

Minnesota Uniform Credentialing Application

Reappointment

Dentist

Applicant Name

Last

First

Middle

Suffix

Title

CREDENTIALING CONTACT INFORMATION

Name _____

Phone Number _____

Address _____

Fax Number _____

Email _____

Instructions

1. The recredentialing application and attachments should be typed or electronically generated.
2. If more space is needed than provided on the application, please attach additional sheets and reference the question being answered.
3. Please do not use abbreviations when completing the application.
4. **Please mark all non-applicable sections with N/A.**
5. When you have completed the form, click *Submit*. A pre-addressed email for submission to **credentialing@primewest.org** will open. Your completed application will be attached to the email.
6. To this email, please attach any additional sheets you used to respond to the questions on this application.
7. Send the email.

Please verify that you have:

- ☐ Provided complete street addresses wherever indicated, including past employment, hospital affiliations, and references
- ☐ Designated dates by month and year time frames
- ☐ Answered all of the Disclosure Questions on page 5 and included explanations for affirmative answers
- ☐ Malpractice liability insurance documentation
- ☐ Signed and dated the Attestation Signature and Date statement (Page 10)
- ☐ Signed and dated the Authorization and Release (Page 7)

All Information Must Be Typed or Electronically Generated

Personal Data

Name: _____
Last First Middle Suffix Title

Maiden/Former/Other Name(s): _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Social Security Number: _____ NPI: _____

Do you speak a language other than English with sufficient fluency to treat patients who speak only that language? ☐ Yes ☐ No

If yes, specify languages: _____

Primary or Pending Practice Location

Primary Practice Location/Clinic Name: _____

Address: _____
Street City/State/County Zip Code

Office Phone Number: _____ Fax Number: _____

Federal Tax ID Number: _____ E-mail Address: _____

Type II (facility) NPI: _____

Start date at this location: _____ Specialty in which care will be provided: _____

Additional Practice Location(s) (If additional space is required, attach a separate sheet)

Other Practice Name: _____

Address: _____
Street City/State/County Zip Code

Office Phone Number: _____ Fax Number: _____

Federal Tax ID Number (if different than primary): _____ E-mail Address: _____

Type II (facility) NPI (if different than primary): _____

Start date at this location: _____ Specialty in which care will be provided: _____

Other Practice Name: _____

Address: _____
Street City/State/County Zip Code

Office Phone Number: _____ Fax Number: _____

Federal Tax ID Number (if different than primary): _____ E-mail Address: _____

Type II (facility) NPI (if different than primary): _____

Start date at this location: _____ Specialty in which care will be provided: _____

Other Practice Name: _____

Address: _____
Street City/State/County Zip Code

Office Phone Number: _____ Fax Number: _____

Federal Tax ID Number (if different than primary): _____ E-mail Address: _____

Type II (facility) NPI (if different than primary): _____

Start date at this location: _____ Specialty in which care will be provided: _____

Licensure - List all past, current and pending professional licenses.

State	License Number	Date Issued	Expiration Date	License Status
		/ /	/ /	☐ Active ☐ Inactive ☐ Pending
		/ /	/ /	☐ Active ☐ Inactive ☐ Pending

Drug Enforcement Administration Registration

Do you currently hold a DEA registration? ☐ YES ☐ NO

If YES:

DEA Number: _____ State: _____ Expiration Date: ____/____/____

NOTE: Address on DEA certificate must be in state where you will be practicing as applicable to this application

If NO:

- ☐ DEA certificate is pending: Date application submitted to DEA: ____/____/____
- ☐ List name of the alternate practitioner or practice that will be covering prescriptions on your behalf:
Name: _____
- ☐ Not required due to scope of practice (i.e. Orthodontics, Pediatric Dentistry, teaching institution)
- ☐ If an alternate practitioner or practice is not designated (because of scope of practice OR office policy to not prescribe controlled substances), please indicate how you will manage prescribing controlled substances if necessary (i.e. referral to primary care physician, etc.):

Specialty/Subspecialty Certification

☐ I do not hold specialty/subspecialty certification

Certifying Board	Specialty/Subspecialty	Date Certified	Date Recertified	Expiration Date	Cert. Pending
		/ /	/ /	/ /	☐
		/ /	/ /	/ /	☐

Primary Hospital Affiliation (pertinent to Primary or Pending Practice Location listed on page 2)

☐ I do not have hospital affiliation.

