assigned:			
3) Facility Name:			
Street:			
City:	ST:	Zip :	
Telephone :		Fax :	
Appointment Dates:			
Type of Appointment:			
Privileges Assigned:			

MILITARY INFORMATION

MILITARY INFORMATION	
Are you subject to mobilization as a member of a reserve or Guard unit, as an individual mobilization augmentee, or subject to recall to active duty as a retired military provider? ☐ Yes ☐ No	
If Yes to above, which Service Status applies? (Check appropriate box)	Which Service Branch applies? (Check appropriate box)
☐Active Reserve ☐Active National Guard ☐Retired Reserve ☐Retired Regular ☐Retired National Guard	☐US Army ☐Army National Guard ☐US Air Force ☐Air National Guard ☐Commissioned Corp NOAA ☐US Navy ☐US Coast Guard ☐Commissioned Corp USPHS ☐ US Marine Corp

MALPRACTICE/LIABILITY INSURANCE (Attach copy of current malpractice certificate)		
CURRENT CARRIER:	POLICY #:	
ADDRESS:	CITY, ST, ZIP:	
AMOUNTS OF COVERAGE:	ISSUE DATE:	EXP DATE:

PROFESSIONAL LIABILITY CLAIMS HISTORY
DETAIL/EXPLANATION

Please provide the following information for all current open, settled, dismissed and/or judgments for professional liability claims filed against you within the last ten years. Please answer the following questions for EACH claim. Duplicate this page as necessary.

Patient name:	Plaintiff name (if other than patient):		
Your involvement in the case (Attending, consulting):	Date of occurrence (month/day/year):		
Your status in the case (Primary or co-defendant):	Date claim was filed (month/day/year):		
Professional liability insurance carrier involved:			
Additional defendants:			
Describe the allegation and alleged injury to the patient:			
Provide explanation or information of the events leading to the allegation:			
Claimant/Plaintiff filed suit in court? ☐ Yes ☐ No	Court Case #:	State:	County/Parish:
Federal Court (US District Court) Case Number:	District:		
Present status of claim: ☐ Open ☐ Closed			
If closed, indicate the method of resolution: ☐ Dismissed Date: ☐ Settled (with prejudice) Date: ☐ Settled (without prejudice) Date: ☐ Judgment for defendant(s) Date: ☐ Judgment for plaintiff(s) Date:	Amount paid on your behalf (if any):		

SPECIALTY BOARD CERTIFICATIONS ☐ Not Applicable

Are you Board Certified? ☐ Yes ☐ No

Note: *If you are not Board Certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty,* ***please give a brief explanation as to why not on an attached sheet.***

1st Specialty Certification			
Board Name:			
☐ Primary ☐ Secondary	**Date Certified:**	**Date Last Recertified:**	**Expiration Date:** ☐ Lifetime
2nd Specialty Certification			
Board Name:			
☐ Primary ☐ Secondary	**Date Certified:**	**Date Last Recertified:**	**Expiration Date:** ☐ Lifetime
3rd Specialty Certification			
Board Name:			
☐ Primary ☐ Secondary	**Date Certified:**	**Date Last Recertified:**	**Expiration Date:** ☐ Lifetime

Do you have a Supervising Physician? ☐ **Yes** ☐ **No**

Name of Supervising Physician: _____

Address of Supervising Physician: _____

Contact Phone Number for Supervising Physician: _____

Please identify the age and gender groups you provide services for:

- ☐ Male patients
- ☐ Female patients
- ☐ Preschool (0 – 5)
- ☐ Children (6 – 12)
- ☐ Adolescent (13-17)
- ☐ Adult (18 – 65)
- ☐ Geriatrics (65+)

Behavioral Health Specialists

Please check those capabilities in which you are certified or have received specific or on-going training:

