Practitioner Credentialing

Thank you for your interest in becoming a participating provider with PacificSource Health Plans. Prior to execution of a new contract or addition to an existing group contract, you will need to complete the credentialing process with PacificSource. Please complete the credentialing application and return to the PacificSource Health Plans Credentialing Department. The following information lists criteria to be verified by our Credentialing team and your rights as an applicant.

PacificSource Health Plans makes every effort to contract with highly qualified practitioners by using clear and standardized credentialing requirements. Before a practitioner can be participating with PacificSource, the practitioner is required to successfully complete the credentialing process, which includes submitting an application supported by qualifying criteria. Credentialing applications are processed within 90 days of receipt of a complete application. Incomplete applications will be returned (to address any missing information), which will delay the credentialing process.

Qualifying Criteria Checklist

- ☐ Submit a completed application in full, with all necessary attachments and supporting documentation.
- ☐ Include the attestation page; make sure the information is completed, signed, and dated.* Explanations for any "yes" answers must be provided.
- ☐ Include the authorization and release form with the application; make sure the form is signed and dated.*
- ☐ Provide a current, valid, and unrestricted license to practice for each state in which you will be providing services to PacificSource members.
- ☐ Provide a copy of all valid DEA certificates or prescribing plan for each state in which you will be providing services to PacificSource members.
- ☐ Include proof of admitting privileges at a participating hospital, or a written admit plan.
- ☐ Include the most recent five years of relevant work history with an explanation for any gaps of 60 days or more.
- ☐ Provide proof of board certification, or completed, verifiable education/training as applicable to your degree. Board certification is required for all MDs, DOs, and DPMs.
- ☐ Provide evidence of current professional liability insurance coverage with amounts of at least $1,000,000 per occurrence and $3,000,000 aggregate. Please include a copy of the face sheet when returning the application.

* Signatures: Faxed, digital, electronic, scanned, or photocopied signatures are acceptable. Signature stamps are not acceptable unless the practitioner is physically impaired and the disability is documented in the practitioner's file. Signatures cannot be older than 180 days at the time of credentialing approval.

Other qualifying considerations

The National Practitioner Data Bank (NPDB) will be queried and the received information will be stored with the credentialing file.

A review of Medicare's opt-out list to ensure those listed are not applying for participation in Medicare Advantage plans.

You will be notified if anything is missing. Failing to submit the necessary information by the timeframe communicated by the PacificSource Credentialing Department will disqualify the application from consideration.

Applicant rights

1. The applicant/practitioner has the right to review information submitted to support their credentialing application, e.g., malpractice claims history, state licensing board actions, board certification, etc. The practitioner is not allowed to review references, recommendations, or other peer-review-protected information.
2. PacificSource will notify applicants of any information received that is possibly erroneous, or that substantially deviates from the information provided by the practitioner on the application, curriculum vitae, supplemental documents, or from other sources. Examples might include substantial variations in information on license actions, malpractice claims, or undisclosed board certification decisions. Written notification to the practitioner will occur upon discovery of conflicting information and will include a clear explanation of the conflicting information received. If information is not received within the requested timeframe of the notification, a second request will be sent by certified mail or secured email by the credentialing specialist/coordinator with a new-response timeframe indicated in the letter. Lack of response to the second request may result in closing the initial file, or termination of recredentialing/revalidation and contract participation. The practitioner must provide a complete and written explanation and documentation to support their response to the Credentialing team and/or Chief Medical Officer within the timeframe outlined in the request. Upon receipt of corrected information, Credentialing will date-stamp and initial the corrected documents. Practitioners will be promptly notified via email, telephone, fax, or mail, that their explanation and/or supporting documents have been received.
3. Credentialing will provide updates on status of credentialing/validation processing upon reasonable request, informing the applicant of projected timelines, information pending, or missing and substantial variations in information, but will not share peer-protected information. Credentialing will respond to these requests via email, telephone, fax, or mail.
4. Practitioners will receive notification of these rights at the time of initial credentialing/validation included in the application packet, upon request for a new contract or a request for an application for a practitioner wishing to be added to an existing group contract.
5. PacificSource will take steps to protect the confidentiality of information obtained and generated during the credentialing/validation process.
6. Initial applicants completing the credentialing/validation process are not subject to appeal rights.

Questions?

For more information about credentialing or validation, please contact the Credentialing team at **541-225-3747,** TTY: 711. We accept all relay calls. Or email Credentialing@PacificSource.com.