(Month and year required)

From: ____/____/____ Facility Name: _____
To: ____/____/____ Street Address: _____
City: _____ State: _____

☐ Application Pending Admitting Privileges ☐ Yes ☐ No

Other Current Hospital Affiliations

(Month and year required)

From: ____/____/____ Facility Name: _____
To: ____/____/____ Street Address: _____
City: _____ State: _____

If hospital changed name, list current name and address

☐ Application Pending Admitting Privileges ☐ Yes ☐ No

Insurance Carrier for Primary and/or Pending Practice Location and 5-year insurance history.

Enclose a copy of professional liability insurance coverage (e.g., certificate of insurance, face sheet, or verification of self-insurance) for primary practice location to include effective dates, insurance carrier, expiration date, coverage limits, and name of each provider covered.

Coverage dates:

(Month, day, year required)

Start: _____ Current Insurance Carrier Name: _____

Expire: _____ Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

☐ Certificate Pending

Name in which policy issued: _____

Policy number (if applicable): _____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

Please list all insurance policies you have held in the past 5 years, including policies covering Residency and Fellowships.

Specify dates of coverage for each policy. If additional space is required, complete the Liability Addendum, page 9.

Additional documentation of insurance coverage may be required.

For coverage provided by the Federal Tort Claims Act, attach a copy of the federal tort letter and provide applicable dates of coverage.

(Month, day, year required)

Start: _____ Insurance Carrier Name: _____

Expire: _____ Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Name in which policy issued: _____

Policy number (if applicable): _____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

Start: _____ Insurance Carrier Name: _____

Expire: _____ Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Name in which policy issued: _____

Policy number (if applicable): _____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

☐ Check here if you have additional Liability Insurance on attached Liability Insurance Addendum (page 9)

Disclosure Questions for Recredentialing**Applicant Name:**

Please complete and sign this form, attesting to its accuracy. If any of the following questions are answered in the affirmative, provide an explanation by completing the **Disclosure Explanation Form** on the following page.

1. ☐ Yes ☐ No In the past three years, has your **professional license or registration** been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished or not renewed by any licensing board or any health-related agency organization, or is there a review pending?
2. ☐ Yes ☐ No In the past three years, has your **professional license or registration** been investigated or is it currently being investigated? *If so, provide details to include the reason for the investigation and the results on the following page.*
3. ☐ Yes ☐ No In the past three years, has your **DEA registration** been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your DEA registration, or is there a review pending?
4. ☐ Yes ☐ No In the past three years, has your **membership, participation, clinical privileges, or employment** been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?
5. ☐ Yes ☐ No In the past three years, have you voluntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license, or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency?
6. ☐ Yes ☐ No In the past three years, have you involuntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license or registration?
7. ☐ Yes ☐ No In the past three years, has your **membership or fellowship** in any professional organization or your specialty **board certification** been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?
8. ☐ Yes ☐ No In the past three years, have you been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing **board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?**
9. ☐ Yes ☐ No In the past three years, has your certificate or participation in any **private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?
10. ☐ Yes ☐ No Are there any charges pending or are you currently charged with or have you, in the past three years, pled guilty or no contest, been indicted or found guilty of a felony, gross misdemeanor, misdemeanor, or other offense?
11. ☐ Yes ☐ No In the past three years, have you been charged with, pled guilty or no contest to, or otherwise been subject to allegations of having engaged in **sexual harassment, sexual misconduct**, stalking, or any other similar behavior or crime, or are you aware of any current allegations or charges pending of the same? *Allegations include, but are not limited to, any made by a third party, such as through a lawsuit, restraining order, or other civil proceeding, or allegations made by a colleague to a previous or current employer.*
12. ☐ Yes ☐ No In the past three years, have you ever had any **professional liability claims or lawsuits** brought against you, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments?
13. ☐ Yes ☐ No In the past three years, has your **professional liability carrier** refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?
14. ☐ Yes ☐ No In the past three years, have you practiced within your profession without **professional liability insurance?**
15. ☐ Yes ☐ No Do you currently have any condition that adversely affects your ability to provide appropriate care to patients or perform the essential functions of your practice in a competent, ethical, and professional manner? *You are not required to disclose a health condition if it is being appropriately treated or otherwise does not affect your ability to provide appropriate care to patients or perform the essential functions of your practice in a competent and professional manner.*
16. ☐ Yes ☐ No Do you use any legal/illegal drugs or substances which adversely affect your ability to perform your duties as a member of the healthcare team?

