



PHYSICIAN / PROVIDER DATA FORM

(Please Print)

GROUP / FACILITY / PRACTICE INFORMATION

Practice Name:	
Federal Tax ID:	Addresses (from Practice Form): <input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> Other:

PHYSICIAN / PROVIDER INFORMATION

First:	Middle:	Last:	Suffix:	Degree:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Social Security Number:	Citizenship:	

SPECIALTY
Please provide Copy of Certification

Specialty 1:	Board Certified <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eligible	Date Certified:
Certifying Board:		
Specialty 2:	Board Certified <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eligible	Date Certified:
Certifying Board:		
Specialty 3:	Board Certified <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eligible	Date Certified:
Certifying Board:		
Specialty 4:	Board Certified <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eligible	Date Certified:
Certifying Board:		

MEDICAL SCHOOL

Medical School:	Start Date:	Graduation Date:
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LANGUAGES (NON ENGLISH)

1:	2:	3:	4:
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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:

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: