



Instructions: Please PRINT in **BLACK** ink.

IDENTIFICATION AND DEMOGRAPHICS

Last Name: _____ Suffix (e.g., Jr): _____
First Name: _____ Middle: _____
Other / Previous Surname(s): _____
Social Security Number: _____ Date of Birth: _____ Gender: Male Female
Provider Classification: Primary Care Physician Specialist Physician Other Health Professional
Provider Type: MD DO DPM DC OD DDS DMD PHD PSYD
 Other: _____

PROFESSIONAL IDS

National Provider Identification Number: _____
Medicare Number: _____ Medicare UPIN: _____
Medicaid Number: _____ (Medicaid) State: _____
Have you submitted an affidavit with Medicare to opt out of the Medicare program? Yes No

OFFICE INFORMATION – PRIMARY LOCATION

Practice Name / Group or Organization Name: _____
Date Joined Practice (MM/YYYY): _____ Federal Tax ID Number: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
Practitioner Email: _____ Acceptable to send confidential info: Yes No

OFFICE INFORMATION – MAILING ADDRESS

Practice Name / Group or Organization Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____

OFFICE INFORMATION – OFFICE MANAGER & CREDENTIALING CONTACT

Office Manager Email: _____ Phone: _____ Fax: _____
Office Manager Name: _____ Acceptable to send confidential info: Yes No
Credential Contact Email: _____ Phone: _____ Fax: _____
Credential Contact Name: _____ Acceptable to send confidential info: Yes No
Credentialing Mailing Address, City, State, and Zip (only if different from office address): _____

STATE LICENSURE

Include all licenses current or held in last five years.

Name of State Board Issued by: _____ State: _____

License Number: _____ License Type: _____

Exp. Date: _____ First Issued: _____ Active License Inactive License

Name of State Board Issued by: _____ State: _____

License Number: _____ License Type: _____

Exp. Date: _____ First Issued: _____ Active License Inactive License

DEA

DEA Number: _____ State: _____

Schedules (please circle): 1 2 2N 3 3N 4 5 Expiration Date: _____

CDS / STATE CONTROLLED SUBSTANCE INFORMATION

State Controlled Substance Number: _____ State: _____

Schedules (please circle): 1 2 2N 3 3N 4 5 6 Expiration Date: _____

Please check if you have additional licensure (State License, DEA, and/or CDS) and include the information above for each license in an attachment.

BOARD CERTIFICATON/ SPECIALITY

List any certification received from any nationally recognized specialty certification boards.

Primary Specialty: _____

Board Certified? Yes No If no, eligible to take Exam? Yes No If yes, planning to take exam? Yes No

(If applicable) Name of certifying board: _____

Certificate #: _____ Exp date: _____ Original Effective Date: _____ Re-cert Date: _____

Other Specialty: _____

Board Certified? Yes No If no, eligible to take Exam? Yes No If yes, planning to take exam? Yes No

(If applicable) Name of certifying board: _____

Certificate #: _____ Exp date: _____ Original Effective Date: _____ Re-cert Date: _____

Please check if there are additional Board Certifications and include a copy in attachments

EDUCATION

Please provide all relevant professional education.

Education Level: Doctorate Masters Bachelors Associates Other: _____

School Name: _____ Graduation Date: _____

Address / City / State/ Zip: _____

Degree Awarded: _____

ECFMG Certificate Number: _____ Date Rec'd: _____

TRAINING

For initial credentialing, please complete this section in its entirety. For re-credentialing, this section is only necessary if additional training has occurred in the past 3 years (since your last credentialing event with AlohaCare.)

Training Level: Internship Residency Fellowship Other: _____

Program Type / Description of Study: _____

School / Institution Name: _____

Dates Attended: _____ to _____ Program Successfully Completed? Yes No

Address / City / State/ Zip: _____

Training Level: Internship Residency Fellowship Other: _____

Program Type / Description of Study: _____

School / Institution Name: _____

Dates Attended: _____ to _____ Program Successfully Completed? Yes No

Address / City / State/ Zip: _____

Training Level: Internship Residency Fellowship Other: _____

Program Type / Description of Study: _____

School / Institution Name: _____

Dates Attended: _____ to _____ Program Successfully Completed? Yes No

Address / City / State/ Zip: _____

Please check if there is additional education and/or training completed; include this information as an attachment.

PROFESSIONAL LIABILITY INSURANCE

AlohaCare minimum requirement is \$1 million per occurrence and \$3 million aggregate.

