



PARTICIPATING PROVIDER APPLICATION INSTRUCTIONS

Please print legibly or type and answer all questions. If a question is not applicable to you or your practice, please indicate with "N/A".

*****DO NOT COPY APPLICATION BACK TO BACK*****

It is your responsibility to complete the application in full, including complete addresses, phone numbers etc. Failure to do so will delay the approval process.

Please attach a copy of the following documents with your application:

- All State Professional License(s), with Controlled Substance Past and Current
- Current Federal Drug Enforcement Agency Certificate (if applicable)
- Current Curriculum Vitae
- Copy of Board Certification (if applicable)
- Copy of diploma from Medical School (If foreign language, provide English Translation)
- Copy of ECFMG Certificate (If applicable)
- Current malpractice insurance coverage verification
- Professional Liability Information Sheet (must sign)
- Results of TB Test or clear chest x-ray documentation
- MMR and Hepatitis B documentation
- Pharmacy Signature Registration form (if applicable)
- Privilege Delineation form (if applicable)
- Current photo identification (i.e. driver's license, passport)
- Continuing Education (Please note if still in training)

Practitioner Rights

Practitioners are provided the opportunity to review information used in the credentialing process.

Evaluation may include information obtained from outside primary sources (e.g., malpractice insurance carriers or state licensing board.) This review does not include NPDB reports, references or recommendations or other information that is peer review protected. The MSO is not required to reveal the source of information if the information is not obtained to meet credentialing verification requirements or if disclosure is prohibited bylaw.

In the event that credentialing information obtained from other sources varies substantially from that supplied by the practitioner, the practitioner is notified by the MSO and offered the opportunity to correct erroneous information submitted by another party. Upon request practitioners are informed of the status of their credentialing or recredentialing application by telephone, email or letter.

If you have any questions regarding completion of this application, please call Lynette Bertocchini (801-587-6024) Please return the completed application and attachments as follows:

University Health Care
University of Utah Neuropsychiatric Institute
Attn: Medical Staff Office
650 Komas Drive, Suite 100
SLC, UT 84112

Revised 10/10/11

Clinic Location:

Clinic Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: () _____ Fax Number: () _____

Provider Pager No: _____

Office Manager: _____ Office Mgr. Phone: () _____

Office Manager's Email Address: _____

III. Academic/Medical Education/Training

1. Academic Education:

College/University: _____ Telephone: _____

Address: _____

City _____ State & Zip Code: _____ Country: _____

Degree: _____ Dates From: ____/____/____ To: ____/____/____

Academic Education:

College/University: _____ Telephone: _____

Address: _____

City _____ State & Zip Code: _____ Country: _____

Degree: _____ Dates From: ____/____/____ To: ____/____/____

2. Medical Education

Medical School: _____ Telephone: _____

Address: _____

City _____ State & Zip Code: _____ Country: _____

Degree: _____ Dates From: ____/____/____ To: ____/____/____

If foreign medical graduate, please indicate: Certificate No.: _____ Date Issued: _____

