

MCC Health Care
Systems
311 N Pecos Road
Ste 100
Henderson, NV 89074
Ph: (702) 792-2994



Re: Initial Credentialing Application

Dear Provider,

Thank you for applying to the Managed Care Consultants, Inc., AlterNet PPO network. Please find the enclosed Provider Credentialing Application to complete, sign and return to our office as soon as possible.

In order for credentialing to be processed quickly, it is imperative that the credentialing application be completed thoroughly. Please attach a copy of the following:

**Customer Service
Call Center
Fax: (702) 451-6768**

- Copy of Current Primary License
- Copy of Current DEA (as applicable)
- Copy of Current State Pharmacy Certificate
- Copy of Current Malpractice Insurance Certificate
- Signed and Dated Questionnaire
- Explanations for all "Yes" answers on the Questionnaire

**Account Managers
Fax: (702) 932-2137**

**Claims Administration
Fax: (702) 433-5465**

In addition, there is a one-time non-refundable credentialing application fee of \$75.00. Furthermore, there is a \$300.00 Credentialing & Re-credentialing Provider file maintenance fee. This fee will be pro-rated only on the first year of your credentialing process.

**Provider Relations
Provider Network
Fax: (702) 898-3870**

All elements listed above, including the credentialing application fee, must be received by Managed Care Consultants, Inc., Credentialing Department prior to the starting of the credentialing process.

**Executives
Fax: (702) 451-7307**

Please be advised that the credentialing process may take 60 to 120 days to complete once the minimum requirements have been received. Provider will be notified in writing when the process is completed.

**Sales & Marketing
Fax: (702) 932-2137**

If you have any questions or concerns, please call me directly at (702) 792-2994x484.

Sincerely,

**Utilization
Management
Fax: (702) 932-2142**

MCC Provider Relations

**Worker's Comp
Fax: (702) 451-7204**

**Accounting
Fax: (702) 450-1099**

**Information Services
Fax: (702) 451-6768**

Additional Practice Location(s)

Primary Practice Name _____

Address _____
Street City State Zip Code

Office Phone Number _____ Fax Number _____

Federal Tax ID Number _____ E-mail Address _____

Specialty/Subspecialty in which care will be provided _____

Other Practice Name _____

Address _____
Street City State Zip Code

Office Phone Number _____ Fax Number _____

Federal Tax ID Number _____ E-mail Address _____

Specialty/Subspecialty in which care will be provided _____

Other Practice Name _____

Address _____
Street City State Zip Code

Office Phone Number _____ Fax Number _____

Federal Tax ID Number _____ E-mail Address _____

Specialty/Subspecialty in which care will be provided _____

Other Practice Name _____

Address _____
Street City State Zip Code

Office Phone Number _____ Fax Number _____

Federal Tax ID Number _____ E-mail Address _____

Specialty/Subspecialty in which care will be provided _____

Other Practice Name _____

Address _____
Street City State Zip Code

Office Phone Number _____ Fax Number _____

Federal Tax ID Number _____ E-mail Address _____

Specialty/Subspecialty in which care will be provided _____

Medical/Graduate/Professional Education

From ___/___/___ Institution Name _____
To ___/___/___ Degree Received _____ Completed Yes No
Address _____
Street City State Zip Code
Phone Number (if known) _____

ECFMG – Applicable to International Medical Graduates

ECFMG Number _____ Date Issued _____ Valid Through _____

Internship/Post-Graduate/Professional Training (If Applicable)

From ___/___/___ Institution Name _____
To ___/___/___ Internship Type/Specialty (Transitional, rotating, 5th pathway, etc) _____
Address _____
Street City State Zip Code
Phone Number (if known) _____
Completed Training Yes No If no, expected completion date _____
If not successfully completed, explain _____
Program Director _____
Address _____
Street City State Zip Code
Phone Number _____ Fax Number _____

Residency/Post-Graduate/Professional Training (If additional space is required, attach a separate sheet.)

From ___/___/___ Institution Name _____
To ___/___/___ Residency Type/Specialty _____
Address _____
Street City State Zip code
Phone Number (if known) _____
Completed Training Yes No If no, expected completion date _____
If not successfully completed, explain _____
Program Director _____
Address _____
Street City State Zip Code
Phone Number _____ Fax Number _____

Residency/Post-Graduate/Professional Training - Continued

From ___/___/___ Institution Name _____

To ___/___/___ Residency Type/Specialty _____

Address _____

Street City State Zip Code

Phone Number (if known) _____

Completed Training Yes No If no, expected completion date _____

If not successfully completed, explain _____

Address _____

Street City State Zip Code

Phone Number _____ Fax Number _____

Fellowship/Post-Graduate/Professional Training (If additional space is required, attach a separate sheet).

