Banner Certification, Credentialing, Licensing
PO Box 16950
Mesa, AZ 85211-6950

RE: Banner Health Network Recredentialing

Dear

Enclosed, is a Banner Health Network (BHN) recredentialing application. As you review the reappointment application please make any appropriate changes and complete any blanks or indicate N/A where applicable. Incomplete applications will be returned.

Photocopies of the following documents must accompany your reappointment application:

- Curriculum Vitae with current work history. Please provide a detailed explanation for any gaps exceeding 3 months.
- Board Certificate(s) (if applicable or new)
- W-9 form
- Face Sheet of your professional Liability Insurance Policy

Please submit the requested materials within the next two weeks. The process will not begin until all the documents are received. If your application and documents are not received by _____, your membership will expire.

If you do not intend to renew your membership, please submit a written notification.
For any questions or concerns regarding your credentialing, please contact the Provider Experience Center:
ProviderExperienceCenter@bannerhealth.com (480) 684-7070 option 6

Thank you for your time and prompt attention.

Please return your recredentialing application & appropriate documentation via:

	Email:	BHNPayerCredentialing@bannerhealth.com
	Fax:	(480) 655-2546
Or	Mail:	BCCL – Credentialing Dept. PO Box 16950 Mesa, AZ 85211-6950

Banner Health Network
Provider Re-credentialing Application

Please type or print legibly. Application must be filled out completely.

Leave no blank spaces; write "N/A" if a question does not apply. If additional space is needed, please attach supplemental page(s). In accordance with NCQA and URAC Standards, applicants have the right to review the information submitted in support of their re-credentialing application; to correct erroneous information; and to be informed of the status of their re-credentialing application upon request. Please contact the Credentialing Coordinator if you would like to review your re-credentialing documentation.

STATUS

Today's Date:_____ Initial Credential Date:_____ Reappointment Date:_____

Primary Specialty:_____ Secondary Specialty:_____

Sponsoring Network: _____

PERSONAL DATA

Last Name_____ Middle Initial____ First_____

Degree: ☐ MD ☐ DO ☐ DPM ☐ Other _____

Home Address: _____

City, State, Zip:_____

Home Telephone: _____ 2nd Home Phone: _____

Cell Phone:_____ Marital Status:_____

E-mail:_____ Pager/Beeper:_____

Answering Service:_____

NOTE: This section is intentionally left blank to protect your personal information. Please complete so that we may ensure that we have the correct information on file.

ID NUMBERS

AZ State License Number: _____Expiration date:_____
(Please complete the addendum on page 10 for out of state licenses, including inactive or pending.)

DEA Number: _____Expiration date: _____

ECFMG Number: _____Expiration date: _____(attach copy)

Medicaid #:_____

NATIONAL PROVIDER ID: | |

PRACTICE/OFFICE INFORMATION

Designation: ☐Primary ☐Secondary ☐Mailing ☐Billing
Group Name _____

Tax ID: _____(Complete attached W9)

Address:_____

City, State, Zip:_____

Phone:_____Fax:_____

Office E-mail address: _____

Office Manager_____ Contact Phone:_____

Office Credentialing Contact: _____ Phone_____

Office Hours: _____Handicap Access: Yes☐ No☐

Office accepts new patients: Yes☐ No☐ Group Website/URL: _____

Include Office in Directory: Yes☐ No☐ If no, please indicate why:_____

Call Coverage Associates:_____

Practice Associates: _____

Designation: ☐Primary ☐Secondary ☐Mailing ☐Billing
Group Name _____

Tax ID: _____(Complete attached W9)

Address:_____

City, State, Zip:_____

Phone:_____Fax:_____

Office E-mail address: _____

Office Manager_____ Contact Phone:_____

Office Credentialing Contact: _____ Phone_____

Office Hours: _____Handicap Access: Yes☐ No☐

Office accepts new patients: Yes☐ No☐

Include Office in Directory: Yes☐ No☐ If no, please indicate why:_____

Call Coverage Associates:_____

Practice Associates: _____

PRACTICE/OFFICE INFORMATION Continued

Note: If additional location(s) should be listed, please attach to your application when submitting

Designation: ☐Primary ☐Secondary ☐Mailing ☐Billing

Group Name _____

Tax ID: _____(Complete attached W9)