Attach copies of: ECFMG certificate and International medical school diploma

3. Internship: Program/Specialty: _____

Institution: _____ Telephone: _____

Address: _____

City: _____ State & Zip Code: _____ Country: _____

Dates From: ____/____/____ To: ____/____/____ Program completed? Yes No

4. Residency: Program Specialty: _____

Institution: _____ Telephone: _____

Address: _____

City: _____ State & Zip Code: _____ Country: _____

Dates From: ____/____/____ To: ____/____/____ Program completed? Yes No

5. Residency: Program Specialty: _____

Institution: _____ Telephone: _____

Address: _____

City: _____ State & Zip Code: _____ Country: _____

Dates From: ___/___/___ To: ___/___/___ Program completed? Yes No

6. Fellowship: Program/Specialty: _____

Institution: _____ Telephone: _____

Address: _____

City: _____ State & Zip Code: _____ Country: _____

Dates From: ___/___/___ To: ___/___/___ Program completed? Yes No

7. Fellowship: Program/Specialty: _____

Institution: _____ Telephone: _____

Address: _____

City: _____ State & Zip Code: _____ Country: _____

Dates From: ___/___/___ To: ___/___/___ Program completed? Yes No

IV. Certification Specialty

| <i>Name of Specialty Board</i> | <i>Certification Date</i> | <i>Expiration Date</i> | <i>Re-Certification Date</i> |
|--------------------------------|---------------------------|------------------------|------------------------------|
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If not certified, do you intend to apply for certification examination? Yes No

If yes, when? _____

Have you been accepted to take the certification examination? Yes No

If yes, what dates are you scheduled to take the certification examination? _____

V. Licenses/Certifications

1. List all state professional licenses, past and current (please attach a copy)

| State | License No. | Date Issued | Expiration Date |
|-------|-------------|----------------|-----------------|
| _____ | _____ | ____/____/____ | ____/____/____ |
| _____ | _____ | ____/____/____ | ____/____/____ |
| _____ | _____ | ____/____/____ | ____/____/____ |
| _____ | _____ | ____/____/____ | ____/____/____ |

2. Federal DEA Certificate and Controlled Substance Certificate for all states: (Please attach a copy.)

Federal DEA
Certificate Number: _____ Expiration Date: ____/____/____

Controlled Substance Numbers (if applicable)
Certificate Number: _____ Expiration Date: ____/____/____
Certificate Number: _____ Expiration Date: ____/____/____
Certificate Number: _____ Expiration Date: ____/____/____
Certificate Number: _____ Expiration Date: ____/____/____

VI. Professional History

List in reverse chronological order current and previous professional experience. Since Graduatim. **PLEASE DO NOT WRITE, "SEE CV." PLEASE PROVIDE EXPLANATIONS OF ANY GAPS IN HISTORY ON A SEPARATE SHEET OF PAPER.**

Do not include educational training in this section. Please attach a Curriculum Vitae. List additional employment on a separate page.

Dates: From ____/____/____ To: ____/____/____ Supervisor: _____

Current Practice/Employment: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Reason for Leaving: _____

Dates: From ____/____/____ To: ____/____/____ Supervisor: _____

Previous Practice/Employment: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Reason for Leaving: _____

Dates: From ____/____/____ To: ____/____/____ Supervisor: _____

Previous Practice/Employment: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Reason for Leaving: _____

Dates: From ____/____/____ To: ____/____/____ Supervisor: _____

Previous Practice/Employment: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Reason for Leaving: _____

VII. Professional Liability Insurance Information: Minimum coverage amounts are 1M per occurrence and 3M aggregate. Please attach copy of professional liability face sheets. Please list insurers for last 10 years.

Current Insurance Carrier: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy Number: _____ Phone Number: () _____

Retro Active Date: ___/___/___ Expiration Date: ___/___/___

Coverage Amounts: Per Occurrence: _____ Aggregate: _____

Length of Time with current insurer: _____

Previous Insurance Carrier: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy Number: _____ Phone Number: () _____

Retro Active Date: ___/___/___ Expiration Date: ___/___/___

Coverage Amounts: Per Occurrence: _____ Aggregate: _____

Length of Time with current insurer: _____

Previous Insurance Carrier: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy Number: _____ Phone Number: () _____

Retro Active Date: ___/___/___ Expiration Date: ___/___/___

Coverage Amounts: Per Occurrence: _____ Aggregate: _____

Length of Time with current insurer: _____

VIII. Professional Peer References: List Peers who have first hand knowledge of your clinical practice during the last two years.

