Credentialing Application

Please complete the Facility Section for each facility applying AND complete the Physician Section for each physician working in the facility(s).

Return application to:
Specialty Provider Imaging Network
1225 Franklin Avenue
Suite 325
Garden City, NY 11530

STOP! Please copy and complete this **Facility Section** for each separate facility location!

Include copies of the following documents:

- ☐ Certificate of Facility Insurance Face Sheet (General Liability Insurance)
- ☐ Operating License
- ☐ Copy of W-9 Form

Facility Address

Name _____

Street Address _____

City/State/Zip _____County_____

Phone_____ Fax_____

State Facility License Number _____Email Address_____

Email Address for Scheduling (preferred) _____

If email is not possible, scheduling phone number _____ and fax _____.

Facility Medicare #_____ Facility Medicaid # _____ _____

Office Manager _____Phone/Ext._____Email_____

Scheduling Manager_____ Phone/Ext._____Email_____

Claims Manager_____ Phone/Ext._____Email_____

Credentialing Manager_____ Phone/Ext._____Email_____

Mailing Address (if different from above)

Name_____

Address_____

City/State/Zip_____ County_____

Billing Name and Address (if different from above)

Check Payable Name (as it appears on W-9)_____

Address_____

City/State/Zip_____ County_____

Billing Phone_____ Fax_____

Billing Manager_____ Phone/Ext_____ Email_____

Do you have the capacity to bill electronically? Yes ___ No ___

Group or Corporate Name Agreement is under:_____

Federal Tax ID#_____ Facility NPI #_____

Name of Practice Management System Used_____

Do you have a PACS system? Yes___ No___
Are you ACR accredited? Yes___ No___
Are you capable of providing images on a disk? Yes___ No___
What languages are spoken by the office? _____
Meet ADA accessibility standards? Yes___ No___
Have other services for the disabled (TTY, American Sign Language)? _____

Services: Please circle all those that apply

MRI Open MRI CT Scan Ultrasound Mammography X-Ray

Digital Mammography Fluoroscopy Nuclear Medicine PET Scan

Bone Density Bone Scan MRA Capability EMG/NCV Other_____

Insurance Information

General Liability Carrier Name_____

Address_____ City/State/Zip_____

Policy Number_____ Coverage limits_____

Annual Premium_____ Coverage Dates From: _____ To: _____

Facility Hours	**From:**	**To:**
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____
Saturday	_____	_____
Sunday	_____	_____

Equipment: Please complete all that apply to your facility

Magnetic Resonance Imaging (MRI)

Make/Model_____ Year Manufactured_____ Tesla_____

Table Weight_____ Software Upgrades_____ Coils_____

Computed Tomography (CT)

Make/Model_____ Year Manufactured_____

Table Weight_____

Mammography

Make/Model_____ Year Manufactured_____

Ultrasound

Make/Model_____ Year Manufactured_____

Nuclear Medicine

Make/Model_____ Year Manufactured_____

Radiography and Fluoroscopy

Make/Model_____ Year Manufactured_____

Utilizes the following exposure reducing technologies (circle all that apply):
Collimation Grids Intensifying Screens

Disclosure Information

	Circle Answer
Has Medicare, Medicaid, or any other medical reimbursement plan ever voluntarily or involuntarily suspended limited, revoked, denied, not renewed or terminated your participation for reasons related to professional competence or conduct?	YES NO
Have you ever been or are you currently excluded from participation with Medicare or any other federally funded health care program?	YES NO
Has your professional liability coverage ever been restricted, limited, denied, not renewed, or special rated (for reasons other than the carrier's termination of operations in your state)?	YES NO
Have any complaints been filed against you from a licensing authority?	YES NO
Have you ever been refused participation in the network of a managed care organization or been disciplined by or terminated from such a plan or organization?	YES NO

Authorization/Attestation

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I understand that this application does not entitle me to participation in the network of any entity using this application.

I Release SPECIALTY PROVIDER IMAGING NETWORK, LLC, its representatives, or entities providing information to this entity from liability for any act or omission related to the evaluation or verification contained in this application provided the entity, its representatives and individuals providing information to the entity act in good faith and without malice. I further agree to notify the entity of any change to the information provided in this application within 30 days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by the entity.