Provider information

Type of provider: ☐ PCP ☐ Urgent Care ☐ Specialist

Last name (include suffix: Jr., Sr., III) _____ First _____ Middle _____

Other name(s) under which you have been known by reference, licensing, and/or educational institutions:

_____ Degree(s) _____ Gender: ☐ Male ☐ Female ☐ X

Home phone number _____ Pager number _____ Cell number _____

Home mailing address _____ City _____ State _____ Zip _____

Birth date _____ Birth place (city, state, country) _____

Social Security number _____ Email address _____

Race/ethnicity (optional) _____ Languages spoken by provider _____

Individual NPI number _____ Individual Medicare number _____

Individual Medicaid number(s) _____

Specialty at the primary practice location _____ Subspecialties _____

Taxonomy (10-digit code identifying specialty or subspecialty) _____

Primary practice information

Effective date at primary practice location _____ Do you offer telehealth? ☐ Yes ☐ No

Name of practice/affiliation/clinic name _____

Office street address _____ City _____ State _____ Zip _____

Patient appointment phone number _____ Fax number _____

Name affiliated with tax ID number _____ Federal tax ID number _____

Billing address (if different from above)

Street address _____ City _____ State _____ Zip _____

Credentialing address (if different from above)

Street address _____ City _____ State _____ Zip _____

Office manager/admin name _____ Admin phone number _____

Admin email address _____ Admin fax number _____

Credentialing contact (if different from above) _____ Credentialing phone number _____

Credentialing email address _____ Credentialing fax number _____

Secondary practice information

Effective date at secondary practice location (MM/YY) _____ Do you offer telehealth? ☐ Yes ☐ No

Name of practice/affiliation/clinic name _____

Department name _____

Office street address _____ City _____ State _____ Zip _____

Patient appointment phone number _____ Fax number _____

Name affiliated with tax ID number _____ Federal tax ID number _____

Billing address (if different from above)

Street address _____ City _____ State _____ Zip _____

Credentialing address (if different from above)

Street address _____ City _____ State _____ Zip _____

Office manager/admin name _____ Admin phone number _____

Admin email address _____ Admin fax number _____

Credentialing contact (if different from above) _____ Credentialing phone number _____

Credentialing email address _____ Credentialing fax number _____

List other office locations with above information on a separate sheet.

Professional licensure

State professional license/registration/certificate number _____

Issue date (MM/YY) _____ Expiration date (MM/YY) _____ Status: ☐ Active ☐ Temporary

Name of supervisor if required (e.g., Physician's Assistant) _____

DEA registration number _____ Issue date (MM/YY) _____ Exp. date (MM/YY) _____

State controlled substance certificate number _____ Issue date (MM/YY) _____ Exp. date (MM/YY) _____

All other professional licenses

State _____ License/registration/certificate number _____ Date issued (MM/YY) _____

Expiration date (MM/YY) _____ Year relinquished _____ Reason _____

State _____ License/registration/certificate number _____ Date issued (MM/YY) _____

Expiration date (MM/YY) _____ Year relinquished _____ Reason _____

State _____ License/registration/certificate number _____ Date issued (MM/YY) _____

Expiration date (MM/YY) _____ Year relinquished _____ Reason _____

Medical/professional education

Medical/professional school _____ Phone _____ Fax _____

Start date (MM/YY) _____ Graduation date (MM/YY) _____ Degree received _____

Mailing address _____ City _____ State _____ Zip _____

Medical/professional school _____ Phone _____ Fax _____

Start date (MM/YY) _____ Graduation date (MM/YY) _____ Degree received _____

Mailing address _____ City _____ State _____ Zip _____

Graduate education

Institution _____ ☐ Does not apply

Program or course of study _____

Mailing address _____ City _____ State _____ Zip _____

Dates attended _____ Phone _____ Fax _____

Internship/PGYI

Institution _____ ☐ Does not apply

Mailing address _____ City _____ State _____ Zip _____

Start date (MM/YY) _____ Completion date (MM/YY) _____ Phone _____ Fax _____

Type of internship _____ Specialty _____

Did you successfully complete the program? ☐ Yes ☐ No If no, explain: _____

Residencies

Institution _____ ☐ Does not apply

Mailing address _____ City _____ State _____ Zip _____

Start date (MM/YY) _____ Completion date (MM/YY) _____ Phone _____ Fax _____

Type of residency _____ Specialty _____

Did you successfully complete the program? ☐ Yes ☐ No If no, explain: _____

Institution _____ ☐ Does not apply

Mailing address _____ City _____ State _____ Zip _____

Start date (MM/YY) _____ Completion date (MM/YY) _____ Phone _____ Fax _____

Type of residency _____ Specialty _____

Did you successfully complete the program? ☐ Yes ☐ No If no, explain: _____

Fellowships

Institution _____ ☐ Does not apply

Mailing address _____ City _____ State _____ Zip _____

Start date (MM/YY) _____ Completion date (MM/YY) _____ Phone _____ Fax _____

Course of study _____

Did you successfully complete the program? ☐ Yes ☐ No If no, explain: _____

Institution _____ ☐ Does not apply

Mailing address _____ City _____ State _____ Zip _____

Start date (MM/YY) _____ Completion date (MM/YY) _____ Phone _____ Fax _____

Course of study _____

Did you successfully complete the program? ☐ Yes ☐ No If no, explain: _____

Board certification

Are you board or otherwise professionally certified? ☐ Does not apply

☐ No If no, describe your intent for certification, if any, and dates of testing for certification:

_____

_____

☐ Yes If yes, please complete the information below.

Issuing board/entity	Certificate number	Specialty	Date certified	Date recertified	Expiration date (if any)

Have you applied for certification other than those indicated above? ☐ Yes ☐ No

If so, list certification and date _____

Inpatient coverage plan

This section only applicable for those without admitting privileges. ☐ Does not apply

Provider may attach signed letter of agreement from the physician or group representative that admits and manages the inpatient care for your patients.

Name of participating admitting physician/practice/clinic/group	Hospital where privileged

Hospital and other institutional affiliations

In the sections below, please list in reverse chronological order (with the current affiliations first) all institutions where you: ☐ Does not apply

- have current affiliations
- applications in process
- have had previous affiliations

This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheets. List only affiliations here; list employment in Work History section.

Current affiliations

Name of primary facility _____ Do you have admitting privileges? ☐ Yes ☐ No

Department _____ Department/clinical chair _____

Status (active, provisional, courtesy, temporary) _____

Mailing address _____ City _____ State _____ Zip _____

Phone number _____ Fax number _____ Appointment date (MM/YY) _____

Name of secondary facility _____ Do you have admitting privileges? ☐ Yes ☐ No

Department _____ Department/clinical chair _____

Status (active, provisional, courtesy, temporary) _____

Mailing address _____ City _____ State _____ Zip _____

Phone number _____ Fax number _____ Appointment date (MM/YY) _____

Name of other facility _____ Do you have admitting privileges? ☐ Yes ☐ No

Department _____ Department/clinical chair _____

Status (active, provisional, courtesy, temporary) _____

Mailing address _____ City _____ State _____ Zip _____

Phone number _____ Fax number _____ Appointment date (MM/YY) _____

Applications in process

Hospital/institution _____

Mailing address _____ City _____ State _____ Zip _____

Phone number _____ Fax number _____ Date application submitted (MM/YY) _____

Hospital/institution _____

Mailing address _____ City _____ State _____ Zip _____

Phone number _____ Fax number _____ Date application submitted (MM/YY) _____

Hospital/institution _____

Mailing address _____ City _____ State _____ Zip _____

Phone number _____ Fax number _____ Date application submitted (MM/YY) _____

Hospital/institution _____

Mailing address _____ City _____ State _____ Zip _____

Phone number _____ Fax number _____ Date application submitted (MM/YY) _____

Previous affiliations

Name of facility _____ ☐ Does not apply

Department _____ Department/clinical chair _____

Previous status (active, provisional, courtesy, temporary) _____

Mailing address _____ City _____ State _____ Zip _____

Phone number _____ Fax number _____ Appointment date (MM/YY) _____

Reason for leaving _____

Name of facility _____

Department _____ Department/clinical chair _____

Previous status (active, provisional, courtesy, temporary) _____

Mailing address _____ City _____ State _____ Zip _____

Phone number _____ Fax number _____ Appointment date (MM/YY) _____

Reason for leaving _____

Work history

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vita may be substituted as long as it is current and has exact dates of employment.

Name of current practice/employer _____

Contact name _____ Phone number _____ Fax number _____

Mailing address _____ City _____ State _____ Zip _____

Date started (MM/YY) _____ Date left (MM/YY) _____

Reason for leaving _____

Name of practice/employer _____

Contact name _____ Phone number _____ Fax number _____

Mailing address _____ City _____ State _____ Zip _____

Date started (MM/YY) _____ Date left (MM/YY) _____

Reason for leaving _____

Name of practice/employer _____

Contact name _____ Phone number _____ Fax number _____

Mailing address _____ City _____ State _____ Zip _____

Date started (MM/YY) _____ Date left (MM/YY) _____

Reason for leaving _____

Please account for all gaps in time between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity, and names where applicable.