Name: _____ Telephone No.: () _____

Professional Relationship: _____ Length of Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Peer Reference Email Address: _____

Name: _____ Telephone No.: () _____

Professional Relationship: _____ Length of Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Peer Reference Email Address: _____

Name: _____ Telephone No.: () _____

Professional Relationship: _____ Length of Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Peer Reference Email Address: _____

IX. Questionnaire

If the answer is "Yes" to any of the following questions, please provide complete details on a separate sheet of paper.

| | | |
|----|---|--|
| 1. | Professional License: a. Have proceedings ever been instituted to have your license to practice medicine limited, suspended, revoked, denied, restricted or voluntarily withdrawn (examples probationary conditions or disciplinary proceedings)? b. Have you ever allowed a license to expire? c. Have proceedings ever been instituted to have your DEA License or other controlled substance authorization denied, revoked or suspended? d. Have you ever entered into a consent agreement or stipulation, or have you voluntarily surrendered your license pending a disciplinary action or investigation? | ◇ Yes ◇ No ◇ Yes ◇ No ◇ Yes ◇ No ◇ Yes ◇ No |
| 2. | Hospital Privileges: a. Have any of your clinical privileges ever been denied, revoked, suspended, reduced, limited, not renewed, or voluntarily relinquished? b. Have you every voluntarily or involuntarily terminated any medical staff membership here or at another facility? c. Have you ever been the subject of disciplinary proceedings at any hospital or health care facility? | ◇ Yes ◇ No ◇ Yes ◇ No ◇ Yes ◇ No |
| 3. | Have proceedings ever been instituted to have your specialty board certification denied, revoked or suspended? | ◇ Yes ◇ No |
| 4. | a. Have you ever been convicted or pleaded guilty or no contest for any felony? Is any such action pending? b. Have you ever been convicted or pleaded guilty or no contest for any misdemeanor related to the practice of health care, including fraud or abuse relating to a government health program, violations of law pertaining to controlled substances, insurance fraud, or abuse, physical abuse, neglect, sexual abuse, or exploitation of individuals in vulnerable populations? Is any such action pending? | ◇ Yes ◇ No ◇ Yes ◇ No |
| 5. | a. Have you ever been investigated by or suspended, sanctioned, or restricted from participating in any Private, federal or state health insurance program, HMO, PPO, provider network or regulatory agency (e.g., Medicare, Medicaid)? | ◇ Yes ◇ No |
| 6. | Professional Liability: a. Have you ever practiced medicine without malpractice insurance? b. Have you ever been denied malpractice insurance or has your policy been canceled or denied renewal? c. Has your malpractice carrier ever excluded any specific procedures from your insurance coverage? d. Have you ever received notification alleging malpractice on your part through a letter from an attorney, Notice of Intent, Notice of Claim, Summons and Complaint, or otherwise? e. Have prior malpractice claims been resolved through private settlement negotiations, mediation, arbitration, court action, or otherwise? f. Have any professional liability suits been filed against you which are presently pending? | ◇ Yes ◇ No ◇ Yes ◇ No ◇ Yes ◇ No ◇ Yes ◇ No ◇ Yes ◇ No ◇ Yes ◇ No |

Attestation

I hereby certify that the information in this application is true and complete and that it accurately discloses all matters requested. I understand that it is my ongoing duty to report any changes relating to information provided in this application. I understand that any omissions, misrepresentations, or false information in this application constitute cause for denial of my appointment or membership and may be cause for my summary dismissal from the staff and the summary removal of any privileges or membership granted to me.

Applicant Name: (Please Print) _____

Applicant Signature: _____
(original signature required)

Date: _____

Notice to Providers

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 in 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.

Applicant Name: _____
(Please Print)

Applicant Signature: _____

Date: _____

NPI #: _____

**RECOMMENDATION AND APPROVAL FOR MEDICAL STAFF APPOINTMENT AND
CLINICAL PRIVILEGES AT UNIVERSITY OF UTAH HOSPITALS & CLINICS / UNI**

Name of Applicant: _____

DEPARTMENT CHAIR/DIV. CHIEF RECOMMENDATION: *I have reviewed this application for appointment in regard to clinical privileges requested (attached), physical and mental fitness, and ethical and moral character, and the quality and content of Continuing Education completed.*

I recommend appointment to the Professional Staff at the University of Utah Hospitals & Clinics.