From ___/___/___ Institution Name _____

To ___/___/___ Fellowship Type/Specialty _____

Address _____

Street City State Zip Code

Phone Number (if known) _____

Completed Training Yes No If no, expected completion date _____

If not successfully completed, explain _____

Address _____

Street City State Zip Code

Phone Number _____ Fax Number _____

Primary Hospital Affiliation (Pertinent to Practice Location(s) (If additional space is required, use a separate sheet).

From ___/___/___ Facility Name _____

To ___/___/___ Department/Specialty/Privilege Affiliation _____

Application Pending Address _____

Admit Plan Street City State Zip Code

Phone Number _____ Fax Number _____

From ___/___/___ Institution Name _____

To ___/___/___ Department/Specialty/Privilege Affiliation _____

Application Pending Address _____

Admit Plan Street City State Zip Code

Phone Number _____ Fax Number _____

From ___/___/___ Institution Name _____

To ___/___/___ Department/Specialty/Privilege Affiliation _____

Application Pending Address _____

Admit Plan Street City State Zip Code

Phone Number _____ Fax Number _____

Chronological Employment/Practice History

Chronological listing [month/year] of employment/practice history for the previous 5 years. List all experience, including armed service and public health, time out of medical practice in pursuit of other business or professional activities, sabbaticals, parenting, personal travel, personal crisis, etc. LEAVE NO GAPS IN CHRONOLOGY. If additional space is required, attach a separate sheet.

From ___/___/___ Organization Name/Activity _____

To ___/___/___ Reason for Leaving _____

Address _____

Street City State Zip Code

Phone Number _____ Fax Number _____

From ___/___/___ Organization Name/Activity _____

To ___/___/___ Reason for Leaving _____

Address _____

Street City State Zip Code

Phone Number _____ Fax Number _____

From ___/___/___ Organization Name/Activity _____

To ___/___/___ Reason for Leaving _____

Address _____

Street City State Zip Code

Phone Number _____ Fax Number _____

From ___/___/___ Organization Name/Activity _____

To ___/___/___ Reason for Leaving _____

Address _____

Street City State Zip Code

Phone Number _____ Fax Number _____

From ___/___/___ Organization Name/Activity _____

To ___/___/___ Reason for Leaving _____

Address _____

Street City State Zip Code

Phone Number _____ Fax Number _____

Explain gaps/interruptions of greater than three (3) months to practice of medicine/professional practice (if additional space is required, use separate sheet.)

From ___/___/___ Organization Name/Activity _____

To ___/___/___ Reason for Leaving _____

Address _____

Street City State Zip Code

Phone Number _____ Fax Number _____

From ___/___/___ Organization Name/Activity _____

To ___/___/___ Reason for Leaving _____

Address _____

Street City State Zip Code

Phone Number _____ Fax Number _____

Specialty/Subspecialty Certification

Certifying Board	Specialty/Subspecialty	Date Certified	Date Re-Certified	Expiration Date
_____	_____	___/___/___	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___	___/___/___

If not certified, please state your intent for certification and describe the status of your efforts and eligibility, including scheduled date of exam, past failures of exams, if any. _____

Licensure – List all past, current and pending professional licenses

State	License Number	Date Certified	Date Re-Certified	License Status
_____	_____	___/___/___	___/___/___	Active Inactive
_____	_____	___/___/___	___/___/___	Active Inactive
_____	_____	___/___/___	___/___/___	Active Inactive
_____	_____	___/___/___	___/___/___	Active Inactive

Drug Enforcement Administration Registration

DEA Number _____ State _____ Expiration Number _____

Approved for all schedules? Yes No, Please Explain _____

DEA Number _____ State _____ Expiration Number _____

Approved for all schedules? Yes No, Please Explain _____

If you do not maintain a DEA certificate, please explain _____

Not applicable to Practice DEA Pending Date application sent to DEA ___/___/___ Other _____

State Controlled Substance Certification Registration

CDS Number _____ State _____ Expiration Number _____

Liability Insurance – Insurance Carrier for Primary and or pending location (s)

Enclose a copy of professional liability insurance coverage (face sheet Verification of self-insurance) to include effective dates, insurance carrier, expiration dates, coverage limits, and name of each provider covered.