Activity/name	From (MM/YY)	To (MM/YY)

Peer references

List **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who, through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. One reference must be from same discipline.

Name of reference _____ Title and specialty _____

Mailing address _____ City _____ State _____ Zip _____

Email address _____ Phone number _____ Cell number _____

Name of reference _____ Title and specialty _____

Mailing address _____ City _____ State _____ Zip _____

Email address _____ Phone number _____ Cell number _____

Name of reference _____ Title and specialty _____

Mailing address _____ City _____ State _____ Zip _____

Email address _____ Phone number _____ Cell number _____

Professional liability

Current insurance carrier _____ Policy number _____

Mailing address _____ City _____ State _____ Zip _____

Phone number _____ Fax number _____ Origination (retroactive) date (MM/YY) _____

Per claim amount _____ Aggregate amount _____ Effective date (MM/YY) _____ Exp. date (MM/YY) _____

Please list **all** professional liability carriers within the past five years.

Name of carrier _____ Policy number _____

Mailing address _____ City _____ State _____ Zip _____

Phone number _____ Fax number _____ From _____ To _____

Name of carrier _____ Policy number _____

Mailing address _____ City _____ State _____ Zip _____

Phone number _____ Fax number _____ From _____ To _____

Name of carrier _____ Policy number _____

Mailing address _____ City _____ State _____ Zip _____

Phone number _____ Fax number _____ From _____ To _____

Professional liability action detail (confidential)

Provider name _____ ☐ Does not apply

Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected health information (PHI). Photocopy this page as needed and submit a separate page for **each** claim/event. A legible signed provider narrative that addresses all of the following details is an acceptable alternative.

Date (MM/YY) _____ Clinical details of the incident, with preceding events: _____

Your role and specific responsibility in the incident: _____

Subsequent events, including patient's clinical outcome: _____

Date suit or claim was filed (MM/YY) _____ Current status of suit or other action _____

Name and address of insurance carrier that handled the claim: _____

Your status in the legal action (primary defendant, codefendant, other) _____

Date of settlement, judgment, or dismissal _____

If case was settled out of court, or with a judgment, settlement amount attributed to you: _____

Universal provider attestation questions (to be completed by the provider)

Please answer **all** of the following questions. If your answer to any of the following questions is "Yes," provide details as specified on a separate sheet. If you attach additional sheets, sign and date each sheet.

A		Professional sanctions	Yes	No
1		Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?	☐	☐
	a	License to practice any profession in any jurisdiction	☐	☐
	b	Other professional registration or certification in any jurisdiction	☐	☐
	c	Specialty or subspecialty board certification	☐	☐
	d	Membership on any hospital medical staff	☐	☐
	e	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	☐	☐
	f	Medicare, Medicaid, FDA, governmental, national or international regulatory agency or any public program	☐	☐
	g	Professional society membership or fellowship	☐	☐
	h	Participation/membership in an HMO, PPO, IPA, PHO, or other entity	☐	☐
	i	Academic appointment	☐	☐
	j	Authority to prescribe controlled substances (DEA or other authority)	☐	☐
2		Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association, or education/training institution?	☐	☐
3		Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?	☐	☐
4		Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?	☐	☐
B		**Criminal history** (Please include an explanation sheet for any "Yes" answers in this section)	**Yes**	**No**
1		Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?	☐	☐
	a	Do you have notice of any such anticipated charges?	☐	☐
	b	Are you currently under governmental investigation?	☐	☐
C		**Affirmation of abilities**	**Yes**	**No**
1		Do you presently use any drugs illegally?	☐	☐
2		Do you currently have any condition that adversely affects your ability to practice medicine in a safe, competent, ethical, and professional manner?	☐	☐
		It is common for clinicians to feel overwhelmed from time to time and feel the need to seek help when appropriate. We emphasize the importance of well-being, appropriate treatment, and support for all health conditions, both mental and physical. SouthworthAssociates.net/professional-programs-idaho MontanaRecoveryProgram.com		
D		**Litigation and malpractice coverage history**	**Yes**	**No**
If you answer "Yes" to any of the questions in this section, please document in the Professional Liability Action Detail section on page 10.				
1		Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?	☐	☐
2		Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?	☐	☐
3		Are there any such claims being asserted against you now?	☐	☐
4		Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?	☐	☐
5		Are any of the privileges that you are requesting not covered by your current malpractice coverage?	☐	☐
E		**Attestation**		
		I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.		