Attestation Signature and Date

I hereby certify that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary so that it remains complete, true and accurate while my application is being processed. I understand that the race, ethnicity, and language information I have provided (or withheld) on this application is optional and will not be used as basis for credentialing decisions or discrimination.

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Signature _____ Date _____

Name _____

CONFIDENTIAL INFORMATION

If you answered **yes** to any of the Disclosure Questions on the previous page, provide an explanation for each by completing the following form. Please attach external documentation of your response as applicable (e.g., statement from an attorney, court records, etc.). Make additional copies of this form if needed.

Applicable Disclosure Question(s): _____ Date of Occurrence: _____

Location of Occurrence: Facility (if applicable) _____ State: _____

Provide a complete explanation regarding the reason you answered the applicable disclosure question(s) in the affirmative.

*Do **not** include name of patient or any other information that may identify a patient.*

Describe outcome, as applicable. Note: If responding to disclosure question #12, skip this section and complete next section.

If you answered yes to Disclosure Question #12, complete the following section.

Describe Outcome of Claim or Lawsuit

Date Filed: _____

CONCLUDED WITH NO PAYMENTS: (month/year)

☐ Dropped/Closed Date: _____

☐ Verdict for you Date: _____

☐ Dismissed with prejudice* Date: _____

☐ Dismissed without prejudice** Date: _____

CONCLUDED WITH PAYMENTS: (month/year)

☐ Verdict for Plaintiff Date: _____ Amount \$ _____

☐ Settled Date: _____ Amount \$ _____

PENDING

☐ Filed, pending Date: _____

**Dismissed with prejudice – set aside the lawsuit and deny the right to file another suit on the same claim*

***Dismissed without prejudice – set aside the lawsuit but leave open the possibility of another suit on the same claim*

Represented by Legal Counsel for this lawsuit: ☐ Yes ☐ No - If yes, provide name and address of counsel.

Counsel Name _____ Phone _____

Address _____

Insurance company or employer that provided coverage for this claim.

Name _____ Policy# _____

Address _____ Phone _____

I hereby certify that all the information on this form is complete, true and accurate.

Applicant Signature _____ Date _____

Print Name _____ Phone _____

Authorization and Release

(Please read carefully before signing)

I understand and acknowledge that, as an applicant for membership, participation and/or clinical privileges (hereinafter, referred to as "Participation") at PrimeWest Health hereafter referred to as Entity), it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics and any other criteria adopted by the Entity for Participation.

I further acknowledge that I am responsible for knowing the contents of the applicable bylaws, rules and regulations, and requirements of the Entity and its professional/medical staff/network, and agree to be bound by them in the application process and if granted Participation.

