Quad City Community HEALTHCARE

Credentialing and Information Check List

Please complete all sections of the credentialing and information form by printing or typing. Also note that you may attach or enclose a curriculum vitae with complete education and work history in lieu of completing the Education/Training/Work History section of the application.

By using the check list below it will insure all documents are returned with your application and that we will be able to process your credentialing application in a more timely manner.

Please return the signed release, check list and credentialing application along with the requested documents to:

Quad City Community Healthcare
PO Box 389
Dubuque IA 52004-0389

If you have any questions please call us at 563-587-4258 or 1-800-457-4726 ext. 4258

Below is a check list of what documents need to be enclosed with the application:

- ☐ Credentialing application completed and signed by provider
- ☐ Waiver of liability and consent for release of information
- ☐ Copy of all current board certifications
- ☐ Copy of all current Professional State License documents
- ☐ Copy of all Federal DEA License documents
- ☐ Copy of all State Controlled Substance documents
- ☐ ECFMG if applicable
- ☐ Curriculum vitae in lieu of education/training/work history section
- ☐ Current certificate of liability insurance
- ☐ Narrative of any liability or malpractice judgments or pending cases
- ☐ Narrative of any explanations to the questions within the application answered yes
- ☐ Radiology certifications
- ☐ CLIA certifications
- ☐ W-9

Quad City Community HEALTHCARE

Please print or type

Last Name _____First Name _____MI _____Degree _____

List Alias_____

Male☐ Female☐ Birth Date _____

Birth Place _____

Social Security Number _____Individual NPI Number_____

Preferred E-mail Address _____

Languages Spoken _____

Are you a US Citizen? Yes☐ No ☐

If no, do you have the legal right to reside and work in the US? Yes☐ No ☐

Emergency Contact Name _____ Phone Number _____

Specialty to be listed in directory _____ Board Certified Yes ☐ No ☐

Secondary Specialty _____ Board Certified Yes ☐ No ☐

Please attach or enclose a copy of all current board certifications

Illinois Professional License Number _____ Exp Date _____

Iowa Professional License Number _____ Exp Date _____

Please attach or enclose a copy of all current Professional State License documents

Federal DEA License Number _____ State Issued to _____ Exp Date _____

Federal DEA License Number _____ State Issued to _____ Exp Date _____

List other Federal DEA Licenses issued

Please attach or enclose a copy of all current Federal DEA License documents

Illinois State Controlled Substance Number _____Exp Date_____

Iowa State Controlled Substance Number _____Exp Date_____

Please attach or enclose a copy of all current State Controlled Substance document

Quad City Community HEALTHCARE

Education/Training/Work History

You may complete the Education/Training/Work History Section OR attach/enclose a curriculum vitae

Medical/Professional School Name _____

Address_____

City_____State_____Zip_____

Telephone Number_____

Degree_____ Year Graduated_____ Years attended From _____to_____

If you graduated from a foreign medical school please attach your ECFMG

Internship Institution Name_____

Address_____

City_____State _____Zip _____

Telephone Number_____

Type of Residency_____ Dates attended From _____to_____

First Residency Internship Institution Name_____

Address_____

City_____State _____Zip _____

Telephone Number_____

Type of Residency_____ Dates attended From _____to_____

Second Residency Internship Institution Name_____

Address_____

City_____State _____Zip _____

Telephone Number_____

Type of Residency_____ Dates attended From _____to_____

First Fellowship Institution Name_____

Address_____

City_____State _____Zip _____

Telephone Number_____

Type of Fellowship_____ Dates attended From _____to_____

Second Fellowship Institution Name_____

Address_____

City_____State _____Zip _____

Telephone Number_____

Type of Fellowship_____ Dates attended From _____to_____

Quad City Community HEALTHCARE

List most recent employment first and then in reverse chronologic order all work or employment, self employment, independent contractor and military service. Do not duplicate educational history. If there is a gap of more that 30 days please enclose a narrative to explain.

Current work place _____

Address_____

City_____State _____Zip _____

Telephone Number_____

Title or Occupation_____

Time in this employment From _____To _____

Prior work place _____

Address_____

City_____State _____Zip _____

Telephone Number_____

Title or Occupation_____

Time in this employment From _____To _____

Prior work place _____

Address_____

City_____State _____Zip _____

Telephone Number_____

Title or Occupation_____

Time in this employment From _____To _____

Prior work place _____

Address_____

City_____State _____Zip _____

Telephone Number_____

Title or Occupation_____

Time in this employment From _____To _____

If you have not enclosed a curriculum vitae and you have additional work history please enclose in a separate narrative.

