# PHYSICIAN / PROVIDER DATA FORM

(Please Print)

| GROUP / FACILITY / PRACTICE INFORMATION | | | | | |
|---|---|---|---|---|---|
| Practice Name: | | | | | |
| Federal Tax ID: | Addresses (from Practice Form): ☐All ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐Other: | | | | |
| **PHYSICIAN / PROVIDER INFORMATION** | | | | | |
| First: | Middle: | Last: | | Suffix: | Degree: |
| Sex: ◯ Male ◯ Female | Date of Birth: | Social Security Number: | Citizenship: | | |
| **SPECIALTY** Please provide Copy of Certification | | | | | |
| Specialty 1: | Board Certified ◯ Yes ◯ No ◯ Eligible | Date Certified: | | | |
| Certifying Board: | | | | | |
| Specialty 2: | Board Certified ◯ Yes ◯ No ◯ Eligible | Date Certified: | | | |
| Certifying Board: | | | | | |
| Specialty 3: | Board Certified ◯ Yes ◯ No ◯ Eligible | Date Certified: | | | |
| Certifying Board: | | | | | |
| Specialty 4: | Board Certified ◯ Yes ◯ No ◯ Eligible | Date Certified: | | | |
| Certifying Board: | | | | | |
| **EDUCATION** | | | | | |
| School: | Start Date: | Graduation Date: | | | |
| **LANGUAGES (NON ENGLISH)** | | | | | |
| 1: | 2: | 3: | 4: | | |
| **HOSPITAL AFFILIATIONS** | | | | | |
| Hospital: | Effective: | | | | |
| Hospital: | Effective: | | | | |
| Hospital: | Effective: | | | | |
| Hospital: | Effective: | | | | |
| Hospital: | Effective: | | | | |
| Hospital: | Effective: | | | | |
| **LICENSURE AND PROFESSIONAL IDS** | | | | | |
| State License 1: | State: | Effective: | | | |
| State License 2: | State: | Effective: | | | |
| State License 3: | State: | Effective: | | | |
| DEA: | | Effective: | | | |
| UPIN: | | Effective: | | | |
| CDS Certificate Number: | State: | Effective: | | | |
| Medicare Number: | | Effective: | | | |
| Medicaid Number: | State: | Effective | | | |
| NPI Individual: | | Effective: | | | |

IGS InterGroup Services

## MALPRACTICE INSURANCE

Please provide copy of Malpractice Face Sheet

| Carrier Name: | | Policy Number: |
|---|---|---|
| Effective Date: | Per Claim Amount: | Aggregate Amount: |

## DISCLOSURE QUESTIONS

If you answer yes to any of these questions, please provide detailed documents for each.

| | | |
|---|---|---|
| Do you have any professional liability claims pending? | ○ Yes ◉ No | If yes, how many? |
| Have you had any liability claims previously resolved? | ○ Yes ◉ No | If yes, how many? |
| Have you had any formal action taken against you by a professional society? | ○ Yes ◉ No | |
| Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? | ○ Yes ◉ No | |
| Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs? | ○ Yes ◉ No | |
| Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? | ○ Yes ◉ No | |
| Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?* | ○ Yes ◉ No | |
| Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony? | ○ Yes ◉ No | |
| In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? | ○ Yes ◉ No | |

## SIGNATURE

**I warrant that all of the statements and data provided in this document are true and correct** ○

| Signature: | |
|---|---|
| Print: | Date: |

## CONTACT FOR THIS APPLICATION

Please provide a contact person that InterGroup Services may contact if there are any questions or missing information regarding this application

| Name: | Phone: |
|---|---|
| Email: | Fax: |