

PHYSICIAN INITIAL CREDENTIALING APPLICATION

OUR GUIDE TO CREDENTIALING

INTRODUCTION

Telehealth is an emerging field and is another area in which the credentialing standards for physicians will evolve. As a leader in the telehealth field, our network physicians must meet the highest standards relevant to this industry. The goal of this guide is to familiarize our network physicians with the collecting and organizing of the information and documents required for our credentialing process.

This guide refers to specific documentation for credentialing. We strongly suggest that you use a secure cloud storage medium or a USB storage drive for the documents. We recommend using the most commonly saved file formats - .pdf or .tif.

Most of the required items may already be familiar to you.

What is Credentialing?

Credentialing is the process of verifying the qualifications, background, and legitimacy of physicians and allied health providers. It is an objective evaluation of a provider's current licensure, training and/or experience, competence, and ability to provide particular services and/or perform particular procedures.

How Does The Credentialing Process Work?

The Credentialing Process at e-Telmed begins with a comprehensive application. Your file is reviewed, cross-checked, and verified (i.e. Background Checks, NPDB, FSMB, OIG, EPLS, State License & DEA) for accuracy by a Credentialing Processor.

Our processors are tasked with collecting supporting documents from providers, cross-checking the information, verifying the authenticity of what is provided, and preparing the file for the credentials committee.

Our Credentialing Committee is composed of three to five executives who represent our organization. The committee meets biweekly to review and discuss all provider files prepared by the Credentialing Processors. The Committee will either approve or decline a provider based on the file. Applicants should remember that virtually everything represented in the documentation will be verified.

What documents do we need?

As the field of telemedicine grows, the requirements for credentialing will change. It is important for telemedicine physicians to understand that while something might not have been required in the past, it is now being required or soon will be. We encourage all physicians to scan copies of their supporting documentation into image files that can be kept and transmitted electronically. This will assist in the organization of required documents.

Application:

We will provide an application that must be completed in its entirety. Keep copies of the applications that you have prepared, as they are good to refer to from time to time should a question arise.

When filling out our application, be prepared with all the important data of your practice history. You should list all hospitals where you have had privileges, all State Licenses you have held (whether currently active or not), your Board Certification dates, and the details of any malpractice claims or disciplinary actions. If something is left out and subsequently discovered as the credentialing processors do their research, it is a red flag that could result in a denial.

CV:

The primary thing to remember about the CV that you submit as part of the credentialing process is that it must show the chronological progression of your career with dates being in month/year format.

Education Diplomas & Certificates:

To complete the application, you will need copies of your Undergraduate, Medical School, Residency, and Fellowship diplomas and/or certificates. If your Medical School Diploma is in a language other than English, a certified translation will be necessary.

If you are still in your training program, you may need a letter of good standing from your program director.

Board Certificates:

You will need copies of your Board Certification Certificates. The certificate you present should clearly state the expiration date thereof (if your certification is a lifetime certification, it may not have expiration).

ECFMG or Fifth Pathway:

If you studied at a non-U.S. accredited medical school, you will need to provide your ECFMG or Fifth Pathway certificate.

Licenses and Controlled Substance Registrations:

You will need current copies of all state licenses you hold. You will also need copies of all Federal DEA registrations you hold as well as any state-issued controlled substance registrations. Each of these documents should have their respective expiration date indicated. - *N/A for Telehealth Credentialing.*

Life Support Cards:

You will need to provide copies of all current BLS, ACLS, ATLS, NRP, APLS, and PALS Certificate cards that you hold. These should all indicate the expiration date. - *N/A.*

CME Certificates:

You will need copies of your Continuing Medical Education Certificates for the past 2 years.

Certificates of Professional Liability Insurance:

You will need copies of your certificates of insurance (also called a "binder") for your professional liability coverage (malpractice coverage) for the past 5 years. Your practice manager should have these and your hospital's medical staff office may also be able to provide you with a copy (hospitals require it in their files).

Driver's License:

You will need a notarized copy of your Driver's License or other state-issued identification with your picture on it. Make a color copy of your Driver's License and then have a notary attest and sign that it is you. Most banks offer notary services free of charge to their customers.

Passport Size Photos:

We require a recent passport-size photo or uploaded equivalent when you send in the application. If applicable be sure to write your name on the back of each.

PPD & MMR:

We do not require PPD & MMR information.

Case Logs:

We do not require case logs.

