Premier Health Networks of Alabama

Comp1One & NAMCI

APN NAMCI ALABAMA PREMIER NETWORK

Preferred Provider Network

Provider Renewal Information

PLEASE REVIEW AND MAKE NECESSARY CORRECTIONS ON THIS FORM
THIS INFORMATION IS UTILIZED FOR DIRECTORY LISTINGS AND PUBLICATION MAILINGS

PROVIDER NAME	GENDER M F	DEGREE	SSN	NPI #	DATE OF BIRTH

PRIMARY SPECIALTY	BOARD CERTIFIED? ☐ YES ☐ NO	STATE LICENSE NUMBER	EXPIRATION

SECONDARY SPECIALTY	BOARD CERTIFIED? ☐ YES ☐ NO	FEDERAL DEA NUMBER	EXPIRATION

IF YOU ARE NOT BOARD CERTIFIED, ARE YOU ELIGIBLE TO TAKE A BOARD EXAMINATION? ☐ YES ☐ NO	BOARDS FOR WHICH YOU ARE ELIGIBLE EXPIRES	RACE	ETHNICITY

DOES THE PROVIDER SPEAK MORE THAN ONE LANGUAGE? IF YES, LIST LANGUAGES	ACCEPTING NEW PATIENTS? WHAT AGES?

HOSPITALS AT WHICH YOU CURRENTLY HAVE PRIVLEGES:	PROFESSIONAL LIABILITY INSURANCE CARRIER POLICY NUMBER POLICY RENEWAL DATE

MEDICAL GROUP AFFILIATION	GROUP NPI NUMBER	TAX ID NUMBER

BILLING ADDRESS:	PRIMARY OFFICE LOCATION:
Phone: Fax: **Email Address:**	Office Manager: Phone: **Fax:** Email: **Credentialing:** **Email:**

I CERTIFY THAT THE ABOVE INFORMATION AND CERTIFICATES ATTACHED ARE TRUE AND COMPLETE. I UNDERSTAND THAT ANY MISSTATEMENT IN THIS RENEWAL APPLICATION MAY CONSTITUTE GROUNDS FOR DENIAL OF THIS APPLICATION OR FOR SUMMARY DISMISSAL AS A PARTICIPATING PROVIDER.

PROVIDER SIGNATURE	DATE

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LIST ANY ADDITIONAL OFFICE LOCATION BELOW:

FACILITY NAME:		BILLING INFORMATION:	
ADDRESS:		ADDRESS :	
CITY:		CITY:	
STATE:	ZIP:	STATE:	ZIP:
PHONE:	FAX:	PHONE:	FAX;

LIST ANY ADDITIONAL OFFICE LOCATION BELOW:

FACILITY NAME:		BILLING INFORMATION:	
ADDRESS:		ADDRESS :	
CITY:		CITY:	
STATE:	ZIP:	STATE:	ZIP:
PHONE:	FAX:	PHONE:	FAX;

LIST ANY ADDITIONAL OFFICE LOCATION BELOW:

FACILITY NAME:		BILLING INFORMATION:	
ADDRESS:		ADDRESS:	
CITY:		CITY:	
STATE:	ZIP:	STATE:	ZIP:
PHONE:	FAX:	PHONE:	FAX;

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Confidential Provider Renewal Information	YES	NO
1. A. Have you now or have you in the last 5 years been involved in any malpractice suit including arbitration?		
B. Has any malpractice claim settlement, not involving litigation or arbitration, been paid by you or on your behalf in the last 5 years		
Date and details of the incident(s) leading to the suit or settlement Date of suit or settlement Professional Liability insurer involved Your role in the incident(s) Your status in any suit or other legal action (primary defendant, co-defendant, other) Amount reserved by carrier for each claim, or amount paid as an out of court settlement, or amount of jury award or court award Please obtain this information from your carrier if necessary		
2. Has your professional liability insurance been denied, suspended, cancelled, or not renewed?		
3. A. Do you now have, or within the last 5 years, have you had any physical condition, mental condition or chemical dependency condition (alcohol or other substance dependency) that does or has interfered with your ability to practice medicine?		
B. Have you ever received treatment or been advised to receive treatment for alcohol or other substance dependency?		
C. Are you currently using illegal drugs?		
4. Have you had any of the following items denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed, or have you voluntarily relinquished any item in anticipation of any of these actions pending with respect to any of the following items?		
State License?		
DEA Registration or other narcotic license?		
Hospital or other Health Care Facility staff membership or privilege?		
Professional Organization Membership?		
Medicare, Medicaid, or other government program participation?		
HMO, PPO, or other Prepaid health plan participation?		
If the answer to any of the above items is yes, please explain in an attachment.		
5. If you have ever been employed as a physician by a military service, a hospital, an HMO or any other health care organization, was your employment ever terminated by the employer? N/A Not Applicable		
6. Have you ever been convicted of a crime (other than a traffic offense), or are you currently under indictment for an alleged crime? **If yes, please explain in an attachment.**		

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS ABOVE PLEASE EXPLAIN IN AN ATTACHMENT

Please be sure to enclose with this application any explanatory statements related to questions 1 - 6

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I authorize Premier Health Networks of Alabama dba NAMCI and Comp1One to consult with members of hospital medical staffs, professional liability carriers and other persons or entities to obtain information concerning my professional qualifications, including competence, ethics, and other qualifications. I release Premier Health Networks of Alabama, its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my application. I consent to the release, by any person, to Premier Health Networks of Alabama of all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions, other confidential or privileged information including health, psychiatric and chemical dependency information. I release, from any and all liability, anyone providing this information in good faith and without malice. I understand that any misstatement in this application may constitute grounds for denial of this application or for summary dismissal as a participating Premier Health Networks of Alabama provider. If any material changes occur affecting my professional status, it is my obligation to notify Premier Health Networks of Alabama as soon as possible. I consent to the release of this information, as well as other quality assurance data relating to me, to health plans owned or managed by Premier Health Networks of Alabama or to medical groups, IPA's, or other similar entities contracting with those plans. Premier Health Networks of Alabama does not discriminate or base credentialing decisions on an applicant's race, ethnicity or language and providing this information is optional. I certify the above information is true and complete.

Print _____ Signature _____ Date _____