DATE

DIVISION CHIEF _____

DEPARTMENT CHAIR _____

CREDENTIALS COMMITTEE MEMBER _____

OFFICAL COMMITTEES

DATE

CREDENTIALS COMMITTEE _____

MEDICAL BOARD COMMITTEE _____

HOSPITAL BOARD _____

For participation with the University of Utah Neuropsychiatric Institute

RECOMMENDATION: *I have reviewed this application for appointment in regard to privileges requested (attached), physical and mental fitness, ethical and moral character, and the quality and content of Continuing Education completed.*

I recommend appointment to the Professional Staff at the University of Utah Neuropsychiatric Institute.

DATE

CREDENTIALS COMMITTEE _____

MEDICAL DIRECTOR _____

EXECUTIVE COMMITTEE _____

HOSPITAL BOARD _____

UNIVERSITY OF UTAH PRACTITIONER'S AUTHORIZATION AND RELEASE OF LIABILITY

By applying for appointment or reappointment to the Medical Staff of the University of Utah Hospitals and Clinics (UUHC), including the University, University of Utah Neuropsychiatric Institute (UNI) University of Utah Medical Group (UUMG) participation and/or University of Utah Health Plans (UUHP) participation, I:

Fully understand that any significant misstatements in or omissions from the Application constitute cause for denial of appointment, reappointment and/or participation or cause for summary dismissal from the UUHC, UNI Medical Staff and UUMG and/or UUHP participation. All information that is submitted by me in this application is true to my best knowledge and belief. I agree to keep this application current by informing the University of Utah Health Care Medical Staff Services Department of any material changes including but not limited to any change in my professional liability insurance coverage, filing of a lawsuit against me, any change in my status with a licensing body, and any change in my medical staff status at any other hospital.

- Signify my willingness to appear for interviews in regard to my Application.
• Authorize the UUHC, UNI, UUMG, UUHP and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character, and ethical qualifications; and I hereby consent to the release of such information.
• Consent to the inspection by the UUHC, UNI, UUMG, UUHP and its representatives of all records and documents (including medical records at other hospitals) that may be material to an evaluation of my professional qualifications and competence to carry out the requested clinical privileges, as well as moral and ethical qualifications for Medical Staff membership and/or UUMG participations.
• Extend absolute immunity to, and release from any liability all UUHC, UNI, UUMG, UUHP and it's representatives for their acts performed in good faith and without malice in connection with evaluation of my Application, my credentials, and qualifications.
• Release from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to the UUHC, UNI, UUMG, and UUHP in good faith and without malice concerning my competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff appointment, clinic privileges and/or UUMG and UUHP participation.
• Authorize and consent to the release of information by the UUHC, UNI, UUMG, UUHP or its Medical Staff, to other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care, with any information relevant to such matters that the UUHC and UUMG may have concerning me, I extend absolute immunity to, and release from any liability UUHC, UUMG, UUHP and its representatives from liability for so doing, provided that such furnishing of information is done in good faith and without malice..
• Where allowed by state or federal law, consent to the inspection and release of any documents produced in the course of any federal Drug Enforcement Agency, or state/local medical board investigation into my competence, professional ethics or character while practicing medicine. This includes but is not limited to voluntary stipulations, findings of fact, and any other judicial, quasi-judicial or administrative documents produced in the course of an investigation into my competence, professional ethics or character.
• Agree to immediately report to the UUHC, UNI, UUMG and/or UUHP any investigation into my competence, professional ethics or character while practicing medicine initiated by any state/local medical boards, professional certifying boards or federal agency and/or failure to retain board certification, licensure, clinical privileges or malpractice coverage.
• Agree to immediately report to the UUHC, UNI, UUMG, and/or UUHP any action on my part, whether voluntary or involuntary, to enter a substance abuse treatment program.
• Certify that I have received, read and agree to abide by the:
UNI Professional Staff Bylaws □ http://healthcare.utah.edu/UNI/PDFs/bylaws.pdf
UUHC Medical Staff Bylaws □ http://uuhsc.utah.edu/mso/pdfs/bylaws.pdf
UUMG Medical Staff Bylaws □ http://uumg.med.utah.edu/uumginfo.cfm
UUMG Credentialing Policy & Procedures □ http://uumg.med.utah.edu/uumginfo.cfm