Signature _____ Name _____ Date _____

Provider authorization to release information

I hereby authorize the presenter of this Release and/or its representatives to consult with others who have information bearing on my professional competence, character, professional practice, or ethical qualifications. I authorize all malpractice carriers to release coverage and/or claims history information, which may exclude direct patient identification including name, address, or telephone numbers, to the presenter of this Release and/or its representatives. I hereby further consent to the inspection by the presenter, and/or its representatives, of all documents, including medical records, which may be relevant to evaluation of my professional competence, character, professional practice or ethical qualifications. The presenter complies with the Health Insurance Portability and Accountability Act of 1996 "HIPAA" (as defined in 45 CFR § 160 et seq.) as well as other state and federal statutes, rules, and regulations relating to confidentiality and privacy. I understand that I have the right to review any information submitted in support of this Provider Application.

I hereby release from liability any and all individuals and organizations that provide information to the presenter concerning my professional competence, practices, ethics, character, or ethical qualifications for participating provider status, and hereby consent to the release of such information. I further agree to release and hold harmless from any liability the presenter and/or its representatives who participate within the scope of their duties in review of any information obtained under this Release. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, professional practice, or ethical qualifications for resolving any doubts regarding such qualifications. A copy of any portion/section of the Authorization and Release, Criteria Sheet, and/or Application has the same force and effect as the original.

I also understand that to participate, this application must be verified and I must be notified in writing whether this application has been approved or denied. I agree to immediately notify the entity to which this authorization has been given, in accordance with executed Agreements, of any change in submitted information. Failure to notify the entity of changes in the information contained in this application may result in immediate termination from participation with the entity to which this Release is given.

Attestation

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Signature _____ Name _____ Date _____

(Stamped signature is not acceptable)

How to submit form

If credentialing a new provider, email to: Credentialing@PacificSource.com.

Questions?

Please email Credentialing@PacificSource.com or call **541-225-3747.** TTY: 711. We accept all relay calls.

Provider Information Request

PacificSource

The information provided on this form is required for claims processing and directory listings.
Please use separate forms for additional practice locations or practitioners/organizations.

☐ Credential new provider
Effective date at your organization _____
CAQH # _____

☐ Change information
☐ Add provider to new/additional location
☐ Add provider at facility-based location only*
☐ Termination Date _____
Termination Reason _____

1. Provider information (name as shown on CMS 1500 field 31 or UB box 1)

☐ Facility ☐ Primary care practitioner ☐ Specialist care practitioner

Name _____ SSN _____ Birth date _____

NPI _____ Specialty _____

Medical license number _____ DEA number _____

☐ Male ○ Female ○ X Race/ethnicity (optional) _____

Languages spoken by provider _____

Offers telehealth ☐ Yes ○ No (If it differs from practice location, list telehealth location in section 4.)

Note: Telehealth regulations require practitioners to be licensed by the state listed in section 2.

2. Practice location information (for patient visits and directory listing)

Practice name (as it should appear in directories) _____

Address _____

City _____ State _____ Zip _____ County _____

Practitioner specialty (as practicing at this location) _____

List this location in directories? Note: facility-based locations will not be listed. ☐ Yes ○ No

Location NPI _____ Tax ID number (attach matching IRS W9) _____

Practice contact name _____ Practice contact email _____

Practice contact phone _____ Practice contact fax _____

3. Billing information (as listed on CMS 1500 field 33 or UB box 2)

☐ Same as above

Billing name (as it appears on claims) _____

Address _____

City _____ State _____ Zip _____ County _____

Billing contact name _____ Billing contact email _____

Billing contact phone _____ Billing contact fax _____

Credentialing contact name _____ Credentialing contact email _____

Credentialing contact phone _____ Credentialing contact fax _____

***Facility-based providers** are those who practice exclusively in an inpatient setting; a credentialing application is not required.

Continued >

4. Summary of changes/notes

Form completed by _____

Email _____ Phone _____

How to submit form: If credentialing a new provider, email form to: Credentialing@PacificSource.com.
For all other reasons, please email form to: ProvNetSup@PacificSource.com.
Questions? Please contact your Provider Relations Representative. Visit PacSrc.co/PRV-Reps for contact info.