I authorize SPECIALTY PROVIDER IMAGING NETWORK, its representatives, and any individual's information to the entity to investigate and evaluate my provider application, and consult with any person, organization, or entity that has, or could have any information, data, or documents regarding my background, competence, and credentials.

This application will not be processed if not signed and dated. STAMPED SIGNATURES ARE NOT ACCEPTED.

_____ _____

Owner or Authorized Representative Signature Date

_____

Print Name

STOP! Please copy and complete this **Physician Section** for all Physicians working in your facility!

Include copies of the following documents:

- Copy of current professional liability insurance policy face sheet showing expiration dates, limits and provider's name

Physician Information

Physician First Name_____ MI_____ Last Name_____

Other Names Used if applicable (i.e. maiden name) _____

Date Of Birth (Required For Data Bank Query)_____ Sex _____M _____F

Languages Spoken_____ Citizenship_____

Social Security Number_____

State License Number (list all past and current)

_____ State_____ Expiration Date_____

_____ State_____ Expiration Date_____

_____ State_____ Expiration Date_____

DEA Number_____ Expiration Date_____ Date Issued_____

State Narcotics Registration # (CDS) (if applicable)_____ Expiration Date_____

Medicare #_____

Medicaid #_____ NPI#_____

Workers' Compensation Provider Number (if applicable)_____

Primary Facility Name &Address_____

Start Date w/ Facility_____

Board Certification

Primary Specialty_____ Are you board certified? ____YES ____NO

Board_____ Date Certified_____ Expiration Date_____

Certificate #_____ If not certified, are you board eligible? ____YES ____NO

Secondary Specialty

Secondary Specialty_____ Are you board certified? ____YES ____NO

Board_____ Date Certified_____ Expiration Date_____

Certificate #_____ If not certified, are you board eligible? ____YES ____NO

Education

Medical School_____ State_____ From___/___/___ To___/___/___

Completed ___YES ___NO Degree/Rank_____ Specialty_____

Internship_____ State_____ From___/___/___ To___/___/___

Completed ___YES ___NO

Residency (ies) _____ State_____ From___/___/___ To___/___/___

Completed ___YES ___NO

Residency (ies) _____ State_____ From___/___/___ To___/___/___

Completed ___YES ___NO

Fellowship (s)_____ State_____ From___/___/___ To___/___/___

Completed ___YES ___NO

Five (5) Year Work History

Please fill out sections completely. Both <u>month and year required</u> for work start and end dates. Gaps in work history greater than 6 months must be explained below or on a separate piece of paper.

Institution/Facility Name	Address	Dates of Affiliation From:	To:
_____	_____	___/___	___/___
_____	_____	___/___	___/___
_____	_____	___/___	___/___
_____	_____	___/___	___/___
_____	_____	___/___	___/___

Gaps in work history greater than 6 months? If yes, please describe.

Professional Liability Insurance (Include copy of Insurance Face Sheet)

Provide information for all cases occurring in previous ten (10) years. Copy this sheet as necessary.

Primary Liability Carrier Name_____

Address_____ City/State/Zip_____

Policy Number_____ Policy Period From_____ To_____

Carrier Phone Number_____ ____Occurrence ____Claims Made

Coverage Limits_____

Do you have any claims to date? ___YES ___NO

If yes, date of occurrence_____ Carrier Involved_____

Patient Name_____ Age___ Sex___ Status of Case_____

Amount of award settlement, if applicable_____

Describe the allegations against you_____
_____
_____

Describe the alleged injury to the patient_____
_____
_____

Disclosure Information

Please answer the following questions "yes" or "no". If your answer to any question is "yes", please provide a written explanation below or on a separate sheet if needed.