- ☐ ADD/ADHD
- ☐ Addictions
- ☐ Adoption Issues
- ☐ Anger Management
- ☐ Anxiety Disorder
- ☐ Applied Behavior Analysis
- ☐ Asperger's Syndrome
- ☐ Autism
- ☐ Behavior Modification
- ☐ Bi-Polar Disorder
- ☐ Biofeedback
- ☐ Child Abuse
- ☐ Christian Counseling
- ☐ Chronic Mental Illness
- ☐ Chronic Physical Illness
- ☐ Co-dependency
- ☐ Cognitive Behavioral Therapy
- ☐ Compulsive Gambling
- ☐ Conduct/Disruptive Disorders
- ☐ Couples/Marriage Therapy
- ☐ Crisis Diversionary Services
- ☐ Crisis Intervention Svcs
- ☐ Critical Incident Debriefing
- ☐ Depressive Disorder
- ☐ Developmental Disabilities
- ☐ Dialectical Behavioral Therapy
- ☐ Disability Evaluation
- ☐ Dissociative Disorder
- ☐ Divorce
- ☐ Domestic Violence
- ☐ Dual Diagnosis
- ☐ Eating Disorders
- ☐ Electro-Convulsive Therapy (ECT)
- ☐ Faith Based Counseling
- ☐ Family Therapy
- ☐ Forensic/Sex Offenders
- ☐ Gay/Lesbian Identified Children
- ☐ Grief Counseling
- ☐ Group Therapy
- ☐ Head Injury Patients
- ☐ Hearing Impaired issues
- ☐ HIV Positive/AIDS Patients
- ☐ Home Care/Home Visits
- ☐ Hypnosis
- ☐ Independent Qualified/Medical Ex
- ☐ Infertility
- ☐ Inpatient Therapy
- ☐ Learning Disabilities
- ☐ Medical Stress/Behavioral Med
- ☐ Medication Management
- ☐ Men's Issues
- ☐ Mood disorders
- ☐ Multicultural Issues
- ☐ Neuropsych Assessment
- ☐ Nursing Home Visits
- ☐ Obesity Assessment/ Counseling
- ☐ Obsessive Compulsive Disorder
- ☐ Organic Brain Syndrome
- ☐ Pain Management
- ☐ Panic Disorder
- ☐ Parenting Skills
- ☐ Pastoral Counseling
- ☐ Personality Disorder
- ☐ Pervasive Development Disorders
- ☐ Phobias
- ☐ Physical abuse/violence
- ☐ Physically impaired patients
- ☐ Play therapy
- ☐ Police personnel
- ☐ Post Partum Depression
- ☐ Post Traumatic Stress Disorder
- ☐ Psych. Disability Eval/Mgmt
- ☐ Psychological Testing
- ☐ Psychosomatic
- ☐ Psychotic Disorders
- ☐ Rape Issues
- ☐ Rape Victims
- ☐ Schizophrenic Disorders
- ☐ Sex Offender
- ☐ Sexual abuse/violence
- ☐ Sexual Dysfunction
- ☐ Sexual Harassment
- ☐ Sexual Identity Issues
- ☐ Sleep Disorders
- ☐ Somatoform Disorders
- ☐ Substance Abuse
- ☐ Terminally Ill patients
- ☐ Visually Impaired patients
- ☐ Weapons Clearance
- ☐ Women's Issues

PROFESSIONAL PRACTICE QUESTIONS

If you answer "Yes" to any question, please give details: *including name, address, and telephone number of significant parties, explanation, and copies of all judgments, decisions, orders, agreements, and surrenders.*

QUESTIONNAIRE/PERSONAL STATEMENTS

A complete detailed written explanation is required for any question that is answered "yes". If any question does not apply write N/A and a complete detailed written explanation is required

1	Do you currently have any physical impairment or disability that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?	Yes ☐	No ☐
2	Do you currently have any mental impairment or disability that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?	Yes ☐	No ☐
3	Do you currently have any substance abuse problems that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?	Yes ☐	No ☐
4	Have you received treatment for substance abuse related conditions in the past five years?	Yes ☐	No ☐
5	Have you **ever been** convicted of a felony, fraud, narcotics offense, moral, or any other type of ethical crime?	Yes ☐	No ☐
6	Have you **ever been** convicted of a misdemeanor case?	Yes ☐	No ☐
7	Has your license or certification to practice in any jurisdiction **ever been** limited, restricted, revoked, suspended, voluntarily relinquished, terminated, subjected to disciplinary action or otherwise acted upon in an adverse manner?	Yes ☐	No ☐
8	Have you **ever been** sanctioned or penalized by any hospital, licensing board, government entity or managed care organization?	Yes ☐	No ☐
9	Have you **ever** voluntarily or involuntarily refused or denied membership on a hospital medical staff?	Yes ☐	No ☐
10	Have your specific clinical privileges at a facility in any jurisdiction **ever been** denied, limited, suspended, diminished, revoked, withdrawn or denied renewal?	Yes ☐	No ☐
11	Have you **ever been** subjected to disciplinary action by any medical organization?	Yes ☐	No ☐
12	Have you **ever been** subjected to any claim(s) or under investigation for unethical conduct?	Yes ☐	No ☐
13	Have you **ever been** the subject of a malpractice claim or are there currently pending malpractice claims, suits, settlements, arbitration proceedings, or complaints filed involving your professional practice?	Yes ☐	No ☐
14	Have any judgments been made against you or settlements paid by and for you in any professional liability claim?	Yes ☐	No ☐
15	Have you **ever been** denied liability insurance, in whole or in part, or has your policy ever been canceled, involuntarily restricted, denied renewal, or rated up because of the nature of volume of claims against you?	Yes ☐	No ☐
16	Has your DEA license or narcotics registration **ever been** suspended or revoked?	Yes ☐	No ☐

CERTIFICATION/ATTESTATION AND CONSENT TO THE INSPECTION OF RECORDS AND DOCUMENTS RELEASE OF INFORMATION AND LIABILITY

I certify and attest to the fact that all the information submitted by me in this application is true and accurate to the best of my knowledge and belief.

I authorize TriWest Healthcare Alliance, its professional staff and legal representatives for the purpose of evaluating my professional competence, character, criminal history and ethical conduct, to contact and consult with administrators and members of the professional staff of any treatment facility, institution, professional society, school, employer, law enforcement agency, or practice with which I have been associated. In addition, I consent to the inspection by TriWest Healthcare Alliance, its professional staff and legal representatives of all records and documents, including health records at other treatment facilities that may be material for evaluation of my professional qualifications. I also release from liability all individuals or organizations for their acts performed in good faith and without malice who honestly initiate and respond to the inquiries authorized for use by TriWest Healthcare Alliance. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

_____ _____

Practitioner Signature Date

_____

Type/Print Provider Name

PLEASE INCLUDE A COPY OF YOUR W-9 (REQUIRED)