



## Participating Provider Application

Thank you for your interest in joining the network of participating providers in North American Preferred (NAP). Please make sure you have done the following before returning your documents:

1. Completed Participating Provider Application including the signed Provider Statement and signed Authorization Section.
2. Signed Participating Provider Agreement
3. Enclosed copies of:
  - a. Residency or Fellowship Certificate (if not Board Certified).
  - b. Current DEA/CDS Certificate.
  - c. Declaration Face Sheet of Professional Liability Insurance Coverage.
  - d. Malpractice History (past 5 years).
  - e. Work History/Curriculum Vitae (attach explanation of work history for gaps of 6 months or more).
  - f. ECFMG Certificate (if not Board Certified and a Foreign Medical School Graduate).
  - g. Practice & Protocols agreement (**if a NP, PA, or CNM**).

Please contact the Provider Relations Department with any questions at (716) 319-5341 or (877) 777-5993.

Mail signed, original documents and attachments to:

North American Preferred  
Attention: Provider Relations Department  
300 Corporate Parkway  
Amherst, New York 14226

Thank you.

# Participating Provider Application (cont'd)

PLEASE TYPE OR PRINT

## Identifying Information

Name <i>Last</i> <span style="margin-left: 150px;"><i>First</i></span> <span style="margin-left: 150px;"><i>Middle</i></span>		
Title	Social Security #	Date of Birth
License Number(s)		State(s)

## Applying As

<input type="checkbox"/> Primary Care Physician <i>(including OB/GYN)</i>	Requested Specialty(ies) 1. _____  2. _____  Practice Restriction(s): _____	Accepting New Patients <input type="checkbox"/> Yes, ALL <input type="checkbox"/> Yes, Limited to <input type="checkbox"/> No  _____ <input type="checkbox"/> Yes, ALL <input type="checkbox"/> Yes, Limited to <input type="checkbox"/> No  _____
<input type="checkbox"/> Specialist Physician	Requested Specialty(ies) 1. _____  2. _____  Practice Restriction(s): _____	Accepting New Patients <input type="checkbox"/> Yes, ALL <input type="checkbox"/> Yes, Limited to <input type="checkbox"/> No  _____ <input type="checkbox"/> Yes, ALL <input type="checkbox"/> Yes, Limited to <input type="checkbox"/> No  _____
<input type="checkbox"/> Both	Requested Specialty(ies) 1. _____  2. _____  Practice Restriction(s): _____	Accepting New Patients <input type="checkbox"/> Yes, ALL <input type="checkbox"/> Yes, Limited to <input type="checkbox"/> No  _____ <input type="checkbox"/> Yes, ALL <input type="checkbox"/> Yes, Limited to <input type="checkbox"/> No  _____

• Please list any specialized training and/or additional services that you provide (Attach documentation and/or certification where applicable).

## Primary Office Location

Please check all that apply:    This office is a     Billing Location     Service Location    County \_\_\_\_\_

Group Practice Name <i>(if applicable)</i>	Contact Name
Office/Professional Building Name	
Street Address	Room/Suite #
Town/City	State
Telephone	Fax
E-mail	
Tax ID # used at this location	
Your reimbursement checks should be made payable to:	

# Participating Provider Application (cont'd)

**Other Location**

Please check all that apply: This office is a  Billing Location  Service Location  County

Group Practice Name (if applicable)	Contact Name
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Office/Professional Building Name

Street Address	Room/Suite #
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Town/City	State	Zip+4
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Telephone	Fax	E-mail
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Tax ID # used at this location

Your reimbursement checks should be made payable to:

**Other Location**

Please check all that apply: This office is a  Billing Location  Service Location  County

Group Practice Name (if applicable)	Contact Name
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Office/Professional Building Name

Street Address	Room/Suite #
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Town/City	State	Zip+4
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Telephone	Fax	E-mail
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Tax ID # used at this location

Your reimbursement checks should be made payable to:

**Please attach additional sheets for other locations, if necessary.**

**Correspondence Address** Which address(es) would you like to receive your correspondence

Billing Address     
  Office Location(s)     
  Both Billing Address and Office Location(s)  
 Other (please specify) \_\_\_\_\_ Contact \_\_\_\_\_

**Medical Education and Training**

Institution Name	Street
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City/State/Zip	Degree	Graduation Date
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• If you are certified by the Educational Commission for Foreign Medical Graduates (ECFMG), please attach Certificate.