Current Carrier Name: _____ Policy Number _____

Address / City / State/ Zip: _____

Effective Date: _____ Expiration Date: _____ Retroactive Date: _____

Occurrence Amount: _____ Aggregate Amount: _____ Umbrella Amount: _____

OTHER LIABILITY COVERAGE

Carrier Name: _____ Policy Number: _____

Address / City / State/ Zip: _____

Effective Date: _____ Expiration Date: _____ Retroactive Date: _____

Occurrence Amount: _____ Aggregate Amount: _____ Umbrella Amount: _____

HOSPITAL AFFILIATIONS

Primary Hospital Affiliation Name: _____

Address / City / State/ Zip: _____

Initial Appointment Date: _____ Next Re-Appointment Date: _____

Staff Category: _____ Admitting privileges?* Yes No

Other Hospital Affiliation Name: _____

Address / City / State/ Zip: _____

Initial Appointment Date: _____ Next Re-Appointment Date: _____

Staff Category: _____ Admitting privileges?* Yes No

****If no admitting privileges, you are required to have a written arrangement with another healthcare practitioner that has admitting privileges with an acute care hospital that is within the AlohaCare Network and on the island of service.***

Please list each physician's information below **AND** provide a copy of the written agreement.

Admitting Physician Name: _____ Name of Hospital: _____

Address / City / State/ Zip: _____

Phone: _____ Fax: _____ Email: _____

Admitting Physician Name: _____ Name of Hospital: _____

Address / City / State/ Zip: _____

Phone: _____ Fax: _____ Email: _____

Admitting Physician Name: _____ Name of Hospital: _____

Address / City / State/ Zip: _____

Phone: _____ Fax: _____ Email: _____

 Please check if there are additional Hospital Affiliations and include a copy in attachments

PROFESSIONAL PRACTICE HISTORY

For Initial Credentialing, five (5) years of work history is required in MM/YYYY format. For re-credentialing the requirement is three (3) years. If attaching Curriculum Vitae (CV) in lieu of completing below, please include Month and Year of start and end date.

Organization Name: _____

From (MM/YYYY): _____ To (MM/YYYY): _____

Organization Name: _____

From (MM/YYYY): _____ To (MM/YYYY): _____

Organization Name: _____

From (MM/YYYY): _____ To (MM/YYYY): _____

Explain any gaps greater than 6 months: _____

QUESTIONNAIRE

Practitioner Name: _____

If you answer 'YES' to any of the questions in this section, on a separate sheet please provide an explanation of each occurrence, including the date, parties involved, circumstances surrounding the situation and outcome; attach copies of court documents and/or MCCP decisions.

NOTE: For re-credentialing – please provide information for the past three (3) years ONLY.

1. Have there ever been any actions against or investigations relating to your professional license(s) in any jurisdiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever voluntarily or involuntarily surrendered your license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are there any past, current or pending due-process action(s) relating to denial, revocation, suspension or restriction for any of your professional license(s) or application(s) for professional license in any jurisdiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4. Have there ever been any actions against or investigations relating to your hospital, HMO and/or health/managed care plan privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5. Have you ever voluntarily or involuntarily surrendered your hospital, HMO and/or health/managed care plan privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6. Have you ever been named in any malpractice action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Does your current liability malpractice insurance coverage exclude any specific procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you been without malpractice coverage in the past five consecutive years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has your professional liability insurance coverage ever been denied, suspended, restricted, limited, modified, canceled, or not renewed by the action of any insurance company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have there ever been any actions against or investigations relating to your DEA registration and/or CDS Certification or have you ever voluntarily or involuntarily surrendered your DEA registration and/or CDS certification?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
11. Have you ever been convicted of a felony, including, but not limited to, fraud, narcotics, or crimes involving children? (Misdemeanors do <u>not</u> need to be reported.) This statement is being answered under the penalty of perjury, subject to applicable Federal punishment for perjury. If yes, please include the disposition of the arrest or charge and explain all such occurrences in an attachment.	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you ever been named as a defendant in any past, current or pending criminal proceedings, including misdemeanors (excluding traffic violations)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Have you ever been sanctioned or otherwise disciplined by a professional organization/association?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you ever voluntarily or involuntarily surrendered membership in a professional organization/association?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Has there ever been any disciplinary action, suspension, probation, formal reprimand or request to voluntarily or involuntarily resign during your education, internship, residency, fellowship, preceptorship, or additional applicable training?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Has there ever been any action against or investigation relating to your board certification (e.g. medical professional board/society) or have you voluntarily or involuntarily surrendered any board certifications?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
17. Has an adverse action been filed against you or have you received any disciplinary procedures regarding your participation in any private, state, or federal insurance program including Medicare or Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
18. Are there any past, current, or pending investigations or actions being taken against you, or have there ever been any restrictive actions taken against you, by the Medicare Program, Medicaid Program, Regulated Industries Complaints Office (RICO), Medical Complaint Conciliation Panel (MCCP) and the Hawaii Board of Medical Examiners (PVL/DCCA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
19. Is there anything that would prevent you from being able to competently perform essential job-related functions without risk to patient safety or health, with or without reasonable accommodation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Are you currently using any illegal substances or are you chemically dependent on alcohol, drugs, or illegal substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Are you currently or have you ever been treated for alcohol or substance abuse (e.g. drugs, prescription medication)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