Quad City Community HEALTHCARE

Professional references

Name_____ Title _____

Specialty_____Relationship_____Years Known_____

Address_____

City_____State _____Zip _____

Telephone Number_____

Name_____ Title _____

Specialty_____Relationship_____Years Known_____

Address_____

City_____State _____Zip _____

Telephone Number_____

Name_____ Title _____

Specialty_____Relationship_____Years Known_____

Address_____

City_____State _____Zip _____

Telephone Number_____

Hospital Staff Memberships (current only)

Please list member status: Active, Courtesy, Consulting, Provisional etc.

Name of Hospital_____ Member Status _____

Name of Hospital_____ Member Status _____

Name of Hospital_____ Member Status _____

Name of Hospital_____ Member Status _____

Name of Hospital_____ Member Status _____

Name of Hospital_____ Member Status _____

Surgery Center Staff Membership (current only)

Name of Surgery Center_____ Member Status _____

Name of Surgery Center_____ Member Status _____

Name of Surgery Center_____ Member Status _____

Current Professional Liability Insurance

Carrier Name _____

Address _____

Quad City Community HEALTHCARE

City _____State _____Zip_____

Telephone Number_____ Contact Person _____

Policy Number_____ Original Effective Date _____Expiration Date _____

Policy Limits Per Occurrence $_____ Aggregate $_____

Retroactive Date _____

Type of Coverage Claims Made ☐ Occurrence ☐

Has any judgment or payment of claims or settlement exceeded the limits of this coverage? Yes ☐ No ☐

Please attach or enclose a current certificate of liability

If this is the first time you have credentialed with Quad City Community Healthcare, please attach a complete list of professional liability judgments entered against you, settlements ever paid by you or in your behalf of you, any current pending professional liability suits, actions or claims filed against you. Please give a summary of the Date of incident, Applicants Name, Plaintiff's Name, Your involvement in the care, case status, resolutions of the case, amount paid on your behalf if any.

If this is a re credentialing application with Quad City Community Healthcare, please attach a list of professional liability judgments from only the last 5 years entered against you, settlements ever paid by you or in your behalf of you, any current pending professional liability suits, actions or claims filed against you. Please give a summary of the Date of incident, Applicants Name, Plaintiff's Name, Your involvement in the care, case status, resolutions of the case, amount paid on your behalf if any.

If you answered yes to any of the following questions please submit a narrative explanation

Has your license to practice in any jurisdiction every been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation?	Yes ☐	No ☐
Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have been notified that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers?	Yes ☐	No ☐
Have you lost any board certification's and or failed to recertify?	Yes ☐	No ☐
Have you been examined by a Certifying Board but failed to pass?	Yes ☐	No ☐
Has a professional liability judgment ever been filed against you, a claim settlement ever been paid by you and/or paid on your behalf, any person or entity ever been sued for your clinical actions, or are there any current pending professional liability suits, actions and/or claims filed against you?	Yes ☐	No ☐
Has any information pertaining to you, including malpractice judgments and/or disciplinary action ever been reported to the National Practioner Data Bank or any other practitioner data bank?	Yes ☐	No ☐
Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, or have you been notified that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?	Yes ☐	No ☐
Have you or any of your hospital or ambulatory surgery center privileges been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed or any disciplinary acions taken place with respect to privileges?	Yes ☐	No ☐
Have you ever been reprimanded, censured, excluded, suspended or disqualified from participating in Medicare, Medicaid, CHAMPUS or any other governmental health related program?	Yes ☐	No ☐
Have Medicare, Medicaid, CHAMPUS, other governmental programs, third party payers, HMO, PPO, or IPA brought charges against you for alleged inappropriate fees, billing, acceptance of reimbursement or quality of care issues?	Yes ☐	No ☐
Have you been charged with or convicted of a crime (other than a minor traffic offense) or do you have any criminal charges pending against you?	Yes ☐	No ☐
Have you been the subject of a civil or criminal complaint or administrative action or been notified that you are being investigated as the possible subject of a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse?	Yes ☐	No ☐

Quad City Community HEALTHCARE

Do you have or have you had a medical condition, physical defect or emotional impairment which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	Yes ☐	No ☐
Have you been or are you currently engaged in illegal use of any legal or illegal substances?	Yes ☐	No ☐
Have you or do you currently overuse or abuse alcohol or any other controlled substances?	Yes ☐	No ☐
Have you been or are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you for alcohol or substance abuse?	Yes ☐	No ☐

Quad City Community HEALTHCARE

What is your preferred address to receive mail other than for remittance?

Address_____

City_____State _____Zip_____

Telephone Number_____ Fax Number _____

What is the remittance name and address for reimbursement?