as applicable to me, the provider. I will observe and adhere to the aforementioned documents that apply and agree to be bound by the terms thereof. I also agree that when an adverse ruling is made with respect to my Medical Staff appointment, clinical privileges, and/or UUHP panel membership I will exhaust the administrative remedies afforded by the applicable documents before resorting to legal action. BYLAWS AND CREDENTIALING POLICIES ARE AVAILABLE ON CREDENTIALS WEBSITE: http://uuhsc.utah.edu/mso/pdfs/bylaws.pdf

- Understand and agree that I, as an applicant for UUHC, UNI, UUMG and/or UUHP Panel membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.
• Am aware that the UUHC/UNI/UUMG/UUHP will query the national Practitioner Data Bank as a part of the application process.
• Fully understand all information, interviews, reports, statements, memoranda, or other data furnished in connection with my application, and any findings or conclusions resulting therefrom are privileged communications and that I am not entitled to their disclosure. The only exception to this may occur, at the discretion of the University, to the extent that these privileged materials are submitted to a hearing committee.
• I also understand that if I receive privileges at UUHC/UNI and am employed by the University of Utah, I am responsible for timely and accurate completion of medical records, and that upon my departure from UUHC/UNI for any reason, my final paycheck may be withheld at the sole discretion of UUHC/UNI for up to three months pending my accurate and timely completion of all medical records.

A photocopy of this Authorization and Release of Liability shall be as effective as the original when so presented. The above authorization to release information shall remain in full force for the duration of my affiliation.

Applicant Name (Please Print): _____

Applicant Signature: _____ Date: _____

PHARMACY SIGNATURE AND PATIENT CONTROL ANALGESIA (PCA)
REGISTRATION FORM

NAME: _____
(Please Print)

DEPARTMENT/DIVISION: _____

UTAH LICENSE NO: _____

CONTROLLED SUBSTANCE NO: _____

EXPIRATION DATE: _____

DEA CERTIFICATE NO: _____

EXPIRATION DATE: _____

I am certified to prescribe controlled substance level of prescriptions:

◇ Level I RESEARCH ONLY – (high abuse potential/non-acceptable medical use drugs, i.e., heroin)

◇ Level II-V PHYSICIAN WITH CONTROLLED SUBSTANCE LICENSES

◇ Level II-V ALLIED HEALTH PRACTITIONER (PA, APRN) WITH CONTROLLED
SUBSTANCE LICENSES

PCA Training completed? ◇ Yes ◇ No

Date Completed: _____

Applicant Signature: _____

Date: _____

THE UNIVERSITY OF UTAH HOSPITAL AND CLINICS / UNI
STATEMENT OF CONTINUING EDUCATION
(Must be submitted with application)

Applicant Name: _____
(Please print)

The University of Utah Hospitals and Clinics/UNI, in conjunction with state regulation for licensure, require continuing education credits every two years, specific to your occupation/profession. You have the following options:

- 1) You may list on this form the courses taken, sponsor, dates, number and category of hours. If necessary, make an additional copy of this sheet.
- 2) You may prefer to send a copy of your own listing as compiled in your office. That would be satisfactory.

