PROVIDER APPLICATION

PERSONAL INFORMATION

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

Sex: [ ] Male [ ] Female

Tax ID: ____ - _____

Birth Date: ___/___/_____

Tax ID Name: _____

Specialty: _____

SSN: _____ - ____ - _____

Board Certified (*MD/DO only*): [ ] BC

Type 1 NPI: _____

Foreign Language: _____

License: _____ Exp: ___/___/_____

PRACTICE LOCATION

Do Not Publish in Directories: [ ]

Name: _____

Address: _____

_____ ___ _____

Phone: ( ) _____ - _____

Fax: ( ) _____ - _____

E-mail: _____

Type 2 NPI: _____

BILLING ADDRESS

Same as: [ ] Practice Location

Name: _____

Address: _____

_____ ___ _____

Phone: ( ) _____ - _____

Fax: ( ) _____ - _____

E-mail: _____

Type 2 NPI: _____

MAILING ADDRESS

Same as: [ ] Practice Location [ ] Billing Address

Name: _____

Address: _____

_____ ___ _____

Phone: ( ) _____ - _____

Fax: ( ) _____ - _____

ADDITIONAL PRACTICE LOCATIONS

To add a second practice location, please attach a separate sheet.

It is not necessary to add other locations for billing purposes, if you will be billing under the same Tax ID. A second location should be added only when (1) you will be billing under a different Tax ID or (2) you would like the location to be published in our Participating Provider Directory. For billing purposes, all locations covered under the Tax ID provided above will be considered participating in the InterWest network.

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

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

WORK HISTORY *(most recent 3 years, if not on curriculum vitae)*

Organization	*Location*	*Dates*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOSPITAL STAFF PRIVILEGES

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

Primary Hospital: _____

Other Hospitals: _____ _____

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 you presently engaged in illegal drug abuse or excessive use of alcohol? [ ] Yes [ ] No
2. Do you have any history of loss of license or felony convictions? [ ] Yes [ ] No
3. Do you have a history of (a) loss or limitation of privileges or (b) disciplinary action? [ ] Yes [ ] No
4. Within the last 3 years, have you been subject to any:
   a. State sanctions, restrictions on licensure, or limitations on the scope of your practice? [ ] Yes [ ] No
   b. Medicare or Medicaid sanctions? [ ] 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, 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, 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 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 Applications, upon request.

SIGNATURE: _____ **DATE:** _____ Please sign & date here

ITEMS TO BE SUBMITTED WITH YOUR APPLICATION:

- Copy of your current professional license
- Signed Participating Provider Agreement, unless you are covered under an existing group contract

PLEASE RETURN YOUR APPLICATION WITH THE ABOVE-NOTED ITEMS TO:

Email: support@interwesthealth.com
or
Fax: (406) 542-8350