I further understand and acknowledge that the Entity, its designated agent(s) and/or other authorized representatives, including, without limitation, the Entity's designated professional credentials verification organization (CVO), collectively referred to as "Agents," will investigate the information in this Application. By submitting this Application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Entity and its Agents as follows:

1. **Authorization of Investigation and Release of Information Concerning Application for Participation.** I authorize the Entity and its Agents to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation and authorize such third parties to release such information to the Entity and its Agents.
2. **Authorization of Release and Exchange of Disciplinary Information.** I hereby further authorize any health care organization at which I have applied for, currently have or had Participation or employment to release Disciplinary Information about any disciplinary action taken against me to the Entity and/or its Agents, including, without limitation, the CVO, and as otherwise may be required by law. I hereby further authorize the CVO to release Disciplinary Information about any disciplinary action taken against me to its participating entities at which I have Participation, and as otherwise may be required by law. As used herein, Disciplinary Information means information concerning (i) any action taken by such health care organizations, their administrators or their medical or other committees to revoke, deny, suspend, restrict or condition my Participation or impose a corrective action plan; (ii) any other disciplinary actions involving me including but not limited to discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges but after I have knowledge that such formal charges are contemplated and/or in preparation.
3. **Release from Liability.** I hereby further release from liability the Entity and its Agents, state licensing board(s), health care organizations, including, without limitation, hospitals, clinics, and third party payers, medical malpractice insurance carrier(s), and any staff, and all individuals, institutions and entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be in addition to any other applicable immunities provided by law for peer review activities.

I understand and agree that the CVO or Entity may communicate with me via e-mail over the Internet regarding my application for credentialing. I understand that unencrypted, unauthorized Internet e-mail is inherently insecure. I further understand that Internet messages may be corrupted or incomplete, or may incorrectly identify the sender.

I understand and agree that this Authorization and Release is irrevocable for any period during which I am an applicant for Participation at the Entity, or I am a member of Entity's medical or health care staff, or a participating provider of the Entity. I agree to execute another consent if law or regulation limits the application of this irrevocable authorization. Failure to promptly provide another consent may be grounds for termination or discipline of the Participant by the Entity in accordance with the applicable bylaws, rules and regulations, and requirements of the Entity.

I acknowledge that the investigation of information in this Application and the release and exchange of Disciplinary Information by the Entity and its Agents are done to achieve, maintain and improve quality patient care.

All information provided by me in the Application is true to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the Application may constitute grounds for denial or revocation of Participation. I understand and acknowledge that the Entity shall be solely responsible for all decisions concerning the granting of Participation.

I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original.

Signature _____ Date _____

Name _____

Chronological Employment/Practice History Addendum

(Please make as many extra copies as
necessary)

*(This is an extra copy for your use if
needed)*

(Month and year required)

From: ____/____/____ Organization Name/Activity: _____

To: ____/____/____ Reason for Leaving: _____

Street Address: _____

City: _____ State: _____ Country: _____

Phone Number: _____

From: ____/____/____ Organization Name/Activity: _____

To: ____/____/____ Reason for Leaving: _____

Street Address: _____

City: _____ State: _____ Country: _____

Phone Number: _____

From: ____/____/____ Organization Name/Activity: _____

To: ____/____/____ Reason for Leaving: _____

Street Address: _____

City: _____ State: _____ Country: _____

Phone Number: _____

From: ____/____/____ Organization Name/Activity: _____

To: ____/____/____ Reason for Leaving: _____

Street Address: _____

City: _____ State: _____ Country: _____

Phone Number: _____

Please make additional copies of this Addendum as necessary.

Please list all insurance policies you have held in the past 5 years, including policies covering Residency and Fellowships. Specify dates of coverage for each policy.