Remittance Name _____

Remittance NPI if other than your individual NPI _____

Address_____

City_____State _____Zip_____

Telephone Number_____ Fax Number _____

Primary Contact Person _____

Primary Practice Site

Group or Practice Name _____

Group or Practice NPI _____

Address_____

City_____State _____Zip_____

Telephone Number_____ Fax Number _____

Office Manager or Administrator Name _____

After hour contact phone number(s) _____

What restrictions do you have for this location (e.g. age or type of patient) _____

Are you accepting new patients at this location? Yes ☐ No ☐

Please indicate patient wait times for the following at this location:	**New Patient**	**Existing Patient**
Emergency Care		
Urgent Care		
Symptomatic Care		
Routine Visits		
Preventative Routine Care		

Waiting time in office	
Response time for returning patient calls for Urgent or Emergent situations	
Response time for returning a routine call to a patient	

Please list hours for this site only:

Hours	SUN	MON	TUES	WED	THUR	FRI	SAT
From							
To							

Quad City Community HEALTHCARE

Are any radiology, nuclear studies, CT scans, or MRI's performed at this office locations? Yes ☐ No ☐

Certification _____

Type of studies being performed _____

Do you have a laboratory at this office locations? Yes ☐ No ☐

CLIA# _____ Expiration Date _____

Is this location handicap accessible? Yes ☐ No ☐

Do you have accommodations for the hearing impaired at this location? Yes ☐ No ☐

Second Practice location

Group or Practice Name _____

Group or Practice NPI _____

Address _____

City _____ State _____ Zip _____

Telephone Number _____ Fax Number _____

Office Manager or Administrator Name _____

After hour contact numbers _____

What restrictions do you have for this location (e.g. age or type of patient) _____

Are you accepting new patients at this location? Yes ☐ No ☐

Please indicate patient wait times for the followinq at this location:	New Patient	Existinq Patient
Emergency Care		
Urgent Care		
Symptomatic Care		
Routine Visits		
Preventive Routine Care		

Waiting time in office	
Response time for returning patient calls for Urgent or Emergent situations	
Response time for returninq a routine call to patient	

Please list office hours for this site only:

Hours	SUN	MON	TUES	WED	THUR	FRI	SAT
From							
To							

Are any radiology, nuclear studies, CT scans, or MRI's performed at this office locations? Yes ☐ No ☐

Certification _____

Type of studies being performed _____

Do you have a laboratory at this office location? Yes ☐ No ☐

CLIA# _____ Expiration Date _____

Quad City Community HEALTHCARE

Is this location handicap accessible? Yes ☐ No ☐
Do you have accommodations for the hearing impaired at this location? Yes ☐ No ☐

Quad City Community HEALTHCARE

Third Practice location

Group or Practice Name _____ _

Group or Practice NPI _____

Address _____

City _____ State _____ Zip _____

Telephone Number _____ Fax Number _____

Office Manager or Administrator Name _____

Please indicate patient wait times for the following at this location:	New Patient	Existing Patient
Emerqency Care		
Urqent Care		
Symptomatic Care		
Routine Visits		
Preventive Routine Care		

Waitinq time in office	
Response time for returninq patient calls for Urqent or Emerqent situations	
Response time for returning a routine call to patient	

After hour contact numbers _____

What restrictions do you have for this location (e.g. age or type of patient) _____ _

Are you accepting new patients at this location? Yes ☐ No ☐

Please list office hours for this site only:

Hours	SUN	MON	TUES	WED	THUR	FRI	SAT
From							
To							

Are any radiology, nuclear studies, CT scans, or MRI's performed at this office locations? Yes ☐ No ☐

Certification _____

Type of studies being performed _____

Do you have a laboratory at this office locations? Yes ☐ No ☐

CLIA# _____ Expiration Date _____

Is this location handicap accessible? Yes ☐ No ☐

Do you have accommodations for the hearing impaired at this location? Yes ☐ No ☐

Quad City Community HEALTHCARE

Please list all providers in your practice. Include Physicians, Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, Therapist or any other applicable providers. (You may attach a separate sheet)

Name _____ Title _____

Name _____ Title _____

Name _____ Title _____

Name _____ Title _____

Name _____ Title _____

Name _____ Title _____

Name _____ Title _____

Please enclose a copy of a current W-9. Reimbursement may not be made without a copy of your W-9 on file.

Name as shown on income tax return _____ _

Business name if different from tax name _____ _

Sole Proprietor ☐ Corporation □ Partnership ☐ Other ☐ (please list)

Address _____

City _____ State _____ Zip _____

Tax ID Number _____

Person to contact regarding information within this application

Name _____ Title or Company _____ _

Contact Number_____ Contact E-Mail _____ _

Affirmation/ Attestation

All information submitted by me **in** this application is true to the best of my knowledge and belief. I further certify that I am personally responsible for the accuracy of the responses submitted as part of this application. I understand that falsification or omission of information may result in rejection or termination of this application or result in termination of privileges with Quad City Community Healthcare as a participating provider. I understand that this application does not entitle me to participation in the health plan.

Provider Signature _____ Date _____

Please Type or Print Provider Name _____