PROVIDER CREDENTIALING FORM

PROVIDER INFORMATION

Last Name ______ First Name ______ Middle ______ Degree ______

Social Security Number ___________ Gender ______________________________

Date of Birth ___________City/State/Country of Birth ______________________________

Languages (other than English) Spoken by Provider: ______________________________

PRACTICE INFORMATION

Primary Office ______________________________ ______________________________
Individual/Group Name County

Address: ______________________________
Number Street Suite #

____
City State Zip Code

Telephone Number:______________________________Fax Number:____________________

Office Manager: ______________________________

Office Hours: ______________________________

Federal Tax ID Number:______________________________

Name Affiliated with Tax ID Number______________________________

Partner(s)/Associate(s)

____
Last Name First Name Middle Degree

Secondary Office______________________________ ______________________________
Individual/Group Name County

Address: ______________________________
Number Street Suite #

____
City State Zip Code

Telephone Number:______________________________Fax Number:____________________

Office Manager: ______________________________

Office Hours: ______________________________

Federal Tax ID Number:______________________________

Name Affiliated with Tax ID Number______________________________

Partner(s)/Associate(s)

____
Last Name First Name Middle Degree

EDUCATION

Undergraduate School: ______________________________

____
Address

____
City State Zip Code

______________________________ ______________________________
Graduation (Month/Year) Degree

Professional School: ______________________________
Complete Institution Name (Do not abbreviate)

____
Address

____
City State Zip Code

______________________________ ______________________________
Graduation (Month/Year) Degree

POSTGRADUATE TRAINING AND EXPERIENCE

Institution: ______________________________

____
Address

____
City State Zip Code

Type of Internship: ______________________________

Specialty: ______________________________

______________________________ ______________________________
From: (Month/Year) To: (Month/Year)

RESIDENCIES / FELLOWSHIPS (Attach additional sheets if necessary)

Institution: ______________________________

____
Address

____
City State Zip Code

Type of Training: ______________________________

Specialty: ______________________________

______________________________ ______________________________
From: (Month/Year) To: (Month/Year)

Did you successfully complete the program? Circle one. Y N

(If “N” please explain on separate sheet)

RESIDENCIES / FELLOWSHIPS cont. (Attach additional sheets if necessary)

Institution: ______________________________

____
Address

____
City State Zip Code

Type of Training: ______________________________

Specialty: ______________________________

______________________________ ______________________________
From: (Month/Year) To: (Month/Year)

Did you successfully complete the program? Circle one. Y N

(If "N" please explain on separate sheet)

Institution: ______________________________

____
Address

____
City State Zip Code

Type of Training: ______________________________

Specialty: ______________________________

______________________________ ______________________________
From: (Month/Year) To: (Month/Year)

Did you successfully complete the program? Circle one. Y N

(If "N" please explain on separate sheet)

BOARD CERTIFICATION

Include certifications by board(s) which are duly organized and recognized by:

- A member board of the American Board of Medical Specialties
- A member board of the American Osteopathic Association
- A board or association with equivalent requirements approved by the Medical Board of CA
- A board of association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty

Name of Issuing Board:	Specialty:	Date Certified/Recertified:	Expiration Date (if any):

Have you applied for board certification other than those indicated above? Y N

If so, list board(s) and date(s): ______________________________

If not certified, describe your intent for certification, if any, and date of eligibility for certification on separate sheet.

EMPLOYMENT HISTORY: (Last 10 years to date)

Institution/Employer: ______________________________

Address: ______________________________

Dates of Employment: __________ to __________Reason for Termination: __________
(Month/Year) (Month/Year)

Institution/Employer: ______________________________

Address: ______________________________

Dates of Employment: __________ to __________Reason for Termination: __________
(Month/Year) (Month/Year)

PROFESSIONAL MEMBERSHIPS/SOCIETIES: (Organization/Dates/Offices Held)

____

____

____

PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice.

