INTERWEST Health®

PROVIDER APPLICATION

PERSONAL INFORMATION

Name: _____
(Last Name) *(First Name)* *(MI)* *(Suffix)* *(Degree)*

Sex: [ ] Male [ ] Female Date of Birth: ___/___/_____ Foreign Languages: _____ _____

PROFESSIONAL INFORMATION

Primary Specialty: _____ Board Certified: [ ] Yes

Other Specialty: _____ Board Certified: [ ] Yes

Unique Focus *(if practice is limited)*: _____

PRACTICE LOCATION

Name: _____

Address: _____

_____

Phone: ( ) _____

Fax: ( ) _____

E-mail: _____

SECONDARY PRACTICE LOCATION *

Name: _____

Address: _____

_____

Phone: ( ) _____

Fax: ( ) _____

E-mail: _____

* *If you have more than two practice locations, please provide information on your other locations on a separate piece of paper.*

BILLING ADDRESS *(if different from above)*

Name: _____

Address: _____

_____

Phone: ( ) _____

Fax: ( ) _____

E-mail: _____

PROVIDER IDENTIFICATION

Tax ID #: _____

Tax ID Name: _____

SSN #: _____

NPI #: _____

UPIN #: _____

License #: _____

DEA or CDS #: _____

EDUCATION & TRAINING *(if not on curriculum vitae)*

	Institution	*Location*	*Year Completed*
Medical or Other Professional School	_____	_____	_____
Residency:	_____	_____	_____
Fellowship:	_____	_____	_____

WORK HISTORY *(most recent 5 years, if not on curriculum vitae)* ***On separate cover, please explain any gaps in work history greater than 6 months.***

CURRENT EMPLOYMENT

Organization	*Location*	*Start Date (mo/yr)*
_____	_____	_____

PRIOR EMPLOYMENT

Organization	*Location*	*From-To Dates (mo/yr)*	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOSPITAL STAFF PRIVILEGES

Please list the hospitals at which you hold active staff privileges:

Primary Hospital: _____

Other Hospitals: _____ _____

_____ _____

MALPRACTICE INSURANCE

Dates of Coverage: From: _____ To: _____

Amount of Coverage: Per Occurrence: _____ Annual Aggregate: _____

If you have federal tort coverage, please check here: [ ]

ATTESTATIONS

If answering yes to any of the questions below, please provide a written description of each incident. The description should include the date of the incident, case details, and the final outcome or current status.

1. Are there any reasons why you are unable to perform the essential functions of your practice, with or without accommodation? [ ] Yes [ ] No

2. Are you presently engaged in the unlawful use of drugs or do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? [ ] Yes [ ] No

3. Do you have a history of loss of license or license investigation, voluntary or involuntary revocation, denial, suspension, restriction, fine, reprimand, consent order, probation or other conditions or limitations? [ ] Yes [ ] No

4. Do you have a history of felony convictions? [ ] Yes [ ] No

5. Do you have a history of past or present issues regarding loss or limitation of clinical privileges or other disciplinary action at a facility or organization with which you have had privileges? [ ] Yes [ ] No

6. Has your DEA or CDS certificate ever been denied, challenged, suspended, revoked, restricted, denied renewal or voluntarily or involuntarily relinquished? [ ] Yes [ ] No

7. Has your professional liability coverage ever been restricted, cancelled, declined or not renewed based on your individual liability history? [ ] Yes [ ] No

8. Within the last 5 years based on year of incident, have you been a defendant in a malpractice suit which:

   a. Went to final disposition and resulted in payment from you or your carrier on your behalf to any party? [ ] Yes [ ] No

   b. Is presently pending against you? [ ] Yes [ ] No

9. Within the last 5 years, have you been subject to any:

   a. Medicare or Medicaid sanctions? [ ] Yes [ ] No

   b. State sanctions or limitations on the scope of your practice? [ ] Yes [ ] No

I, the undersigned, hereby attest that the information given in or attached to this Application is accurate and complete and fairly represents the current level of my training, experience, capability, and competence to practice. I specifically authorize InterWest Health and its authorized representatives to consult with any third party which may have information bearing on the subject matter addressed by this Application and to inspect or obtain any reports, records, recommendations, or other documents or disclosures of third parties that may be material to the questions in this Application. I also specifically authorize any third parties to release information to InterWest Health and its authorized representatives upon request. I hereby release InterWest Health and its authorized representatives, and any third parties, from any liability for any reports, records, recommendations, or other documents or disclosures involving me that are made, requested, or received by InterWest Health and its authorized representatives to, from, or by any third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter addressed by this Application.

I warrant that I have the authority to sign this Application, on my own behalf and on behalf of any entity or organization for which I am signing in a representative capacity. I understand that any information which (1) I fail to disclose in this Application or (2) is entered into this Application which subsequently is found to be false could result in InterWest Health's refusal to enter into an Agreement with me or termination of any Agreement with me. I understand that I have the right to: (1) review information InterWest has obtained in the evaluation of this Application, except for references, recommendations or other information that is peer-review protected; (2) be notified in the event that credentialing information obtained from other sources varies substantially from that provided in this Application and to correct erroneous information submitted by another source; and (3) be informed of the status of this Application, upon request.

SIGNATURE: _____ **DATE:** _____

ITEMS TO BE SUBMITTED WITH APPLICATION

- Professional license
- Evidence of education & training:
  - Board certification
  - Residency diploma *(if not board certified)*
  - Professional school diploma *(if not board certified and no residency training*)
- DEA or CDS certificate *(if applicable)*
- Malpractice insurance face sheet *(to include carrier name, dates, and coverage amounts)*
- Curriculum vitae *(if either the Education or the Work History section is not completed)*

PLEASE RETURN APPLICATION, SIGNED AGREEMENT, AND THE ABOVE-NOTED ITEMS TO:

InterWest Health
2809 Great Northern Loop, Suite 400
Missoula, MT 59808
Phone: (406) 542-1912 Fax: (406) 542-8350