Please return all of the above-requested documents via email to **Info@etelmed.com**

Photo/identification required: Photo

General Instructions

The information requested in this application is necessary to complete the credentialing process. Failure to provide the requested information may result in delay and approval of your credentialing file. Please note and skip the areas on the Checklist that are marked as N/A.

- Type or print your responses.
- This application is invalid if modified.
- All questions must be answered fully and truthfully. If an answer requires an explanation, please provide it on the appropriate form provided. Make additional copies of any of the attached forms if more than one is needed and provide your name on all attachments. You may also submit narratives and/or other documentation to support your answer.
- Note that months/years are required for the application's education and work history sections. All periods during your clinical career must be accounted for. Gaps of greater than sixty (60) days require an explanation. Please use the explanation form to provide this information.
- Please do not leave any blanks. If a particular section does not apply to you, write "n/a" in that section.

- A response of "See CV" is not acceptable unless you also submit a current CV containing all of the requested information.
- Please sign and provide a current date on the attestation and release pages of the application, the provider agreement, and any other forms completed.
- After the application has been completed in its entirety, save a copy of the application for future reference. Attach all documentation shown on the next page to your application before e-mailing or sending by postal mail.

Physician Initial Credentialing Checklist

- Complete Credentialing Application
- Signed and Currently Dated Attestation and Release forms
- Completed W-9 Federal Tax Form
- Completed Authorization for Deposit Form
- Current Curriculum Vitae with complete Professional History in chronological order and no gaps (month and year must be included)
- Copy of Medical School Diploma and training Certificate(s), Internship, Residency and fellowship Certificates
- Current CME (CME activity for the past 2 years)
- Copy of ECFMG Certificate (if applicable) of Fifth Pathway Certificate (if applicable)
- Copy of NBME, FLEX, USMLE, or SPEX scores - *N/A*
- Copy of Current Board Certificate
- Copy of All Current Active State License Wallet Card(s) and/or Wall Certificate with expiration date and number
- Copy of current Federal DEA and current State Controlled Substance Registrations or Certificate(s)
- Copy of Any: BLS, ACLS, ATLS, PALS, APLS, NRP Certificate(s) - *N/A*
- Certificate of Professional Liability Insurance Coverage or Declaration Page (Face sheet) of Policy (if applicable)
- Third-party documentation (I.e. court documents, dismissals) for all Malpractice/Disciplinary Action OR completion of appropriate Explanation Form attached (if applicable)
- Permanent Resident Card, Green Card, or Visa Status (if applicable) - All non-US citizens must provide a copy of the green card
- Military Discharge Record - Form DD-214 (if applicable)
- Two (2) written letters of recommendation from providers over the past 24 months.
- Completed Delineation of Privileges Form - *N/A*
- A recent Photograph Signed and Dated in the margin
- Copy of National Provider Identifier (NPI#) documentation and Confirmation Letter

Physician Initial Credentialing Application

Personal Information

Last Name	Suffix (Jr./Sr./III)	First Name	Middle	Degree	Social Security Number
Home Address			Home Phone Number		
City / State / Zip code			Cell Phone Number		
Office Address			Office Phone Number		
City / State / Zip code			Office Fax Number		

Citizenship	Birthplace	Date of Birth	Email address
Present Position		NPI #	Medicare #
UPIN #	Fed Tax ID	Medicaid #	
Please provide name and address of someone who will always know your forwarding address	Contact Name and Phone	Contact Address	

Education And Training

Medical School	Degree	City	State
Dates (From mm/yy To mm/yy)		City	State
PGY1 (Internship) Training -- Facility Name		City	State
Dates (From mm/yy To mm/yy)	Category of Training		
Residency Training -- Facility Name		City	State
Dates (From mm/yy To mm/yy)	Specialty		
Fellowship Training -- Facility Name		City	State
Dates (From mm/yy To mm/yy)	Specialty		
Additional Training -- Facility Name		City	State
Dates (From mm/yy To mm/yy)	Category of Training		

Board Certification/Recertification

Are you currently board certified? Yes No List all current and past board certifications

Name of issuing board	Specialty	Date Certified (mm/yy)	Date Recertified (mm/yy)	Date Recertified (mm/yy)	Expiration Date (if any)(mm/yy)

Please answer the following questions. Attach explanation form(s) if necessary.

