

Northwest Community Health Partners (PHO)

New Physicians Application Instructions

Applicants are required to complete the *State of Illinois Health Care Professional Credentialing and Business Data Gathering Form*, the documents within this packet and licensure as listed below.



PHO APPLICATION DIRECTIONS:

1. Complete electronically and print the State Credentialing Form. To access the form for completion - click on the link below:

http://www.idph.state.il.us/about/IDPH_credentiaing_form_97_pro.doc

Be sure to save an electronic copy of the completed form for your records.

2. Print and complete the forms included in this application packet:

- W-9
- Release of Information Authorization
- Consent for Release of Information/Release From Liability
- Additional Forms can be downloaded and printed at the link below: <http://www.nch.org/pho/additionalforms.shtml>
- Application Checklist

3. Sign and date the Application/Releases when ready to send to the PHO. (Due to the time sensitivity of documentation, please do not date and sign your credentialing forms until you are ready to send your packet to the PHO).

4. Attach required documents listed below.

*** Complete all forms in their entirety. Incomplete applications will be returned. ***

REQUIRED ATTACHMENTS:

- \$175.00 fee (non-refundable) due at submission. Payable to: Northwest Community Hospital.** Please submit one check per application.
- State Medical License
- State Controlled Substance License
- Federal DEA Certificate
- Board Certification Letter/Certificate (If not board certified, documentation of 50 CME credits in area of specialty (50% must be Category I credits))
- Curriculum Vitae
- Current Malpractice Insurance Certificate including effective date, expiration date, & limits
- Current Letter(s) of Loss History Statement from all malpractice insurance carrier(s) within the past five (5) years** including all open, closed, dismissed, pending, settled cases and judgments made. Loss statements are required from residency/internships, if within the last 5 years. Complete a separate Form B for any cases listed. For an Additional Form B or a Sample Carrier Statement Form click on this link: <http://www.nch.org/pho/additionalforms.shtml>
- Loss statements dated over 6 months from date of submission are not accepted.**

**MAIL COMPLETED APPLICATION PACKET TO:
Northwest Community Health Partners
Attn: Credentialing
675 W. Central Road Suite 200
Arlington Heights, IL 60005**

The Health Care Professional Credentials Data Collection Act mandates information that must be submitted on a continual basis and establishes time frames that physicians and other health care professionals must follow when submitting updates.

Report within five (5) business days:

- State health care professional license revocation
- Federal drug enforcement agency license revocation
- Medicare or Medicaid sanctions
- Revocation of hospital privileges
- Any lapse in professional liability coverage required by a health care entity, health care plan or hospital
- Conviction of a felony

Report within 45 days:

- Any other change in information e.g. address, phone, etc.

Updates to credentials information must be submitted on the *Health Care Professional Credentials Data Collection Act Update Form*. To obtain a copy, click here: <http://www.nch.org/pho/additionalforms.shtml>

Should you have any questions regarding the application process, or regarding the application forms, please contact NWHP at 847.618.5250. Thank you.

IMPORTANT TAX DOCUMENT SUBSTITUTE FORM W-9
Request for Taxpayer Identification Number

The Internal Revenue Service requests that we obtain your Taxpayer Identification Number (TIN) for information report requirements. We are required by law to obtain this information from you when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to 31% federal income tax backup withholding. Also, if you do not provide us with this information, you may be subject to a \$50 penalty imposed by the Internal Revenue Service under Section 6723 of the Internal Revenue Code. Please complete the remainder of this Substitute Form W-9.

1. Taxpayer Name _____
(To whom the check is payable) (A legal entity name if a corporation or partnership)

Doing Business as: DBA _____
(A division name if a corporation of the business if a sole proprietor)

2. Taxpayer Address

3. Taxpayer Identification Number
a. Corporation _____
(List employer identification number)

b. Partnership _____
(List employer identification number)

c. Sole Proprietorship _____
(List employer identification number)

d. Tax Exempt Entity _____
(List employer identification number)

e. Other-Please Explain _____

4. Form Completed By _____
(Print name)

5. Signature _____
(Signature)

6. Today's Date _____

7. Daytime Phone Number (_____) _____

PLEASE NOTE: INFORMATION REPORTED ON LINES 1-3 MUST BE CONSISTENT WITH DATA ON FILE WITH THE IRS AND SOCIAL SECURITY ADMINISTRATION.

Northwest Community Health Partners

**CONSENT FOR RELEASE OF INFORMATION/RELEASE FROM
LIABILITY**

I hereby give permission to Northwest Community Health Partners (PHO), its affiliates and the employees, agents and representatives thereof to obtain information about my professional education, training, licensing, competence, ethics, character and other qualifications. I consent to the release of such information, whether in the form of transcripts, records tapes, letters, photocopies/duplications of any of the foregoing, verbal statements, by hospital administrators, chiefs of clinical departments of hospitals in which I have served on staff, state licensing boards or regulatory bodies (by whatever name known in their respective jurisdictions), physicians, clinics, or other individuals or organizations who or which possess information about me. Such information may be released to the above named entity and its affiliates or to representatives of such entity and its affiliates.

I hereby release from liability and agree to hold harmless any person or entity who or which provides the above described information as authorized herein.

I hereby release from liability and agree to hold harmless all employees, agents and representatives of the above named entity and its affiliates for their acts performed and statements made in connection with obtaining, reviewing, and evaluating my credential and qualifications. I further acknowledge that my cooperation by consenting to the production of such information about me does not guarantee that any of the above named entities or their affiliates will contract with me as provider of services to the insured or enrollees. The determination of whether I am qualified to serve as a provider of services is the reason such information is needed for review and evaluation by the above-named organization and their representatives.

I further agree that a photocopy of this document will serve as a duplicate original.

(Signature)

(Date)

(Print Name)

Northwest Community Health Partners

RELEASE OF INFORMATION AUTHORIZATION

I, _____, hereby authorize the Northwest Community Health Partners (PHO) to release the following information (on a yearly basis), when requested by managed care plans with which whom the PHO contracts:

1. A copy of my Board Certification Letter or Certificate;
2. A copy of my current Medical License;
3. A copy of my current State DEA;
4. A copy of my current Federal DEA;
5. A copy of my current Liability Insurance Face Sheet, **with expiration date.**
6. A copy of my completed Provider Application/Record Form.

This authorization shall be in effect for the duration of the term of my Agreement with Northwest Community Health Partners.

Signature

Date

Print Name

Northwest Community Health Partners APPLICATION CHECKLIST

Good News!!

The PHO no longer requires submission of malpractice loss letters.

Due to time sensitivity of documentation, please do not sign and date all forms until ready to submit. (Provide current copies of licensure)

- _____ \$175 Check/Application Fee – *payable to Northwest Community Hospital*
Submit one check per application - combined checks not accepted
- _____ State of Illinois Form (PHO Application) – data entered/signed & dated
 - New applicants Form: www.idph.state.il.us/about/IDPH_credentiaing_form_97_pro.doc
 - Recredentialing Form: www.idph.state.il.us/about/IDPH_recredentialing_form_97_pro.doc
- _____ Release of Information Form
- _____ Release of Information and Liability Form
- _____ Malpractice Face Sheet – with limits & effective/expiration dates
- _____ State Medical License
- _____ State Controlled Substance License
- _____ Federal DEA License
- _____ Curriculum Vitae
- _____ W-9
- _____ NPI Electronic Confirmation Notice
- _____ Board Certificate/Letter
 - OR – (if not board certified)
- _____ 50 hours of CME credits in area of specialty (50% must be Category 1 credits)
- _____ Include Covering Physician Name(s) on application (see Office Site Info. section of application). ***Covering doctor(s) must also be a member of the PHO and practice in the same specialty.** (Contact PHO for a listing/roster, if needed)
- _____ If applicable, attach Explanation of Gap Form (Include explanation(s) for gaps over 30 days in employment or malpractice coverage.)
- _____ Complete/sign Form A, B, C, D, E, or F as applicable for each occurrence (found within last section of the application)

Please complete all forms in entirety and provide current licensure and documents.

INCOMPLETE APPLICATIONS WILL BE RETURNED.