Address:_____

City, State, Zip:_____

Phone:_____Fax:_____

Office E-mail address: _____

Office Manager_____ Contact Phone:_____

Office Credentialing Contact: _____ Phone_____

Office Hours: _____Handicap Access: Yes☐ No☐

Office accepts new patients: Yes☐ No☐

Include Office in Directory: Yes☐ No☐ If no, please indicate why:_____

Call Coverage Associates:_____

Practice Associates: _____

MEDICAL SPECIALTIES

Primary Specialty: _____

Board Certified: Yes☐ No☐ Date certified: _____

Date certification expires:_____ Date(s) of recertification:_____

Name of Board: _____

Secondary Specialty: _____

Board Certified: Yes☐ No☐ Date certified: _____

Date certification expires:_____ Date(s) of recertification:_____

Name of Board: _____

If not board certified, please indicate your intentions of becoming board certified: _____

_____

HOSPITAL AFFILIATIONS

Do you have hospital privileges at a Banner facility: Yes☐ No☐

As stated in the BHN policy & procedures; all providers must have an affiliation with at least one banner facility with the exceptions of PCPs' or Specialists' who are office based with no hospital affiliation(s) anywhere. NOTE: If you would like to be considered for exemption from this policy please submit a letter with your application explaining why an exemption should be considered/granted.

Primary Admitting Hospital:_____ City / State:_____

Status / Specialty:_____ Dates:_____

Hospital:_____ City / State:_____

Status / Specialty:_____ Dates:_____

Hospital:_____ City / State:_____

Status / Specialty:_____ Dates:_____

If you do not have privileges, please list the name and address of the physician(s) who will admit your patients:

Name:_____Address:_____

Phone#:_____ Hospital:_____

PROFESSIONAL PRACTICE/WORK HISTORY

Have there been any changes in your practice/work history in the past three (3) years? Yes☐ No☐

If yes, please provide the following information:

Current Practice Name_____ Phone_____

Mailing Address_____

City, State, Zip _____ Dates_____-_____
Month/Year Month/Year

Previous Practice Name_____ Phone_____

Mailing Address_____

City, State, Zip _____ Dates_____-_____
Month/Year Month/Year

*If necessary, please list additional work history on a separate sheet of paper. Please provide any time gaps greater than 6 months. Work history should also include any military service.

PROFESSIONAL LIABILITY INSURANCE

Current carrier: _____

Address: _____

Policy #: _____ Issue date: _____ Expiration date: _____

Retro date: _____ Occurrence Amount: _____ Aggregate Amount: _____

*Please attach a copy of your certificate of insurance and include documentation on any malpractice claims history for the past 3 years.

Banner Health Network
Provider Re-Credentialing Application

Please type or print legibly. Application must be filled out completely.

CONFIDENTIAL QUESTIONNAIRE

(If YES to questions 1-18, please attach a detailed explanation.)

Name: _____

1. Have you had a malpractice lawsuit filed against you in the past 3 years? Yes☐ No☐
2. Have you settled a malpractice lawsuit filed against you in the past 3 years? Yes☐ No☐
3. Have you had a judgment rendered against you in a malpractice lawsuit in the past 3 years? Yes☐ No☐
4. Has your license to practice medicine in any jurisdiction been limited, suspended, revoked, denied, or subjected to probationary conditions or have proceedings toward any of those ends ever been instituted against you in the past 3 years? Yes☐ No☐
5. Have you received other disciplinary actions, restrictions, reprimands or advisory letters in the past 3 years? Yes☐ No☐
6. Have you ever been convicted of, pled no contest to or pled guilty to any crime related to your professional practice? Yes☐ No☐
7. Have you had an application for membership or privileges at a hospital or other health care facility denied, granted with limitations, limited, suspended, revoked, not renewed, subjection to probationary conditions or have any such actions ever been recommended by a standing medical staff committee or governing board of a hospital or other health care facility in the past 3 years? Yes☐ No☐
8. Have you been denied membership of renewal thereof or been subject to any disciplinary action in any national, state or local medical organizations or professional society or have proceedings toward any of those ends ever been instituted against you in the past 3 years? Yes☐ No☐
9. Has your specialty board certification of eligibility ever been denied, revoked, relinquished, not renewed, suspended, or reduced or have proceedings toward any of those ends ever been instituted against you? Yes☐ No☐
10. Has your Drug Enforcement Administration certificate or any other controlled substances authorization, permit or license been denied, revoked, suspended, reduced, or not renewed or have proceedings toward any of those ends ever been instituted against you in the past 3 years? Yes☐ No☐
11. Have you ever voluntarily relinquished a medical staff membership, a clinical privilege, a professional license or a narcotics registration permit under threat of disciplinary action? Yes☐ No☐
12. Has your participation in a managed care plan ever been denied, revoked, suspended, limited, terminated or not renewed? Yes☐ No☐
13. Have you ever been convicted of a felony? Yes☐ No☐
14. Have you been expelled or suspended from receiving payment under the Medicare/Medicaid programs in the past 3 years? Yes☐ No☐
15. Is your physical or mental condition such that it may impair your ability to perform the essential function of your position with or without accommodation? Yes☐ No☐
16. Are you currently engaged in illegal use of controlled dangerous substances? Yes☐ No☐
17. Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you? Yes☐ No☐
18. Have you ever been denied coverage or renewal of coverage of malpractice liability insurance? Yes☐ No☐