Coverage Dates _____ Insurance Carrier Name _____

From ___/___/___ Address _____

To ___/___/___ Policy Number _____ Street _____ City _____ State _____ Zip Code _____

Expiration Date ___/___/___

Amount of Coverage _____

Disclosure Questions for Initial Credentialing

Please provide complete explanations if any of the following questions are answered in the affirmative. Please use a separate sheet, include question number when answering.

1. **Yes No** **Has your professional license or registration ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished, investigated or is currently being investigated by any licensing board or any health-related agency or organization, and, if so, what were the results?**

2. **Yes No** **Has your DEA or CDS registration ever been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your DEA/CDS registration, or is there a review pending?**

3. **Yes No** **Has your membership, participation with peer review organizations, third party payers, clinical privileges, medical staff, board certification, or employment ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed, or is there a review pending?**

4. **Yes No** **Have you ever voluntarily relinquished your membership, participation, clinical privileges or request for privileges, participation with peer review organizations, third party payers, employment, professional license, board certification or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency?**

5. **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 such action presently underway?**

6. **Yes No** **Are there any charges pending or are you currently charged with or have you ever been indicted or found guilty of a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation), or other offense?**

7. **Yes No** **Have you ever been found liable, guilty or responsible for sexual impropriety or misconduct or sexual harassment with a patient, co-worker, or other?**

8. **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? If yes, please complete the enclosed malpractice Litigation and Professional Complaints Addendum.**

9. **Yes No** **Has your professional liability carrier ever refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?**

10. **Yes No** **Have you ever practiced within your profession without professional liability insurance?**

11. **Yes No** **Do you have a physical or mental condition that would affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions of a practitioner in you area of practice without posing a health or safety risk to you patients?**

12. **Yes No** **Does your use or past use (or have you been told that your use or past use of alcohol or drugs), affect, or has affected, your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions in your area of practice with out posing a health risk to your patients?**

13. Yes No

Are you currently using illegal drugs? (“Currently” means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one’s ability to practice medicine. “Illegal use of drugs” refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec 812.22. It “does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or their provision of Federal Law” The term does include, however, the unlawful use of prescription controlled substances.)

Notice of Applicant’s Rights

You may review your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy, state or federal laws, or Managed Care Consultants policy. If there are discrepancies in the information received during the process, you will be notified and allowed an opportunity to add information to your application.

Attestation Signature and Date

I hereby certify that all the information on this application from 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. Any misrepresentation, false or misleading information may result in denial of application for participation and/or termination of my participation with Managed Care Consultants.

Printed Name _____

Signature _____ Date _____

Update Attestation Signature and Date

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

Printed Name _____

Signature _____ Date _____



CREDENTIALING CONSENT AND RELEASE

I _____ hereby release Managed Care Consultants, Inc (MCC) from liability the Entity and its Agents, state licensing board(s), health care organizations, including, with out limitation, hospitals, clinics, and third party payers, medical malpractice insurance carriers(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 addition to any other applicable immunities provided by law for peer review activities.

All information provided by me in the Application is true, accurate and complete. I understand and agree that any material misstatements 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 _____

Printed Name: _____

Malpractice Litigation and Professional Complaints

Confidential Information

If you answered "Yes" to disclosure question #8 on Current Disclosure question page, please complete the following form. For each lawsuit or complaint, please furnish the following and attach a copy of the complaint including your response and level of participation.

Name(s) of plaintiff(s) or complainants(s)

Month /year of incident _____

Describe the nature of the incident (complaint or allegation)

Provide a narrative description of your participation/level of care

Outcome of incident _____

Pending Dropped / Settled / Closed with no payment **Date Closed** ___/___/___ **Verdict for you** Yes No

Dropped/Settled/Closed with Payment, amount of Payment _____ **Payment Date** ___/___/___

Dismissed with prejudice **Dismissed without prejudice** **Date Closed** ___/___/___

Represented by legal counsel for this claim/malpractice lawsuit? Yes No If yes, give the name and address of Counsel.

Name: _____

Address _____

Phone Number _____ Fax Number _____

Printed Name _____

Signature _____ **Date** _____