

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



Re: Re-Credentialing Application

Dear Provider,

Thank you for responding to your Re-Credentialing notification letter. We thank you for your participation with Managed Care Consultants, Inc., AlterNet PPO network. Please find the enclosed Provider Re-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:

- 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

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

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

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

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

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

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

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

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

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

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

Managed Care Consultants, Inc., Credentialing Department prior to the starting of the credentialing process, must receive all elements listed above.

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.

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

Sincerely,

MCC Provider Relations

Personal Data

Name _____
 Last First Middle Suffix Title

Maiden/Former/Other Name _____

Date of Birth ____/____/____ Birthplace (City/State/Country) _____

Social Security Number _____ UPIN or NPI _____

Medicaid Number _____ State _____ Medicare Number _____ State _____

Current Home Address _____
 Street City State Zip Code

Local Home Address _____
 (if different than above) Street City State Zip Code

Pager Number _____ Cell Number _____ Home Number _____

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 Name _____

Address _____
 Street City State Zip Code

Office Phone Number _____ Fax Number _____

Federal Tax ID Number _____ E-mail Address _____

Credentialing Contact _____ Phone Number _____

Expected Start Date _____ Do you intend to practice as: Primary Care Specialist Urgent Care

Primary Specialty _____ Subspecialty _____

Specialty/Subspecialty in which care will be provided _____

Provide a narrative description of your clinical practice including special interests (if additional space is required, attach a separate sheet) _____

Billing Information

Billing Name _____

Address _____
 Street City State Zip Code

Office Phone Number _____ Fax Number _____

Billing Contact _____ Phone Number _____

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 _____

Street City State Zip Code

Admit Plan Phone Number _____ Fax Number _____

From ___/___/___ Institution Name _____

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

Application Pending Address _____

Street City State Zip Code

Admit Plan Phone Number _____ Fax Number _____

From ___/___/___ Institution Name _____

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

Application Pending Address _____

Street City State Zip Code

Admit Plan 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 Re-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** **Since your last credentialing date 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** **Since your last credentialing date 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** **Since your last credentialing date 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** **Since your last credentialing date 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** **Since your last credentialing date 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** **Since your last credentialing date are there any charges pending or are you currently charged with or have you ever been indicated or found guilty of a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation), or other offense?**

7. **Yes No** **Since your last credentialing date 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** **Since your last credentialing date 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** **Since your last credentialing date 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** **Since your last credentialing date have you ever practiced within your profession without professional liability insurance?**

11. **Yes No** **Since your last credentialing date 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 your area of practice without posing a health or safety risk to your patients?**

12. Yes No Since your last credentialing date 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 Since your last credentialing date 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 car 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 eh process, you will be notified and allowed an opportunity to add information to you 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 an updated all the information on this application, including eh Disclosure Questions, and I certify it is complete True and accurate.

Printed Name _____

Signature _____ Date _____