CERTIFICATION OF TRUTHFULNESS & COMPLETENESS

In furtherance of my application for membership to one or more of the following: Banner Health Network, Banner Physician Hospital Organization, Arizona Integrated Physicians, Samaritan PrimeCare, and/or Banner Medical Group (hereinafter individually and collectively referred to as "Provider Networks"), I authorize the release of my Medical Portfolio, both past and future, to Provider Networks to which I apply, and to their respective employees and agents .
For purposes of this release, my Medical Portfolio means any and all information and documents which may assist in the evaluation of my qualifications for membership in Provider Networks. My Medical Portfolio includes, but is not limited to, information regarding:

- The quality, efficiency or effectiveness of patient care;
- My character, collegiality, conduct and compliance with professional ethics and legal requirements;
- My health status;
- My education, training and competence;
- My affiliation with medical staffs, my performance at hospitals, surgical centers and other facilities, and any limitations imposed upon my privileges I have been granted and any restrictions imposed or pending;
- Licenses I have been granted and any restrictions imposed or pending;
- Any malpractice claims or suits against me.

Signature	Date
Name (please print)	

Applicant Agreement & Release of Information & Release of Liability

Release of Information: I authorize hospitals, healthcare institutions, members of medical staffs, health plans, training programs, insurance carriers, employers or any other person to release all information regarding my Medical Portfolio to Provider Networks or its designees, including the credentialing staff. I release from liability and from any restrictions as to confidentiality or privacy any and all individuals or organizations or their representatives who provide information about me at the request of the Provider Networks or its designees.

If I am granted membership in Provider Networks, I authorize Provider Networks and its designees to release my Medical Portfolio to third party payors or their representatives for the purpose of auditing the credentialing and professional review activities and procedures of Provider Networks or their respective agents as required by contract.

I understand and agree that the authorizations given by me herein shall be irrevocable for a period of thirty six (36) months. A photocopy or facsimile of this authorization shall be as effective as the original when so presented.

Release of Liability: I agree to release from legal liability and hold harmless Banner Health, Provider Networks, and all persons engaged in quality assurance activities, including but not limited to the review of my qualifications and the review of my application for appointment and reappointment. I further agree that the Provider Networks are immune from liability pursuant to Provider Network policies and A.R.S. §35-2401 et. seq.. I agree that no claim for monetary damages may be brought until all appeal rights available under Provider Network policies have been exhausted. I understand that this release applies even if I am not granted membership.

Conditions of Application: Completing this Application does not entitle me to membership. Receipt of this Application by any Provider Network or its designees does not constitute acceptance by any Provider Network.

I have personally completed this Application or have reviewed its contents and attest to their accuracy. I, the undersigned, do hereby certify that the information in this Application is truthful, correct and complete to the best of my knowledge and belief. I will update the Application while it is being processed should there be any change in the information. I understand that the failure to provide accurate and complete information on this Application is grounds for denial or termination of membership, including summary dismissal.

Applicant Agreement & Release of Information & Release of Liability (continued)

I acknowledge that I have the burden of producing adequate information for proper evaluation of my qualifications for membership. In addition to the information provided in this application, I also agree to provide Provider Networks or its authorized representatives with any additional information that may be requested. My failure to provide any requested information will cause my application to be incomplete, and it will not be processed. If and when requested, I will appear for and cooperate in interviews and will submit to an examination of my health status or professional competence. Pictures of me may be used for identification purposes in conjunction with my application

I have read and understand and I agree to abide by Provider Networks Provider Services Agreement policies and procedures, and such rules and regulations of Provider Networks, as may from time to time be revised, without regard to whether membership and/or clinical privileges are granted.

I have read and understand and I agree to abide by Provider Network and applicable Banner policies, including but not limited to those regarding HIPAA, Electronic Transmission of Patient Information and Excluded practitioners.

