MDLinkNow

MDLINKNOW CREDENTIALING APPLICATION

Please print clearly or type

Personal and Practice Information

First Name: _____ ◉ MD ○ DO

Middle Name: _____ Place of Birth: _____

Last name: _____ US Citizen: ○ Yes ○ No

NPI Number: _____ Medicare Number: _____

Home Street Address: _____
(No P.O. Boxes)

Home City: _____ State: _____Zip: _____

Home Phone: _____

Cell Phone: _____

Cell Phone Provider: (for consult alerts) _____

Email: _____

Primary Office Street Address: _____

Office City: _____ Stat: _____ Zip: _____

Office Phone: _____Office Fax: _____

Languages (other than English) in which you are fluent: _____

Are you a provider for any Health Plans? ○ Yes ○ No

If Yes, Please list Health Plans: _____

_____

Professional Certifications (attach copies):

DEA Certificate (Number): _____ Issue Date: _____

DEA Schedules: _____ Expiration Date: _____

ACLS Certification: # _____ Expiration Date: _____

BCLS Certification: # _____ Expiration Date: _____

ATLS Certification: # _____ Expiration Date: _____

PALS Certification: # _____ Expiration Date: _____

ABMS or AOA Board Certification/Recertification: ◯ Yes ◯ No

Name of Board: _____ Expiration Date: _____

Name of Board: _____ Expiration Date: _____

Name of Board: _____ Expiration Date: _____

Education and Training (please provide a copy of completion/diploma)

College or University: _____

Address: _____

Degree: _____ Major: _____

Dates of Attendance: From: _____ To: _____ Successfully Completed: ◯ Yes ◯ No

Post-Graduate Education (Institution): _____

Address: _____

Degree: _____ Major: _____

Dates of Attendance: From: _____ To:_____ Successfully Completed: ◯ Yes ◯ No

Post-Graduate Education (Institution): _____

Address: _____

Degree: _____ Major: _____

Dates of Attendance: From: _____ To: _____ Successfully Completed: ◯ Yes ◯ No

Post-Graduate Education (Institution): _____

Address: _____

Degree: _____ Major: _____

Dates of Attendance: From: _____ To: _____ Successfully Completed: ◯ Yes ◯ No

Are you registered as a provider with Medicaid ? ◯ **Yes** ◯ **No**

If Yes, please provide a list of all Medicaid registration numbers and State(s) of registration:

Medicaid Number: _____ State of Registration: _____

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Medicaid Number: _____ State of Registration: _____

Professional Licenses/Certifications **(please provide copies of ALL Professional Licenses/Certifications)**

Primary State of Licensure-1: _____ Date of Issue: _____

Number: _____ Date of Expiration: _____

State of Licensure-2: _____ Date of Issue: _____

Number: _____ Date of Expiration: _____

State of Licensure-3: _____ Date of Issue: _____

Number: _____ Date of Expiration: _____

State of Licensure-4: _____ Date of Issue: _____

Number: _____ Date of Expiration: _____

State of Licensure-5: _____ Date of Issue: _____

Number: _____ Date of Expiration: _____

(Use additional Sheet if Necessary)

Professional References: Must provide their Email and/or Fax. (Must be a MD or DO, of the same speciality as yours, who can attest to your clinical skills, ethical conduct and health status)

Peer Reference-1: _____ Relationship: _____

Years Known: _____ Phone: _____ Fax: _____

Address: _____

Email: _____

Peer Reference-2: _____ Relationship: _____

Years Known: _____ Phone: _____ Fax: _____

Address: _____

Email: _____

Work History: Please provide at least 5 recent years of Work/Military duty history since completing your training. (On a separate sheet, explain any gap longer than 180 days)

Current Employer: _____Job Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dates of Employment: (mm/yyyy) From: _____ To: _____

Supervisor: _____

Employer: _____ Job Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dates of Employment: (mm/yyyy) From: _____ To: _____

Supervisor: _____

Employer: _____ Job Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dates of Employment: (mm/yyyy) From: _____ To: _____

Supervisor: _____

Employer: _____ Job Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dates of Employment: (mm/yyyy) From:_____ To: _____

Supervisor:

Professional Information:

Please answer each of the following questions either “Yes” or “No” — DO NOT LEAVE ANY QUESTION UNATTENDED. Provide an elaborate and detailed explanation of each “YES” answer along with any and all documentation you have.