For coverage provided by the Federal Tort Claims Act, attach a copy of the federal tort letter and provide applicable dates of coverage.
(Month, day, year required)

Start: _____ Insurance Carrier Name: _____
Expire: _____ Address: _____
Street City/State/Country Zip Code
Phone Number: _____ Fax Number: _____
E-mail address: _____
Name in which policy issued: _____
Policy number (if applicable): _____
Amount of coverage (per occurrence): _____
Amount of coverage (per aggregate): _____

Start: _____ Insurance Carrier Name: _____
Expire: _____ Address: _____
Street City/State/Country Zip Code
Phone Number: _____ Fax Number: _____
E-mail address: _____
Name in which policy issued: _____
Policy number (if applicable): _____
Amount of coverage (per occurrence): _____
Amount of coverage (per aggregate): _____

Start: _____ Insurance Carrier Name: _____
Expire: _____ Address: _____
Street City/State/Country Zip Code
Phone Number: _____ Fax Number: _____
E-mail address: _____
Name in which policy issued: _____
Policy number (if applicable): _____
Amount of coverage (per occurrence): _____
Amount of coverage (per aggregate): _____

Application Addendum

Accepting new patients? ☐ Yes ☐ No Directory Suppress? ☐ Yes ☐ No

Professional/Peer References

List three (3) professional peers who have personal knowledge of your **current (within the past 12 months)** clinical skills, abilities, judgment, professional performance, and clinical competence or have been responsible for professional observation of your work. A *peer* is defined as an individual in the same professional discipline with essentially equal qualifications (MD and DO are considered equivalent; DDS/DMD for DDS/DMD; DPM for DPM; PhD for PhD, etc.) Limit to **one (1) current office associate**. **Do not include your residency director, fellowship director, relatives, or pending partners**. At least one reference should be in your specialty (and if possible from the same subspecialty). Provide current and complete addresses. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you.

Name _____ Title _____

Facility Name _____

Address _____

Street

City/State/Country

Zip Code

Phone Number _____ Fax Number _____

Email Address _____

Name _____ Title _____

Facility Name _____

Address _____

Street

City/State/Country

Zip Code

Phone Number _____ Fax Number _____

Email Address _____

Name _____ Title _____

Facility Name _____

Address _____

Street

City/State/Country

Zip Code

Phone Number _____ Fax Number _____

Email Address _____

Application Attestation Update

The signature blocks below are to be signed **ONLY** if a previously completed application is being reviewed and updated.

Application Attestation Update

The application was designed so that a practitioner need complete it in its entirety only once. If application is then made to another organization that accepts this Initial Credentialing Application and it has been more than 60 days since the practitioner completed or updated the application, the practitioner may do the following:

- Review the application
- Make any needed modification
- Sign the attestation block below, reconfirming that the application is complete, true, and accurate

Please note: It is particularly important that the Disclosure Questions be reviewed and any changes made with appropriate documentation included.

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true, and accurate.

Signature _____ Date _____

Continuing Education Attestation

Please read the following attestation carefully before signing and dating the statement.

I hereby certify that I have a sufficient number of CE credits to meet the licensure requirements and attest that an appropriate percentage relate to my specialty. I understand that these credits may be audited by an individual facility based on their individual requirements.

Signature _____ Date _____

Name _____

Practitioner Race and Ethnicity Information

Race and ethnicity (for health plan use only):

The following information is optional and may be used in provider directories to help members make informed choices and/or to help ensure that our network of providers is adequate to meet the needs of our members.

Race (Select all that apply):

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other (please specify): _____
- ☐ Prefer Not to Say

Ethnicity

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Prefer Not to Say

Providing race, ethnicity and/or language information on the credentialing application is entirely optional and refusal to provide this information will **not** subject you to adverse treatment. We do not discriminate or base credentialing decisions on an applicant's race, ethnicity, and language.

If provided on the credentialing application, the health plan may utilize race, ethnicity and/or language information in provider directories or in internal resources to help members make informed choices and/or to help ensure that our network of providers is adequate to meet the needs of our members.

Check here if you do not wish for your race and ethnicity to be displayed in provider directories: ☐

Practitioner Gender Information

Gender: ☐ M – Male ☐ F – Female ☐ X – Unspecified or Another Gender Identity ☐ U – Undisclosed