I agree to immediately notify Administration of Provider Networks and all Banner facilities/entities where I hold membership of any of the following circumstances arising subsequent to the date of my application for membership:

- Revocation, suspension, or voluntary relinquishment of my professional license or DEA number;
- Imposition of terms of probation or limitation imposed by any state licensing agency or DEA, including stipulation or other voluntary agreement;
- Cancellation or restriction of my professional liability coverage;
- Denial, loss, restriction of staff membership or privileges at any hospital or healthcare institution or any recommendation that, if approved, would result in the denial, loss or restriction of membership or privileges; Managed care participation?
- Investigation or the filing of charges by my applicable licensing board-, the Department of Health and Human Services, DEA or any law enforcement agency.

Signature	Date
Name (please print)	

Banner
Health Network

CONFIDENTIAL INFORMATION REPORT

☐ Does not apply

If you have answered "YES" to any question in the Malpractice History section, you must furnish the information below and **it is your responsibility to provide documentation verifying your response (i.e., a statement from attorney, a narrative statement from you, court records to include case details, etc.).** You may choose to have your attorney complete this form; however, your signature is required.

Failure to comply may delay your application. Please complete one form for each separate incident.

Month / Year of Incident: _____ Where incident occurred: _____

Date lawsuit was filed: _____

Nature of Incident (Complaint, allegation):

_____

_____

_____

_____

_____

Disposition of Claim ☐ Dropped ☐ Dismissed ☐ Pending ☐ Settled, Amount _____

☐ With Prejudice ☐ Without Prejudice

☐ Verdict for you, Amount _____ ☐ Verdict for plaintiff, Amount _____

Represented by Legal Counsel for this claim / malpractice lawsuit? ☐ Yes ☐ No

If yes, give the name and address of counsel. Name: _____

Address: _____
(Street Address) (City) (State) (Zip Code)

Phone: _____ Fax: _____

Insurance Company that provided coverage for this claim:

Company Name: _____

Address: _____
(Street Address) (City) (State) (Zip Code)

Phone: _____ Fax: _____ Policy Number: _____ Claim Number: _____

Practitioner Signature: _____ Date: _____

Print Name: _____

License Addendum

Banner Health Network

☐ Does not apply	**Additional State Licenses:** *List all state health care licenses, registrations, certificates, and/or advanced practice registry as well as other relevant numbers, including pending, expired, and inactive.*
☐ **Active** ☐ **Inactive/Expired** ☐ **Pending**	**Type of License/Certificate/Registration:** ______________________________ **Number:** _________________ **State/Institution:** ______________________ **Issue date:** __________ **Expiration date:** __________ **Year Relinquished** (if applicable)**:** ________
☐ **Active** ☐ **Inactive/Expired** ☐ **Pending**	**Type of License/Certificate/Registration:** ______________________________ **Number:** _________________ **State/Institution:** ______________________ **Issue date:** __________ **Expiration date:** __________ **Year Relinquished** (if applicable)**:** ________
☐ **Active** ☐ **Inactive/Expired** ☐ **Pending**	**Type of License/Certificate/Registration:** ______________________________ **Number:** _________________ **State/Institution:** ______________________ **Issue date:** __________ **Expiration date:** __________ **Year Relinquished** (if applicable)**:** ________
☐ **Active** ☐ **Inactive/Expired** ☐ **Pending**	**Type of License/Certificate/Registration:** ______________________________ **Number:** _________________ **State/Institution:** ______________________ **Issue date:** __________ **Expiration date:** __________ **Year Relinquished** (if applicable)**:** ________
☐ **Active** ☐ **Inactive/Expired** ☐ **Pending**	**Type of License/Certificate/Registration:** ______________________________ **Number:** _________________ **State/Institution:** ______________________ **Issue date:** __________ **Expiration date:** __________ **Year Relinquished** (if applicable)**:** ________
☐ **Active** ☐ **Inactive/Expired** ☐ **Pending**	**Type of License/Certificate/Registration:** ______________________________ **Number:** _________________ **State/Institution:** ______________________ **Issue date:** __________ **Expiration date:** __________ **Year Relinquished** (if applicable)**:** ________
☐ **Active** ☐ **Inactive/Expired** ☐ **Pending**	**Type of License/Certificate/Registration:** ______________________________ **Number:** _________________ **State/Institution:** ______________________ **Issue date:** __________ **Expiration date:** __________ **Year Relinquished** (if applicable)**:** ________
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