	Question	Yes	No
1	Has your license, registration or certification to practice in your primary state of licensure or any other state been denied, restricted, limited, suspended or revoked?	◯	◯
2	Have you been reprimanded by any state licensing agency, or, are any of these actions pending with respect to your license?	◯	◯
3	Have you ever received a reprimand or been fined by any state licensing board?	◯	◯
4	Have your clinical privileges or hospital staff membership at any hospital or healthcare institution 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 records) or have proceeding toward any of those ends been instituted or recommended by hospital or healthcare institution, medical staff or committee, or governing board?	◯	◯
5	Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including PPOs, HMOs, or provider organizations such as IPAs, PHOs?	◯	◯
6	Have you ever been required to obtain additional education or training as a result of peer review or quality assurance activities?	◯	◯
7	Have your privileges or membership with any Professional Provider Organization, Insurance company, Health Maintenance Organization or any other third party payer, network, or delivery system been denied, restricted, limited, suspended, or revoked?	◯	◯
8	Have any complaints been filed against you in a Medical or other professional claim?	◯	◯
9	Has your Federal DEA and/or CDC Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?	◯	◯

	Question	Yes	No
10	Has your participation in Medicare, Medicaid, Railroad Medicare, TriCare, or any other government program been denied, suspended, or revoked; or are you currently under investigation by these or any other regulatory agency?	○	○
11	Are you currently or have you ever been, the subject of an investigation by any hospital, licensing authority, DEA, CDC, education or training program, Medicare or Medicaid program, or any other private, state, or federal health program?	○	○
12	Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during a clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?	○	○
13	Has your certification(s) or eligibility ever beeb revoked?	○	○
14	Have you ever been convicted of or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional?	○	○
15	Have you ever been convicted of or pled nolo contendere to any felony including an act of violence, child abuse or sexual offence?	○	○
16	Have you been court-martialed for actions related to your duties as a medical professional?	○	○
17	To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection data Bank?	○	○
18	Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital facility or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility or any military agency?	○	○
19	Are you now, or have you ever been involved in any malpractice action(s) including litigation, arbitration, or mediation, regardless of the method or amount of the outcome resulted; or have you received any notice of claim or complaint against you?	○	○
20	Have any professional liability claim settlements, not involving litigation or arbitration, been paid by you or on your behalf?	○	○
21	Have you been the subject of any administrative, civil, or criminal investigation involving sexual misconduct or child abuse?	○	○
22	Have you been court-martialed for actions related to your duties as a medical professional?	○	○

	Question	Yes	No
23	Have you ever been denied malpractice coverage or has your coverage ever been limited, reduced or cancelled? Do you currently have medical malpractice insurance?	◯	◯
24	Have you ever practiced in a different geographic area other than the one in which you are now practicing?	◯	◯
25	Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?	◯	◯
26	Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodations?	◯	◯
27	Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you?	◯	◯
28	Are you currently under the care of a physician or psychologist, or have you participated in any recovery program established pursuant to a state statue?	◯	◯
29	Are you currently using illegal drugs or illegally using legal drugs (a controlled substance as defined in Schedules I through V of Section 202 of the controlled substances Act, U.S.C. 812-22?	◯	◯
30	Are you currently taking any medications that may affect either your clinical judgement or motor skills?	◯	◯
31	Which of the following best describe your current health status? (If your status is fair or poor, please give a written explanation on separate paper) Good: ◯ Fair: ◯ Poor: ◯	◯	◯

Current Insurance carrier Name: _____

Amounts: _____ Effective date: _____ Expiration Date: _____

_____ _____

Physician Signature Date

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Last Name	First Name	SSN

Bank Name: _____

Transit/ABA Number: _____

Account Number: _____

State: _____ **Type of Account:** ◯ **Checking** ◯ **Savings**

Please Check One:

◯ New Account

◯ Change the Bank or Account Number on an Existing Direct Deposit

◯ Other (please explain): _____

◯ I have attached a voided personalized check (checking account) or deposit slip (Savings account) for each account specified. (This request will not be processed without the accompanying documentation).

I hereby authorize the company to directly deposit any salary or wages due to me, less any mandatory or authorized withholdings or deductions in the bank account(s) listed above.

The company will credit my account(s) the amount of my payroll check on payday. The company will provide me with check stub on payday listing my deductions and pay. I understand that direct deposit is contingent each pay period on timely receipt of payroll hours or work completed and timely receipt of payroll funding from the client(s) I am assigned to. Deposits are normally available the morning of pay date, however, each bank posts funds to accounts at different times daily, and the company has no control over my bank's posting. Also, I hereby grant the company the right to correct any electronic funds transfer resulting from overpayment by debiting my account to the extent of such overpayment.

I authorize my financial institution to accept direct deposits to my account upon receipt and without advise to me. It is my responsibility to verify deposits on a per pay date basis before writing checks against these funds. I understand that the company is not responsible for bank errors or bank fees. Banking services are provided in accordance with the limitations and restrictions of the Automated Clearing House Association.

This authorization is to remain in force until the company has received written authorization from me of its termination or change. I understand that if my account has closed, my financial institution cannot accept a deposit on my behalf. If this occurs, my employer will not be able to process any further direct deposits without further written authorization from me. IN ORDER TO TERMINATE OR REVOKE THIS AUTHORIZATION, I MUST NOTIFY MY EMPLOYER IN WRITING AT LEAST TWO WEEKS PRIOR TO THE TERMINATION.

Signature: _____ Date: _____

Company Name: _____

Please allow 2-4 weeks for your direct deposit to begin. Please verify with your bank that your first direct deposit has been processed successfully.