# Participating Provider Application (cont'd)

**For Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants, please attach a copy of your Practice Agreement and/or Practice Protocols with your affiliated physician.**

**Internship** *(if more than one, please attach additional sheet)*

Institution Name	Street	City/State/Zip
Dates Attended From (Mo./Yr.)	To	Did you successfully complete this program? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Internship	<input type="checkbox"/> Rotating <input type="checkbox"/> Straight	If straight, list specialty.

**Residency** *(if more than one, please attach additional sheet)*

Institution Name	Street	City/State/Zip
Dates Attended From (Mo./Yr.)	To	Did you successfully complete this program? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate Residency Completion Status: <input type="checkbox"/> Completed Residency		<input type="checkbox"/> Completed Post-Graduate – Year 1
<input type="checkbox"/> Completed Post-Graduate – Year 2		<input type="checkbox"/> Completed Post-Graduate – Year 3 <input type="checkbox"/> Completed Post-Graduate – Years 4-8
Specialty	Attending Physician's License Number	

**Fellowship** *(if more than one, please attach additional sheet)*

Institution Name	Street	City/State/Zip
Dates Attended From (Mo./Yr.)	To	Did you successfully complete this program? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Board Certification**

Primary Specialty	Secondary Specialties		
Are you board certified in this primary specialty?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Board	Certificate Number	Effective Date	Expiration Date
Board	Certificate Number	Effective Date	Expiration Date
If you are you not board certified in this primary specialty, are you board eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of Last Exam	Expiration Date		
Date of Last Exam	Expiration Date		
Are you board certified in these secondary specialties? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Board	Certificate Number	Effective Date	Expiration Date
Board	Certificate Number	Effective Date	Expiration Date
If you are you not board certified in these secondary specialties are you board eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of Last Exam	Expiration Date		
Date of Last Exam	Expiration Date		

# Participating Provider Application (cont'd)

If you are not board certified and have not applied to a board, are you planning to take any specialty boards?

Yes     No     N/A

Subspecialty Board

If you are planning to take the boards, please list the dates you are scheduled to sit for the exam.

Board	Dates

Were you ever board certified in any specialty and allowed that certification to lapse (i.e. chose not to become re-certified, failed to renew certification)?                       Yes                       No

If so, what specialty?

• If you are not Board Certified, please attach a copy of your Residency or Fellowship Certificate.

### **Continuing Medical Education**

List all CME credits earned during the past three years. (Attach additional sheet if necessary)

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Have you earned an AMA certificate for CME?                       Yes                       No                      Expiration Date

**Hospital Affiliations**     Yes     No                      If no, please attach explanation or admitting arrangement.

Please list all PRESENT appointments and status. Attach additional sheet if necessary. Also indicate the status of privileges using the following key (using only one number for each affiliation):    1. Active/Admitting    2. Courtesy    3. Consulting

Primary Hospital Name	Appointment Date (Mo./Yr.)	Status of Privileges	Describe any restrictions
Secondary Hospital Name	Appointment Date (Mo./Yr.)	Status of Privileges	Describe any restrictions
Additional Hospital Name	Appointment Date (Mo./Yr.)	Status of Privileges	Describe any restrictions

### **Call Coverage Arrangements** Please list covering physician(s) (Attach additional sheet if necessary)

Physician or Group Name	Specialty	Telephone
Physician or Group Name	Specialty	Telephone
Physician or Group Name	Specialty	Telephone
Physician or Group Name	Specialty	Telephone

**All Applicants**, please attach copies of the following:

- ◆ Residency or Fellowship Certificate (if not Board Certified)
- ◆ Current DEA/CDS Certificate
- ◆ Current Liability Insurance Coverage
- ◆ Work History for the past five (5) years, or current Curriculum Vitae if work history included
- ◆ ECFMG Certificate (if not Board Certified and a Foreign Medical School Graduate)

# Provider Statement

Please read **AND initial** each statement.