A.	Have you ever been examined by any specialty board, but failed to pass? If yes, provide name of board(s) and date(s):	Yes <input type="checkbox"/> No <input type="checkbox"/>
B.	If you are not currently certified, have you applied for the certification examination? If yes, please provide date you will sit for exam.	Yes <input type="checkbox"/> No <input type="checkbox"/>

Clinical Certification	BLS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration Date: _____	ACLS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration Date: _____	ATLS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration Date: _____	PALS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration Date: _____
Federal Provider Information	Federal DEA Number: _____		DEA Expiration Date: _____	
Foreign Graduates	Permanent ECFMG Certificate Yes <input type="checkbox"/> No <input type="checkbox"/>	ECFMG Certificate #: _____	Fifth Pathway completed Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, where: _____	
Licensing Exams Taken:	National Boards: Yes <input type="checkbox"/> No <input type="checkbox"/> Date Taken: _____	FLEX: Yes <input type="checkbox"/> No <input type="checkbox"/> Date Taken: _____	SPEX: Yes <input type="checkbox"/> No <input type="checkbox"/> Date Taken: _____	
	USMLE: Yes <input type="checkbox"/> No <input type="checkbox"/> Date Taken: _____	State Boards: Yes <input type="checkbox"/> No <input type="checkbox"/> Date Taken: _____ State: _____	LMCC: Yes <input type="checkbox"/> No <input type="checkbox"/> Date Taken: _____	

LICENSURE

Please enter the information below for all states in which you have held a medical license.

STATE	LICENSE NUMBER	LICENSE STATUS	DATE GRANTED (MM/YY)	EXPIRATION DATE (MM/DD/YY)	STATE MEDICARE PROVIDER #	STATE MEDICAID PROVIDER #	STATE CONTROLLED SUBSTANCE PERMIT #
		Initial License <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/>					
		Active <input type="checkbox"/> Inactive <input type="checkbox"/>					
		Active <input type="checkbox"/> Inactive <input type="checkbox"/>					
		Active <input type="checkbox"/> Inactive <input type="checkbox"/>					
		Active <input type="checkbox"/> Inactive <input type="checkbox"/>					
		Active <input type="checkbox"/> Inactive <input type="checkbox"/>					
		Active <input type="checkbox"/> Inactive <input type="checkbox"/>					
		Active <input type="checkbox"/> Inactive <input type="checkbox"/>					

Additional licenses listed on attached sheet

CURRENT HOSPITAL AND OTHER FACILITY AFFILIATIONS

Please list in reverse chronological order with current affiliation(s) first. Include affiliations for the last 5 years. Do not list residencies, internships or fellowships. Attach additional sheet if needed.

Current Hospital And Other Facility Affiliations Does not apply

Primary Facility Name:	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Phone:	Fax:	
Facility Name:	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Phone:	Fax:	
Facility Name:	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Phone:	Fax:	

Facility Name:	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Phone:	Fax:	
Facility Name:	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Phone:	Fax:	
Facility Name:	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Phone:	Fax:	
Facility Name:	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Phone:	Fax:	
Facility Name:	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Phone:	Fax:	
Facility Name:	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Phone:	Fax:	
Facility Name:	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Phone:	Fax:	
Facility Name:	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Phone:	Fax:	
Facility Name:	Appointment Period (mm/yy) From: _____ To: _____	City, State:
Phone:	Fax:	

REFERENCES

Please list six **physician** references that are able to comment upon your **current (within the past year)** clinical and professional capabilities.

Name	Specialty	Phone #	Address	City State Zip	Fax #	Email

WORK HISTORY

Please list all your practice locations and employment affiliations to cover at least the past **5 years** of clinical practice. **Beginning and ending month and year are required for each listing.** Please provide a separate explanation of work gaps over 30 days in duration. If you desire eTelmed not to contact these facilities, please check the appropriate box and attach a letter of explanation. You may attach an additional sheet if all required work history information will not fit in this section.

From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
<input type="checkbox"/> Do Not Contact					
	Address	City	State	Zip Code	
<input type="checkbox"/> Do Not Contact					
	Address	City	State	Zip Code	
<input type="checkbox"/> Do Not Contact					
	Address	City	State	Zip Code	
<input type="checkbox"/> Do Not Contact					
	Address	City	State	Zip Code	
<input type="checkbox"/> Do Not Contact					
	Address	City	State	Zip Code	

DISCIPLINARY ACTIONS

If your answer to any of the following questions is "Yes", please provide a full explanation on the attached Credentialing Application Explanation Form and include any additional documentation if necessary.

Have any of the following ever been, or are currently in the process of, being: denied, revoked, suspended, reduced, limited, placed on probation, not renewed, surrendered or voluntarily relinquished? If the answer is "Yes" to any item please provide an explanation as outlined above.