PLEASE DO NOT SEND COPIES OF THE CERTIFICATES, ETC.

| ACTIVITY TITLE & SPONSOR | DATES | NUMBER OF HOURS | CATEGORY |
|--------------------------|-------|-----------------|----------|
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I hereby certify that I have completed the continuing education listed above. If necessary, I will be able to provide documentation to support the listed credits.

Applicant Signature: _____

Date: _____

UNIVERSITY OF UTAH HEALTH QUESTIONNAIRE

Do you have, or have you had in the past, any physical or mental conditions(s) that:

- a. Have affected or could affect your ability to perform the mental and physical functions related to the specific privileges you are requesting? ◇ Yes ◇ No
- b. Affect, affected or could affect the functions and obligations or medical staff membership as set forth in the Medical Staff Bylaws and/or applicant contract, with or without an accommodation? ◇ Yes ◇ No
- c. Are you taking any medication that may affect either your clinical judgment or motor skills? ◇ Yes ◇ No
- d. Are you under any limitation, in terms of activity or workload? ◇ Yes ◇ No
- e. Have you ever or are you now engaged in the unlawful use of drugs? ◇ Yes ◇ No

If yes, please identify and describe any rehabilitation program you were enrolled in that assures your abstinence prospectively and your adherence to prevailing standards of professional performance.

- f. Have you ever had or do you now have an alcohol consumption problem? ◇ Yes ◇ No

If yes, please identify and describe any rehabilitation program you were enrolled in that assures alcohol consumption will not interfere with your practice of medicine, patient care responsibilities, or adherence to prevailing standards of professional performance.

Immunization documentation is required as follows:

TB – Results of TB Test within the last 12 months, and 2nd Step within 60 days of Approval Date, or 2 Step TB testing documentation. (First step must be completed before approval of credentialing and second step **must** be completed within 60 days of approval date.)

****If TB Positive, attach copy of clear chest x-ray report.****

MMR – Documentation of two MMR Vaccinations or documentation of a positive MMR Titer showing immunity, or documentation from a health care provider of confirmed measles/mumps/rubella disease.

Hep B – Documentation of three Hep B Vaccinations or documentation of positive Hep B titer showing immunity.

Tetanus-Diphtheria – Pertussis – Documentation of tetanus-diphtheria-pertussis (Tdap) immunization within the past 10 years. If had tetanus and diphtheria (Td) vaccine will be required to receive Tdap immunization.

Influenza – Must annually provide documentation of a current influenza immunization or an approved current influenza exemption for an accepted, valid reason.

Chicken Pox (Varicella) – Must provide documentation of two chicken pox (varicella) immunizations or documentation of varicella Titer that proves immunity.

COPIES OF OFFICAL DOCUMENTATION MUST BE ATTACHED

Applicant Name: _____
(Please Print)

Applicant Signature: _____

Date: _____

**The University of Utah
Professional Liability Information and Claims History
CONFIDENTIAL**

| | |
|-----------------------|---|
| New Applicant: | If you have EVER experienced any malpractice claims, lawsuits, settlements, proceedings or notices of intent to commence action against you arising from your medical training or your medical practice, you must complete this form FOR EACH CASE. Make copies as necessary. |
| | If no claims check NO CLAIMS BOX, sign and date section 10. |

All information is strictly confidential. Your response must contain enough clinical detail to allow proper peer review and evaluation. Failure to provide sufficient details will prevent your application from being approved.