	(Circle Answer)
1. Have any of your board certifications or equivalents ever been suspended, revoked, voluntarily surrendered or have you failed to recertify?	YES NO
2. Has your professional license, in any jurisdiction, ever been voluntarily or involuntarily suspended, limited, revoked, denied, or surrendered or subjected to probationary conditions or are any such actions pending?	YES NO
3. Has your DEA license or state narcotics registration ever been voluntarily or involuntarily suspended, limited, revoked, denied, or restricted for reasons other than non-completion of medical records or are any such actions pending?	YES NO
4. Has your hospital or facility medical staff membership or have your hospital or facility professional privileges ever been voluntarily or involuntarily suspended, limited, revoked, denied or surrendered for reasons related to professional competence or conduct, other than non-completion of medical records or are any such actions pending?	YES NO
5. Have you ever been placed on probation or asked to resign an internship or residency training program?	YES NO
6. Has Medicare, Medicaid, or any other medical reimbursement plan ever voluntarily or involuntarily suspended, limited, revoked, denied, not renewed or terminated your participation for reasons related to professional competence or conduct?	YES NO
7. Have you ever been or are you currently excluded from participation with Medicare or any other federally funded health care program?	YES NO
8. Has your professional liability coverage ever been restricted, limited, denied, not renewed, or special rated (for reasons other than the carrier's termination of operations in your state)?	YES NO
9. Have you ever been named as a defendant in any criminal case? (Excluding minor traffic infractions, but not DUIs)	YES NO
10. Have you ever been convicted of a felony?	YES NO
11. Have you ever been disciplined for a violation of ethical standards by a professional organization?	YES NO
12. To your knowledge has information pertaining to you ever been reported to the National Practitioner Data Bank?	YES NO
13. Do you have a history of engaging in the illegal use of drugs? ("Illegal use of drugs" means the use of any controlled substances illegally obtained, i.e. not obtained pursuant to a valid prescription and not taken in accordance with the direction of a licensed health care practitioner.)	YES NO
14. Are you currently engaged in the illegal use of drugs? ("Currently" does not mean on the day of or even the weeks preceding the completion of this application. Rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)	YES NO

15. Are you currently in treatment for addiction to drugs or alcohol? YES NO

16. Within the last five years, have you been reprimanded or disciplined in any manner by any state licensing authority or other professional board for conduct related to the use of alcohol or the use of any drug? YES NO

17. Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital, ambulatory surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies? YES NO

18. Do you have any emotional or physical disabilities that may limit your ability to practice? YES NO

19. Are you unable to perform the procedures and the essential functions of the position for which you have applied or requested privileges, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients? YES NO

If you answered "YES" to any question, please provide a written explanation below or on a separate piece of paper:_____
_____
_____
_____
_____
_____
_____
_____
_____

PROVIDER NOTIFICATION

Each practitioner has the right to review any information submitted in support of his/her credentialing application except for information that is protected by peer review or law. Each practitioner also has the right to be informed of the status of his/her credentialing or recredentialing application. All requests to review information or to obtain the status of an application must be made in writing and directed to the managed care organization for which this application was submitted. Each practitioner also has the right to correct any erroneous information. If information is received in the credentialing process that varies substantially from the information supplied by you, you will be notified in writing of the variance and the procedure to be followed for correction.

Authorization/Attestation

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I understand that this application does not entitle me to participation in the network of any entity using this application.

I Release S.P.I.N, LLC, its representatives, or entities providing information to this entity from liability for any act or omission related to the evaluation or verification contained in this application provided the entity, its representatives and individuals providing information to the entity act in good faith and without malice. I further agree to notify the entity of any change to the information provided in this application within 30 days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by the entity.

I authorize S.P.I.N, or its representatives, to investigate and evaluate my provider application, and consult with any person, organization, or entity that has, or could have any information, data, or documents regarding my background, competence, and credentials.

This application will not be processed if not signed and dated. STAMPED SIGNATURES ARE NOT ACCEPTED.

_____ _____

Provider Signature Date

_____ _____

Print Name Social Security #

STOP! Before completion please remember:

1. **Did you review document checklist and enclose copies of required facility and physician documents?**

2. **Did you sign and date application, using an original signature?**

If you have any questions regarding this application, please contact us at (516) 331-5210, Option 1 -> 2

_____facility name