MAJORIS™

Wyoming Application Instructions

Please complete the entire application, including answering all questions and attach copies of the following documents:

- Current licenses (including DEA)
- Current malpractice insurance coverage
- Certification documentation
- W-9
- Curriculum Vitae
- Complete chart notes from the last three work-related injury patients you have treated, including first visit through last. Please note which provider the chart notes are from. Please mask names for confidentiality.

Applications received without the appropriate documentation cannot be reviewed.

Please return this application and the required documents to Majoris via U.S. Mail to:

Majoris Health Systems Wyoming,
Corporate Offices
ATTN: Provider Relations Department

P.O. Box 1728
Lake Oswego, OR 97035

Or you may fax this information to us at (503) 601-8438 or
email it to us at providerrelations@majorishealthsystems.com

Majoris Health Systems, Inc.
Corporate Office
P.O. Box 1728 • Lake Oswego, OR 97035
Phone (503) 639-6080 • Toll Free (800) 525-0394
Provider Relations Fax 503-601-8438
providerrelations@majorishealthsystems.com

MAJORIS™

CREDENTIALING APPLICATION

Provider Information:

Provider Name:_____ **Degree(s):** _____

DOB: _____ **SS#:**_____ **NPI Number:**_____

Gender: ⃝ Male ⃝ Female **Practice Information:**

Primary Clinic Name: _____

Primary Physical Address: _____

City: _____ **State:** ____ **Zip:** _____ **Office**

Phone:(___) _____ Fax:(___) _____ email:_____ **Tax**

ID: _____**Office Hours:** _____ **Mailing Address** *(if different than above)*_____

City: _____ **State:** ____ **Zip:** _____ **Billing Address** *(if different than above)* _____

City: _____ **State:** ____ **Zip:** _____ **Billing Phone** *(if different than above):*(___) _____**Fax:**(___) _____ **Secondary Clinic**

Name:_____ **Secondary Clinic**

Physical Address:_____

City: _____ **State:** ____ **Zip:** _____ **Office Phone:**

(___) _____**Fax :** (___) _____ **Tax ID***(if different than primary)*_____

Office Hours _____ **Languages Spoken**

_____ **Specialty(s)**

1)_____

Specialty Board Certification Date Board Eligibility Date

2)_____

Sub-Specialty Board Certification Date Board Eligibility Date

3)_____

Sub-Specialty Board Certification Date Board Eligibility Date

Will you see workers for second opinions? Yes No **Are you accepting new Worker's Comp patients?** Yes No

List any practice restrictions *(i.e., procedures you do not perform)*_____

List any areas of specialization *(i.e., hips, hands, backs)*_____

Education:

Medical School/Training Program _____ **City/State**_____
Completion Date _____ **Degree/Specialty:**_____

Internship Program _____ **City/State**_____
Completion Date _____ **Degree/Specialty:**_____

Residency Program _____ **City/State**_____
Completion Date _____ **Degree/Specialty:**_____

Fellowship Program _____ **City/State**_____
Completion Date _____ **Degree/Specialty:**_____

Licenses, Registrations and Certifications:

State License Number _____ **State**_____ **Expiration Date** _____
State License Number _____ **State**_____ **Expiration Date** _____
DEA Certification Number _____ **Expiration Date** _____

Professional Liability Insurance:

Carrier _____ **Policy Number:**_____ **Expiration Date:** _____
Amounts of Coverage: _____

Health Care Facility Privileges

List all hospitals or other health care facilities (i.e. surgery centers) in which you have privileges, as well as the category and current status.

_____ Active Provisional Courtesy Other_____
_____ Active Provisional Courtesy Other_____
_____ Active Provisional Courtesy Other_____

Work History

Please provide a chronological work history for the past five years. You may submit a curriculum vitae as a supplement. Please explain all gaps in employment over six months.

Current Practice Employer Name: **Start Date/End Date:**

Address

Previous Employer Name: **Start Date/End Date:**

Address:

Reason For Leaving:

Previous Employer Name: **Start Date/End Date:**

Address Reason For Leaving:

Any Gaps in employment over six months:
Yes or No If yes, please provide explanation:_____

Attestation Questions:

Please answer the following questions. *If you answer "yes" to any of the questions below, please provide an explanation on a supplemental page.*