1. Medical License in any state?	Yes <input type="checkbox"/> No <input type="checkbox"/>	6. Institutional affiliation / status?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. DEA Registration (federal or state programs)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	7. Professional society membership or fellowship / Board certification?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Other Professional Registration / License?	Yes <input type="checkbox"/> No <input type="checkbox"/>	8. Any professional sanction (e.g. government, administrative agency or other)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Clinical Privileges?	Yes <input type="checkbox"/> No <input type="checkbox"/>	9. Participation in any private, federal, or state health insurance program (e.g. Medicare, Medicaid)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Membership / Rights on any medical staff?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
10.	Do you currently have any physical or mental condition including current alcohol or drug dependency that may affect your ability to practice or exercise the privileges typically associated with the specialty and position for which you are applying?		Yes <input type="checkbox"/> No <input type="checkbox"/>
11.	Are you currently using illegal drugs or legal drugs in an illegal manner?		Yes <input type="checkbox"/> No <input type="checkbox"/>
12.	Is there any reason that you are unable to perform the essential functions of the position for which you are applying safely and according to accepted standards of performance with or without reasonable accommodation? (If yes, explain on the attached form)		Yes <input type="checkbox"/> No <input type="checkbox"/>
13.	Have you ever been convicted of, pled guilty to, or pled nolo contendere for, any criminal offense (excluding parking tickets)?		Yes <input type="checkbox"/> No <input type="checkbox"/>
14.	Are any criminal charges currently pending against you in any jurisdiction?		Yes <input type="checkbox"/> No <input type="checkbox"/>
15.	Have you ever been arrested for or charged with a crime involving children?		Yes <input type="checkbox"/> No <input type="checkbox"/>
16.	Have you ever been arrested for or charged with a sexual offense including sexual harassment?		Yes <input type="checkbox"/> No <input type="checkbox"/>
17.	Have you ever been arrested for or charged with a crime involving moral turpitude?		Yes <input type="checkbox"/> No <input type="checkbox"/>
18.	Is there any other issue which should be disclosed that may have an adverse impact on your ability to deliver effective clinical health care services?		Yes <input type="checkbox"/> No <input type="checkbox"/>

19.	Has any information pertaining to you ever been reported to the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protections Data Bank (HIPDB)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Professional Liability Claims Information Form

The following information is necessary to complete the credentialing verification process and will be kept **confidential**. Please print or type answers for any malpractice claims reported to your malpractice insurance carrier, opened, closed, dismissed, settled or paid. Please complete a separate form for each claim. One case per sheet only (photocopy first if additional sheets needed).

PROVIDER'S NAME (required): _____

1. Name of Patient Involved:	Age:	Month and Year of Occurrence:	Month and Year of Lawsuit:
Event Precipitating Claim:		Insurance Carrier at Time:	

2. What is/was your status:

Primary Defendant Co-defendant Other

Please list other Defendants: _____

What was the patient's outcome? _____

How were you alleged to have caused harm or injury to this patient? _____

Please provide specifics in reference to the adverse event: _____

What is/was your role in this event? _____

Current Status: (please check one)

Still pending as of (date): ___/___/___

Who is handling the defense of the case? _____

Trial date set, awaiting trial

Yes No Trial Date: ___/___/___

Settled out of court

Yes No Date: ___/___/___ Amount of Total Settlement: \$ _____

Amount Paid on Your Behalf: \$ _____

Dismissed Date: ___/___/___

Defense Verdict Date: ___/___/___

Plaintiff Verdict Date: ___/___/___

Judgment Amount \$ _____ Date: ___/___/___ Amount of Total Judgment: \$ _____

This Professional Liability Claims Information Form is required on all claims/lawsuits. Clinical details are required for all suits, regardless of status or settlement amount.

I certify that the information contained in this form is correct and complete to the best of my knowledge.

Applicant's Signature:	Date:	
Print Name:		

MALPRACTICE CLAIMS HISTORY

1. Have you ever been denied professional liability insurance or denied renewal of an existing policy? If "YES" please attach a brief explanation.	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have any malpractice claims, suits, settlements, or arbitration proceedings ever been made against you including any that have been dismissed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Are you aware of any claims, suits, or settlements currently pending or of any intent to file a claim or suit?	Yes <input type="checkbox"/> No <input type="checkbox"/>

If your answer to either of the above questions is "Yes" please provide the following information on each claim and provide a brief clinical summary of each case on the attached Professional Liability Claims Information Form.

Please keep this time frame in mind when anticipating your first direct deposit. If you have any questions concerning whether or not your check will be paper vs. electronic, please call us to verify.