- \_\_\_\_\_ 1. I do not now have, nor have I had in the past five (5) years, any malpractice claims or legal actions brought against me. If you cannot affirm this statement, please complete the attached form (insert anchor 1) describing the following information for each claim or suit.
- patient's name;
  - diagnosis;
  - date of incident, date filed, date closed;
  - your involvement in the case (Attending, Consulting, etc.)
  - nature of the allegation(s);
  - medical facts;
  - patient outcome;
  - other pertinent details;
  - resolution of the case;
  - settlement amount on your behalf (if applicable)
- \_\_\_\_\_ 2. I have never been denied a request for hospital privileges at any time in any state.
- \_\_\_\_\_ 3. I have never relinquished nor have had my privileges reduced at any hospital, other than voluntarily.
- \_\_\_\_\_ 4. There are no professional medical misconduct proceedings or peer review-type proceedings pending wherein I am a party in this state or in any other state or country.
- \_\_\_\_\_ 5. There have been no judgements, settlements, findings, decisions or any other determinations of any kind whatsoever entered or made in any professional medical misconduct proceedings or peer review-type proceedings wherein I was part in this state or any other state or country in the past five (5) years.
- \_\_\_\_\_ 6. My license to practice medicine in any state or country has never been suspended, revoked, or subject to limitations or voluntary relinquishment.
- \_\_\_\_\_ 7. I am not currently under investigation nor have any charges been brought against me by any hospital or other health care institution, third party payor, Medicaid or Medicare, or governmental licensing or other authority.
- \_\_\_\_\_ 8. I am not now, nor have I ever been treated for a physical or mental health condition, including alcohol or substance abuse, which would interfere with my ability to perform my duties as a physician.
- \_\_\_\_\_ 9. My license to prescribe narcotics has never been voluntarily relinquished nor involuntarily refused, suspended or revoked.
- \_\_\_\_\_ 10. I have never been denied participation in, nor terminated from a managed care organization.

**If, for any reason, you cannot affirm to a particular statement with respect to statements 2 through 11 above, submit full details on a separate sheet.**

I hereby affirm and represent that all statements, answers, and information contained in this application are true, correct and complete to the best of my knowledge and belief and that no information of an adverse nature has been knowingly withheld. I understand that misrepresentation or omission of any fact requested may result in automatic termination. I further understand and agree that acceptance of this application does not constitute approval or acceptance of participation status in North American Preferred and grants me no rights or privileges until such time as I receive a formal notice of participation.

My signature on this application indicates my agreement to cooperate fully with North American Preferred and its representatives during the processing of this application and any subsequent recredentialing. I further indicate my willingness to provide documentation and other written or oral information as may be requested of me with regard to my application.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Print or Type)

# Professional Liability History

Please list all past or current professional liability claims or lawsuits which have been filed against you. (Photocopy this page as needed and submit information on each claim/lawsuit.)

Patient's Name	Name of claimant/plaintiff, if other than patient	Diagnosis
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Date of occurrence	Date claims were filed	Date closed
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Professional Liability Carrier involved

Describe your role in the claim/lawsuit:       Primary Defendant       Co-defendant

Describe the nature of the allegation(s) against you

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Describe the alleged injury to the patient

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Describe the patient outcome

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Identify all other defendants

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Describe any other pertinent details

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Has the claimant/plaintiff filed suit in court?       Yes       No

Case number	<input type="checkbox"/> State Court	State	County/Parish
Case number	<input type="checkbox"/> Federal Court (US District Court)		District

Present status of the claim or case

- The case or claim is still pending
- Verdict or judgment for the plaintiff was entered in the amount of \$\_\_\_\_\_
  - The portion of the verdict or judgment which was attributed to me was \$\_\_\_\_\_
- Case or claim settled for \$\_\_\_\_\_
  - The portion of the verdict or judgment which was attributed to me was \$\_\_\_\_\_
- The case was dismissed by the court
- The claimant/plaintiff voluntarily withdrew me from the claim/lawsuit
- The claimant/plaintiff voluntarily dismissed me from the lawsuit

Identify your attorney for this claim/lawsuit	Firm
Name	
Street	City      State      Zip

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name (Print or Type) \_\_\_\_\_

# Authorization for Release of Information

I specifically authorize North American Preferred or its authorized representatives to consult with and obtain any information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my satisfaction of the criteria for appointment or renewal of appointment to the medical staff, as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties relating to such questions.

I specifically authorize and consent to the release of information including otherwise privileged or confidential information to North American Preferred by any hospital or hospital's medical staff, medical associations, National Practitioner Data Bank, State Department of Social Services, State Department of Health, other government agencies, malpractice insurance carriers and previous and present and over interested parties regarding information concerning me. I hereby release North American Preferred, its staff, as well as the institution(s) or organization(s) providing such information and their staff, from any and all liability for the obtaining and release of such information. I also understand that I have a continuing obligation to amend and update my answers.

Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Name (Print or Type)