1. Has your medical license suspended, revoked, limited, placed on probation, or been subject to any type of disciplinary action?	Yes No
2. Has your DEA license suspended revoked, limited, placed on probation, or been subject to any type of disciplinary action?	Yes No
3. Voluntarily surrendered your license or hospital privileges to avoid discipline, revocation or termination?	Yes No
4. Had privileges at any hospital suspended, diminished, revoked or placed on probationary status?	Yes No
5. Been subject to disciplinary action by a state agency or any professional body *(i.e. Medical Society, IPRO, etc.?)*	Yes No
6. Had privileges at any hospital suspended, diminished, revoked or placed on probationary status?	Yes No
1 Been convicted of a crime other than a minor traffic offense?	Yes No
2 Been denied, suspended or removed from participation in Medicare, Medicaid, Health Plan, or any other third party insurer?	Yes No
9. Been involved in a National Practitioner Data Bank reportable, incident?	Yes No
10. Had any health problems, including drug addiction, alcoholism, or psychiatric illness that might affect your ability to diagnose and treat patients?	Yes No
11. Had judgments or settlements made against you in professional liability cases?	Yes No
12. Presently have any professional liability cases pending?	Yes No

All information submitted by me in this application is true to the best of my knowledge and belief. I understand that any misstatement(s) in, or omission(s) from, this application shall be cause for denial of acceptance or termination of membership.

Applicant's Signature _____ **Date** _____

RELEASE OF INFORMATION

By applying to Majoris Health Systems Inc. directly or through participation in an affiliated medical group or IPA of Majoris Health Systems Inc. understand and agree that I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications. I hereby signify my willingness to appear for any interviews deemed necessary in regard to my application for initial credentialing.

I release from liability all representatives of MajorisHealth Systems, Inc. for acts performed in good faith and without malice, in connection with evaluating my application, credentials and qualifications. I consent, without reservation to the release of such information and do hereby release from liability any and all individuals and organizations who provide information to Majoris Health Systems, Inc. in good faith and without malice concerning my professional, ethical and other qualifications.

Further, I hereby consent to inspection by Majoris Health Systems, Inc. all documents and records, including hospital and/or ambulatory medical records, that may be material to an evaluation of my professional qualifications and competence to carry out high quality clinical care.

I authorize and consent to the release of information by any hospital, insurance company, or medical staff, with which I am or have been affiliated or to which I have applied for privileges, to Majoris Health Systems, Inc. as long as such release of information is done in good faith and without malice; and hereby release from liability any hospital, insurance company, medical staff, and other health care organizations for so doing.

Print Name Here:

Signature:

(Stamped signature is not acceptable)

Date:

XXI. ATTESTATION QUESTIONS – This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet. **Please sign and date each additional sheet.**

A.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you ever been fined or received a letter of reprimand or is any such action pending or under review?	YES ☐	NO ☐
B.	Have you ever been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES ☐	NO ☐
C.	Have you ever been denied clinical privileges, membership, or contractual participation by any health care related organization*, or have clinical privileges, membership, participation or employment at any such organization ever been placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES ☐	NO ☐
D.	Have you ever surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review?	YES ☐	NO ☐
E.	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* ever been withdrawn on your request prior to the organization's final action?	YES ☐	NO ☐
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES ☐	NO ☐
G	Have you ever voluntarily or involuntarily left or been discharged from medical school or subsequent training programs?	YES ☐	NO ☐
H	Have you ever had board certification revoked?	YES ☐	NO ☐
I	Have you ever been the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES ☐	NO ☐
J.	Have you ever been charged with a criminal violation (felony or misdemeanor)?	YES ☐	NO ☐
K.	Do you presently use any illegal drugs?	YES ☐	NO ☐
L	Do you now have, or have you had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	YES ☐	NO ☐
M	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES ☐	NO ☐
N.	Have any professional liability claims or lawsuits ever been closed and/or filed against you? If yes, please complete **Attachment A, Professional Liability Action Detail**, for each past or current claim and/or lawsuit.	YES ☐	NO ☐
O.	Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?	YES ☐	NO ☐

*e.g. ***hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system***

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature: _____ **Date:** _____

Addendum to Credentialing

Provider Info:

Applicant's Last: _____ First: _____ Middle I: _____Title_____

Languages spoken: _____

Are you accepting new **work comp** patients? Yes _____ No _____

Will you see **work comp** patients for second opinions? Yes _____ No _____

Will you act as attending physician for patients? Yes_____ No_____

Are you able to perform closing examinations? Yes _____ No _____

Practice Information:

Medical Records Contact Information:

Name: _____Phone: _____Fax: _____Email:_____

Pre-Auth Contact Information:

Name: _____Phone: _____Fax: _____Email:_____

Credentialing Contact:

Name: _____Phone: _____Fax: _____Email:_____

Please provide copies of the following supporting documents when submitting a credentialing application:

- ***License***
- ***DEA License***
- ***Current Malpractice Insurance***
- ***W-9***

_____

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