Name of Reference: ______________________________

Specialty: ______________________________

Address: ______________________________

Name of Reference: ______________________________

Specialty: ______________________________

Address: ______________________________

Name of Reference: ______________________________

Specialty: ______________________________

Address: ______________________________

LICENSE INFORMATION: **(Please attach a copy of licenses with application)**

__________________ Expiration: _____ State: _____ DPA _____ TPA _____
State Medical License #

__________________ Expiration: _____
DEA Registration Number

__________________ __________________
Individual NPI Group NPI (if applicable)

____
CAQH Number

HOSPITAL INFORMATION: (To be completed by MDs, DOs, and PAs, as applicable)

Primary Hospital: ____
Name Address

____
City/State/Zip

Check one: Active [ ] Provisional [ ] Temporary [ ] Proctored [ ] Assists Only [ ]

Initial Appointment Date: ________________

PROFESSIONAL LIABILITY INSURANCE
(Please attach the cover page of current Malpractice Insurance Policy)

Insurance Carrier: ____
Name Address

____
City/State/Zip

Policy Number: __________ Date Issued: __________ Expiration Date: __________

Per Claim Amount: $__________ Aggregate Amount: $__________

HISTORICAL DATA/ATTESTATION QUESTIONS

		YES	NO
1.	Have you ever had your license suspended or revoked by any state licensure board?		
2.	Has a State Board or Optometric Society ever censured you?		
3.	Have you ever had an agreement with Medicare or Medicaid or any public program that was suspended or terminated?		
4.	Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?		
5.	Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct or breach of contact or in return for such an investigation not being conducted or is any such action pending?		
6.	Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship or other clinical education program?		
7.	Has your membership or fellowship in any local, county, state, regional, national or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions or not renewed or is any such action pending?		
8.	Have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?		
9.	Have you ever been convicted of a criminal offense, other than minor traffic violations, such as a misdemeanor or felony?		
10.	Are you currently under indictment for any crime?		
11.	Are you currently under treatment for any physical or mental disorders including alcohol or drug dependency?		
12.	Do you presently use any drugs illegally?		

13.	Are you or have you in the past seven years been involved in a malpractice suit(s)? If yes, please supply the following information: (All information will be treated as confidential) A. Date of occurrence B. Who is/was the involved carrier? C. Jurisdiction D. Details of event E. What is/was your role in the event? F. What is/was your status: Primary defendant, co-defendant, other? G. Subsequent actions H. Amount reserved by carrier for this claim		
14.	Has your malpractice coverage ever been denied, canceled or restricted?		
15.	Has any malpractice carrier ever made an out-of-court settlement or paid a judgment of professional liability claim on your behalf?		
		YES	**NO**
16.	Are you able to perform all the services required by your agreement with March Vision Care with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?		

I certify under penalty of perjury under the laws of the State of California, the foregoing to be true and accurate.

____
Print Name

____ ____________________________
Signed Date

VERIFICATION OF CREDENTIALS RELEASE FORM

I. I acknowledge and agree that March Vision Care, Inc. ("March Vision Care") has a valid interest in obtaining and verifying information concerning my professional competence, in determining whether to enter into an agreement with me for the provision of eyecare services to members of its vision program.

II. I represent and warrant to March Vision Care that the information contained in the foregoing credentialing packet is true and complete to the best of my knowledge and belief, and I agree to inform March Vision Care promptly if any change of the information provided in this credentialing packet occurs, whether before or after entering into an agreement with March Vision Care for provision of vision services;

III. I authorize March Vision Care to consult with hospital administrator, member of medical staffs of hospitals, and malpractice carriers and other persons to obtain information concerning professional competence, character and moral and ethical qualifications and I release March Vision Care and its employees and agents form any liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application and;

IV. I consent to the release by any person to March Vision Care of all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualification, including any information relating to any disciplinary action; suspension or curtailment of optometric services; information from any and all liability for doing so.

Printed Name: ______________________________

Signed: ____________________________________ Date: ______________________________