**THE CREDENTIALS COMMITTEE AND RISK MANAGEMENT DEPARTMENT
HAVE REQUESTED THAT THIS INFORMATION BE TYPED.**
You may attach a different document as long as it addresses all of the same information requested on this form.

| | | | |
|-------------------------|---|---|---|
| <u>NO CLAIMS</u> | | <input type="checkbox"/> – SIGN AND DATE SECTION 10 | |
| 1. | Date of occurrence: | | |
| 2. | Your insurance company: | | |
| 3. | What is/was your status?: | <input type="checkbox"/> Primary Defendant | <input type="checkbox"/> Co-Defendant <input type="checkbox"/> Other? (explain) |
| 4. | Patient name, age, gender: | | |
| 5. | Status of this case (select one): | <input type="checkbox"/> Not pursued, closed without payment <input type="checkbox"/> Notice of intent to commence malpractice action <input type="checkbox"/> Filed and pending lawsuit <input type="checkbox"/> Settled out of court | <input type="checkbox"/> Jury verdict for plaintiff <input type="checkbox"/> Jury verdict for you <input type="checkbox"/> Other (please explain) |
| 6. | Specific allegations: | | |
| 7. | Detailed circumstances of the case: (attach separate sheet if necessary) | | |
| 8. | If the case settled, what was the total settlement amount?, AND... | \$ | How much of that amount was paid by your insurance company on your behalf? \$ |
| 9. | If there was a jury verdict for the patient, what were the total damages awarded?, AND... | \$ | How much of that amount was paid by your insurance company on your behalf? \$ |
| 10. | Applicant's PRINTED NAME: | | |
| | Applicant's Signature & Date: | | |
| | | ORIGINAL SIGNATURE REQUIRED | DATE |

By signing above, I certify that the information herein is true and complete. I understand that this document becomes part of my application as submitted.

**UTAH MEDICAID
HEALTH CARE PROVIDER DISCLOSURE
(Required)**

Instructions:

To be completed by the health care provider.

Answer all questions as of the date of completion of the form.

Italicized terms are defined on accompanying page.

| | | | |
|---|--------------------------------|---------------------------------|--|
| Name | SSN | NPI | |
| Address | City/ST | Zip Code | |
| Section I | | | |
| a. Do you have an <i>ownership or control interest</i> in the <i>disclosing entity</i> , (Healthy U, an operating unit of the University of Utah)? | NO <input type="checkbox"/> | YES <input type="checkbox"/> | |
| b. Are you a <i>managing employee</i> or <i>agent</i> of the <i>disclosing entity</i> , (Healthy U, an operating unit of the University of Utah)? | NO <input type="checkbox"/> | YES <input type="checkbox"/> | |
| Section II | | | |
| If you answered 'yes' in Section I above, have you been convicted of a criminal offense related to any program under Medicare, Medicaid or the title XX services program since the inception of those programs? (If yes, fill out information below). | NO <input type="checkbox"/> | YES <input type="checkbox"/> | |
| Name at Time of Conviction (if different) | | | |
| | | | |
| Section III | | | |
| Do you have an <i>ownership or control interest</i> in any <i>subcontractor</i> in which the health plan (Healthy U, an operating unit of the University of Utah) has direct <i>ownership interest</i> or <i>indirect ownership interest</i> of 5 percent or more? | NO <input type="checkbox"/> | YES <input type="checkbox"/> | |
| Section IV | | | |
| If you answered 'yes' in Section I a. or in Section III above, are you related as spouse, parent, child or sibling to another person who also has an <i>ownership or control interest</i> in the health plan (Healthy U, an operating unit of the University of Utah) or in any <i>subcontractor</i> in which the health plan (Healthy U, an operating unit of the University of Utah) has direct <i>ownership interest</i> or <i>indirect ownership interest</i> of 5 percent or more? (If yes, give name of person and relationship). | NO <input type="checkbox"/> | YES <input type="checkbox"/> | |
| Name | Relationship | | |
| | | | |
| | | | |
| Section V | | | |
| If you answered 'yes' in Section I a, do you have an <i>ownership or control interest</i> in any <i>other disclosing entity</i> ? | NO <input type="checkbox"/> | YES <input type="checkbox"/> | |

Signature of Health Care Provider

Date of Completion

| | |
|--|--|
| | |
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By signing this form I attest that the information is accurate and true.

DEFINITIONS

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider (i.e., the health plan).

