PrimeWest HEALTH™

Pharmacist Initial Enrollment

Read the instructions before you start. An incomplete form may delay the processing of this application.

Instructions: Electronically complete, sign, and date this application. When you have completed the application, click Submit. A pre-addressed email for submission to **credentialing@primewest.org** will open. Your completed application will be attached to this email.

To this email, please attach any additional sheets you used to respond to questions and copies of licenses, malpractice liability insurance, certifications, and, if, you are working in a multidisciplinary setting, a dated letter from the clinic or hospital administrator confirming employment. When you have attached all necessary documents, send the email.

PERSONAL INFORMATION				
LEGAL NAME (LAST) (FIRST) (MIDDLE)			DATE OF BIRTH	GENDER ☐ M – Male ☐ F – Female ☐ X – Unspecified or Another Gender Identity ☐ U – Undisclosed
SOCIAL SECURITY #	NPI #		All Former Aliases:	
DO YOU SPEAK A LANGUAGE OTHER THAN ENGLISH WITH SUFFICIENT FLUENCY TO TREAT PATIENTS WHO SPEAK ONLY THAT LANGUAGE? ☐ YES ☐ NO IF YES, SPECIFY LANGUAGE(S):				

PRIMARY PRACTICE LOCATION			
NAME			
ADDRESS (DO NOT ENTER A PO BOX)			
CITY	STATE	ZIP	EMPLOYMENT START DATE
TELEPHONE #	FAX #	TAX ID #	NPI #
DOES THE PRACTICE SETTING FOR THE MEDICATION THERAPY MANAGEMENT SERVICE MEET THE PRIVACY REQUIREMENTS AS OUTLINED BY THE DEPARTMENT OF HUMAN SERVICES? ☐ YES ☐ NO			
DOES THE PRACTICE HAVE LIABILITY INSURANCE? **IF YES, ATTACH COPY OF CURRENT LIABILITY LIMITS.** ☐ YES ☐ NO			

ADDITIONAL PRACTICING LOCATIONS

FACILITY NAME	TAX ID #	ADDRESS	CITY	STATE	ZIP CODE	START DATE

CHRONOLOGICAL EMPLOYMENT

START DATE	END DATE	PRACTICE NAME	ADDRESS	CITY	STATE	ZIP CODE

COMPLETE THE FOLLOWING LICENSE INFORMATION. ATTACH A COPY OF YOUR CURRENT LICENSE.

LICENSE NUMBER	ORIGINAL LICENSE DATE	END DATE	STATE

EDUCATION (CHECK ONE. ATTACH A COPY OF YOUR COURSE COMPLETION CERTIFICATE.)

START DATE	☐ I GRADUATED AFTER MAY 1996. MY DIPLOMA IS ATTACHED.
END DATE	☐ I GRADUATED BEFORE MAY 1996. THE DHS-APPROVED ACPE PROGRAM I HAVE COMPLETED IS _____
	☐ I HAVE RECEIVED AN MHCP ID# TO PROVIDE MTM SERVICES. THE ID# IS _____

PRACTITIONER NAME		
LAST	FIRST	MIDDLE
NPI #		

PRACTITIONER RACE AND ETHNICITY
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: ☐

LIABILITY INSURANCE

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 Initial Credentialing

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 Has your **professional license or registration** ever 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 Has your **professional license or registration** ever 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 Has your **DEA registration** ever 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 Has your **membership, participation, clinical privileges, or employment** ever 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 Have you ever 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 Have you ever involuntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license or registration?
7. ☐ Yes ☐ No Has your **membership or fellowship** in any professional organization or your specialty board certification ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?
8. ☐ Yes ☐ No Have you ever 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 Has your certificate or participation in any **private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** ever 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 ever pled guilty or no contest, been indicted or found guilty of a felony, gross misdemeanor, misdemeanor, or other offense?
11. ☐ Yes ☐ No Have you ever 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 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 Has your **professional liability carrier** ever refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?
14. ☐ Yes ☐ No Have you ever 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 Plantiff 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 that communication regarding my application may occur via email.

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 _____

Medicare/Medicaid and Other Government Reimbursement Programs Penalty Statement
This statement is required by Medicare/Medicaid and other government reimbursement programs.

Penalty statement according to the Federal Register dated August 31, 1984 and effective October 1, 1984.

"NOTICE TO ALL PRACTITIONERS RECEIVING MEDICARE/MEDICAID AND OTHER GOVERNMENT REIMBURSEMENT PROGRAM PAYMENTS"

Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient as attested to by the patient's attending physician by virtue of his or her signature on the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws.

SIGNATURE	DATE

NAME

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 certification/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

MEDICATION THERAPY MANAGEMENT SERVICES (MTMS) PRIVACY/SPACE REQUIREMENTS		
1. FACILITY	2. TAX ID #	
3. ADDRESS (PRIMARY PRACTICE LOCATION) (DO NOT ENTER A PO BOX)		
4. CITY	STATE	ZIP

The consulting area must meet all the following privacy/space requirements. The consulting area is (check all that apply):

- ☐ Of sufficient size and has accommodations to comfortably seat at least three people around a table
- ☐ Private, so that when a typical patient is sitting or standing in the consulting area, the patient cannot be seen by others (including other patients, customers, and employees)
- ☐ Entirely devoted to enhancing patient outcomes and not used as a storage room for merchandise or other non-related items
- ☐ Accessible to the patient without having to traverse through dispensing or storage areas
- ☐ Enclosed sufficiently to prevent typical patient consultation conversation from being heard from other areas of the store
- ☐ Enclosed sufficiently to prevent noise from other areas of the store interfering with or distracting from typical conversation in the consulting area

NAME OF PHARMACIST	
SIGNATURE OF PHARMACIST	DATE SIGNED

LIABILITY INSURANCE ADDENDUM

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: _____ Current 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: _____

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E-mail address: _____

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Policy number (if applicable):_____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

Submit