ATTESTATION / CONSENT & RELEASE FORM

I hereby give permission to AlohaCare, directly and/or through its designee Aperture Credentialing, Inc. ("Aperture") (an Ingenix® company) to request information regarding my professional credentials and qualifications from educational facilities, the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, federal and state regulatory and licensing agencies, professional liability insurance carriers, other professional monitoring entities, professional associations, managed health care plans, other physicians, present and past employers and federal and state agencies for criminal background checks (hereafter collectively referred to as "persons or entities"). The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter applicable to the credentialing procedure. I release and agree to hold harmless AlohaCare and its designee Aperture, and their respective officers, directors, representatives, employees and agents from any and all liability for any damages, costs and expenses which may result from the gathering of information during the credentialing process.

I hereby authorize the education facilities, the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, federal and state regulatory and licensing agencies, professional liability insurance carriers, other professional monitoring entities, professional associations, managed health care plans, other physicians, present and past employers and federal and state agencies for criminal background checks, to submit information requested by AlohaCare, directly and/or through its designee Aperture, including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and lawsuit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. If applicable, I hereby authorize the Physician Recovery Network or applicable recovery program to release to AlohaCare information regarding my health status and participation status in any treatment program(s). I hereby further release and agree to hold harmless all such persons or entities referenced above, their representatives, employees, and agents from any and all liability for any damages which may result from providing this information.

I agree that the photocopy, facsimile, and/or electronic image of this document with my signature may be accepted by any person or entity from which such information is sought with the same authority as the original, and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is a cause for automatic and immediate rejection of this application by AlohaCare and may result in denial of my application or termination of my participation in the AlohaCare Network. I further understand that any representation, misstatement or omission from this application, if discovered after network participation has been awarded to me, may lead to immediate suspension or termination of those privileges.

I understand and agree that I, as an applicant, have the burden of producing adequate information to demonstrate to the satisfaction of AlohaCare and/or Aperture, my professional qualifications, clinical competence, moral character and ethical qualifications and for resolving doubts thereto. I agree to use my best efforts to inform AlohaCare and/or Aperture in writing within 15 days if there is any change in the information provided or the answers to questions on the application as a result of developments subsequent to my signing this application.

I warrant that I have the authority to sign this application, on my behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of the application does not constitute approval or acceptance as a participating provider.

If I am accepted for participation, I consent to the inspection of my patient records for AlohaCare members as necessary for peer review and utilization review purposes and agree to be bound by the participation agreement, credentialing plan and provider manual.

I understand that I have the right to review and correct erroneous information obtained by the AlohaCare to evaluate my credentialing application. This includes information obtained from primary source (e.g., malpractice insurance carriers, state licensing boards, National Practitioner Data Bank). The review must take place within 6 months of this application. Any corrections must be made in writing within 30 days of the review. This does not require AlohaCare to allow a provider to review references or recommendations or other information that is peer-review protected.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, AlohaCare may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank and/or the Health Care Integrity and Protection Data Bank.

I represent the information provided in or attached to this application is accurate and complete. I attest to having adequate current malpractice insurance. I certify that I hold a full, unrestricted license to practice in the state in which I reside or I have indicated on this application the limitations and/or restrictions imposed. I agree that I have reported any loss or limitation of hospital privileges or any disciplinary activity to the AlohaCare through its designee, Aperture. I attest that I will continue to maintain active admitting and staff privileges at an AlohaCare participating hospital or I have otherwise indicated on this application.

AlohaCare, and its designee, Aperture, do not discriminate on the basis of race, color, national origin, sex, religion, age, or disability.

Your signature is required to complete this application. Stamped signatures are not acceptable.

Practitioner Name (Print)

Practitioner Signature

Date