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency (or the health plan).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity (i.e., health plan) or in an entity that has an indirect ownership interest in the disclosing entity (i.e., health plan).

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency (i.e., health plan).

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

- (a) any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
- (b) Any Medicare intermediary or carrier; and
- (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Ownership Interest means the possession of equity in the capital, the stock or the profits of the disclosing entity (i.e., health plan).

Person with ownership or control interest means a person or corporation that:

- Has an ownership interest totaling 5 percent or more in a disclosing entity (i.e., health plan);
- Has an indirect ownership interest equal to 5 percent or more in a disclosing entity (i.e., health plan);
- Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity (i.e., health plan);
- Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity (i.e., health plan) if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity (i.e., health plan);
- Is an officer or director of a disclosing entity that is organized as a corporation (i.e., health plan); or
- Is a partner in a disclosing entity that is organized as a partnership (i.e., health plan).

Subcontractor means-

(a) An individual, agency, or organization to which a disclosing entity (i.e., the health plan) has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement (i.e., the agreement with the health plan).

U.S. BORN PHOTO ID VERIFICATION

UNIVERSITY OF UTAH HOSPITALS AND CLINICS
PRACTITIONER IDENTIFICATION VERIFICATION FORM

Practitioner Name: _____

Title: _____

Name of Person verifying Practitioner's Identity: _____

Title: _____

Department:

- Type of Identification: Driver's License
 Passport
 Military Identification

Signature of Practitioner: _____

Date: _____

Signature of Person obtaining the verification: _____

Date: _____

Attach copy of verification here

FOREIGN BORN PHOTO ID/LEGAL STATUS VERIFICATION

UNIVERSITY OF UTAH HOSPITALS AND CLINICS PRACTITIONER IDENTIFICATION/LEGAL STATUS VERIFICATION FORM

(Must be completed on all foreign born applicants)

Practitioner Name: _____
(Please print)

Practitioner Signature: _____

Name of person verifying practitioner's identity and eligibility to work in the United States:

(Please print)

Title: _____

Department: _____

Signature of verifying individual: _____ *Date* _____

***Original documents must be viewed by verifying individual.
A copy of the documents viewed must accompany this completed
form.***

| List A (any 1 from this list) | List B (1 from this list AND 1 from List C) | List C (1 from this list AND 1 from List B) |
|--|---|---|
| U.S. passport or passport card | Driver's license or ID card issued by a state or outlying possession of the United States, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | U.S. social security account number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States (A copy such as a metal or plastic reproduction is not acceptable.) |
| Permanent resident card or alien registration receipt card (Form I-551) | ID card issued by federal, state, or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | Certification of birth abroad issued by the U.S. Department of State (Form FS-545) |
| Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa (MRIV) | School ID card with a photograph | Certification of report of birth issued by the U.S. Department of State (Form DS-1350) |
| Employment authorization document (card) that contains a photograph (Form I-766) | Voter's registration card | Original or certified copy of a birth certificate issued by a state, county, municipal authority, or outlying possession of the United States bearing an official seal |

| | | |
|---|--|--|
| In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. | U.S. military card or draft record | Native American tribal document |
| Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association between the United States and the FSM or RMI. | Military dependent's ID card | U.S. citizen identification card (Form I-917) |
| | U.S. Coast Guard Merchant Mariner Card | Identification card for use of resident citizen in the United States (Form I-179) |
| | Native American tribal document | Employment authorization document issued by DHS (other than those listed under List A) |
| | Driver's license issued by a Canadian government authority | |

List A: Documents that establish both identify and employment authorization – need only one unexpired document from this list to meet requirement.

IF USING LIST B & C, MUST HAVE ONE DOCUMENT FROM LIST B AND ONE DOCUMENT FROM LIST C TO MEET THE REQUIREMENT.

List B: Documents that establish identity – need one unexpired document from this list

List C: Documents that establish employment authorization – documents must be unexpired.