Premier Health Networks of Alabama, LLC

Provider Renewal Information

PLEASE REVIEW AND MAKE NECESSARY CORRECTIONS ON THIS FORM - INFORMATION IS UTILIZED FOR DIRECTORY LISTINGS.

PROVIDER NAME	GENDER M F	DEGREE	DOB	SSN	NPI #

PRIMARY SPECIALTY	BOARD CERTIFIED? ☐ YES ☐ NO	STATE LICENSE NUMBER	EXPIRATION

SECONDARY SPECIALTY	BOARD CERTIFIED? ☐ YES ☐ NO	FEDERAL DEA NUMBER	EXPIRATION

IF YOU ARE NOT BOARD CERTIFIED, ARE YOU ELIGIBLE TO TAKE A BOARD EXAMINATION? ☐ YES ☐ NO	BOARDS FOR WHICH YOU ARE ELIGIBLE	DATE ADMISSIBILITY EXPIRES

DOES THE PROVIDER SPEAK MORE THAN ONE LANGUAGE? IF YES, LIST LANGUAGES	ACCEPTING NEW PATIENTS? WHAT AGES?

HOSPITALS AT WHICH YOU CURRENTLY HAVE PRIVILEGES:	PROFESSIONAL LIABILITY INSURANCE CARRIER POLICY NUMBER POLICY RENEWAL

MEDICAL GROUP AFFILIATION	GROUP NPI NUMBER	TAX ID NUMBER

BILLING Phone: Fax:	OFFICE LOCATION: Office Manager: Phone:

I CERTIFY THAT THE INFORMATION AND CERTIFICATES ATTACHED ARE TRUE AND CORRECT STATEMENTS. I UNDERSTAND THAT ANY MISSTATEMENT IN THIS RENEWAL APPLICATION MAY CONSTITUTE GROUNDS FOR DENIAL OF THIS APPLICATION OR FOR SUMMARY DISMISSAL AS A PARTICIPATING PROVIDER.

PROVIDER SIGNATURE	DATE

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	Yes	No
1. A. Are you now or have you in the last 5 years been involved in any malpractice suite including arbitration?		
B. Has any malpractice claim settlement, not involving litigation or arbitration, been paid by you or on your behalf in the last 5 years?		
If the answer to either of the above questions is yes, please attach the following information for each suit or settlement: - Date and details of the incident(s) leading to the suit or settlement - Date of suit or settlement - Professional liability insurer involved - Your role in the incident(s) - Your status in any suit or other legal action (primary defendant, codefendant, other) - Current Status of suit or other legal action - Amount reserved by carrier for each claim, or amount paid as an out of court settlement, or amount of jury award or court award. (Please obtain this information from your insurer if necessary)		
2. Has your professional liability insurance been denied, suspended, cancelled, or not renewed? If the answer is yes, please explain in an attachment.		
3. Do you now have or within the last 5 years have you had any physical condition, mental condition, or chemical dependency condition (alcohol or other substance dependency) that does or has interfered with your ability to practice medicine?		
4. Have you had any of the following items denied, revoked, suspended, not renewed, placed under probation, subjected to disciplinary action, or otherwise limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items?		
- State License		
- DEA Registration or other narcotic license		
- Hospital or other health care facility staff membership or privileges		
- Professional organizations memberships		
- Medicare, Medicaid or other government program participation		
- HMO, PPO, or other prepaid health plan participation		
NOTE: If the answer to any of the above items is YES, please explain in an attachment.		
5. If you have ever been employed as a physician by a military service, a hospital, and HMO or y other health care organization, was your employment ever terminated by the employer? ☐ N/A (Not Applicable)		
6. Have you ever been convicted of a felony or crime (other than a traffic offense), or are you currently under indictment for an alleged felony or crime? If the answer is YES, please explain in an attachment.		

I authorize Premier Health Networks of Alabama (referred to as NAMCI and Comp1One) to consult with members of hospital medical staffs, professional liability carriers and other persons or entities to obtain information concerning my professional qualifications, including competence, ethics, and other qualifications. I release Premier Health Networks of Alabama and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my application. I consent to the release, by any person to Premier Health Networks of Alabama, of all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions or other confidential or privileged information. I release, from any and all liability, anyone providing this information in good faith and without malice. I understand that any misstatement in this application may constitute grounds for denial of this application or for summary dismissal as a participating Premier Health Networks of Alabama Provider. If any material changes occur affecting my professional status, it is my obligation to notify Premier Health Networks of Alabama as soon as possible. I consent to the release of this information, as well as other quality assurance data relating to me, to health plans owned or managed by Premier Health Networks or to medical groups, IPAs, or other similar entities contracting with those plans. I certify that the information provided on this application is true and correct.

PROVIDER NAME	PROVIDER SIGNATURE	DATE

PLEASE BE SURE TO ENCLOSE WITH THIS APPLICATION ANY EXPLANATORY STATEMENTS REQUESTED RELATED TO CONFIDENTIAL QUESTIONS 1 - 6

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LIST ANY ADDITIONAL OFFICE LOCATION BELOW: