FIRSTSIGHT VISION SERVICES, INC

FIRSTSIGHT VISION SERVICES, INC.
Credentialing Application

This application requires an **original** signature; *name stamps will not be accepted.* This form must be submitted with ALL questions answered and all blanks completed or if not applicable, marked with "N/A." If additional space is needed, please provide information on a separate sheet and attach.

You have the right to review information submitted in support of your credentialing application.

IDENTIFYING INFORMATION

Last Name	First Name	Middle Name	AKA Name	Degree
Home Address Street	City	Sate	Zip	Home No.
Date of Birth	Birth City, State, and Country			Social Security No.
Male or Female	Ethnic Origin (Optional)	Citizenship		If not US Citizen, Alien Registration #
Foreign Languages Spoken		E-Mail Address		

OFFICE INFORMATION

Group/Corporate Name (if any)					
Primary Office Address	Suite	City	State	Zip	County
Office Phone No.		Fax No.		Answering Service No.	
Office Hours		Primary Contact		Billing Tax ID #	
Second Office Address	Suite	City	State	Zip	County
Office Phone No.		Fax No.		Answering Service No.	
Office Hours		Primary Contact			
Mailing Address	Suite	City	State	Zip	
Home Address	Suite	City	State	Zip	
Payment Name & Address if Different From Above					
Business Name					
Address	Suite	City	State	Zip	
Office No.	Fax No.	Billing Tax ID No.			

SPECIALTY AND CERTIFICATION INFORMATION

Practice Limited to: ______________________________

List you Board Certifications and Practicing Specialties Below:

Name of Board	Specialty	Certified?	Year Certified	Expiration Date

If you are not currently Board certified, have you applied to take the exam? Yes _____ No _____ Exam Date: __________

If not certified, state you intent to become certified and describe the state of your efforts and eligibility, including past efforts, if any:

____

Have you ever failed either the written or oral part of a Board exam or recertification exam? Yes _____ No _____

If yes, please provide details, including exam and date:

____

Have you been recertified? Yes _____ No _____ Recertification not required: _____

If yes, Name of Board:

INSTITUTIONAL AFFLIATIONS

Please list the names of all of the hospitals and surgery centers at which you currently have privilege or staff membership. List primary admitting facility on line 1.

If you do not have admitting rights, who admits patients on your behalf? ______________________________ ______________________________

Provider Name | Provider Phone No.

Current Affiliations

1.		
Primary Hospital/Surgery Center	City/State	
		Yes No
Category/Status	From (M/Y)	Do you have admitting rights?
2.		
Hospital/Surgery Center	City/State	
		Yes No
Category/Status	From (M/Y)	Do you have admitting rights?
3.		
Hospital/Surgery Center	City/State	
		Yes No
Category/Status	From (M/Y)	Do you have admitting rights?

Prior Affiliations

1.	
Hospital/Surgery Center	City/State
Category/Status	From (M/Y)
2.	
Hospital/Surgery Center	City/State
Category/Status	Category/Status

EDUCATION			
UNDERGRADUATE			
College/University Name	City/State	Degree	Date of Graduation (M/Y)
GRADUATE			
College/University Name	City/State	Degree	Date of Graduation (M/Y)
PROFESSIONAL EDUCATION			
Institute/University Name	City/State	Degree	Date of Graduation (M/Y)
Please print your name exactly as it appears on your diploma:			

POSTGRADUATE TRAINING – Include every postgraduate training program, whether or not you completed the program.			
INTERNSHIP			
			Yes No
Training Institution Name	City/State		Was Program Completed?
Specialty		From (mm/dd/yy)	To (mm/dd/yy)
RESIDENCY			
			Yes No
Training Institution Name	City/State		Was Program Completed?
Specialty		From (mm/dd/yy)	To (mm/dd/yy)
RESIDENCY			
			Yes No
Training Institution Name	City/State		Was Program Completed?
Specialty		From (mm/dd/yy)	To (mm/dd/yy)
FELLOWSHIP			
			Yes No
Training Institution Name	City/State		Was Program Completed?
Specialty		From (mm/dd/yy)	To (mm/dd/yy)

PRACTICE INFORMATION			
List Physicians in ON-CALL Group or individuals: ____________________			
Patient Age Limitations, if any:	Minimum _____	Maximum _____	
Patient Gender Limitations, if any:	Female _____	Male _____	Both _____
Are you currently accepting new patients?	Yes _____	No _____	

LICENSING AND CERTIFICATES TO PRESCRIBE

License Type (MD, DO, DDS, etc.)	License Number	License State	Original Licensure Date	Expiration Date

Drug Enforcement Administration Registration	Certificate Number	Expiration Date

State Controlled Substance Registration	Certificate Number	State	Expiration Date

ECFMG Certification or USMLE (If graduated from a Foreign Medical School)

Note: *The following documents must be submitted with this application: Copies of current Board Certification Certificate(s); State Professional License(s); DEA Registration Certificate(s), if applicable; State Controlled Substances Registration Certificate(s), if applicable; and ECFMG/USMLE certificate, if applicable.*

Have you ever failed a state licensing exam, including the SPEX or the FLEX exam? Yes _____ No _____

If yes, provide details: ____

Other State License or Certifications (All Past/Present)

Name of License: ______________________ License Number: ______________________ Expiration Date: ______________________

Name of License: ______________________ License Number: ______________________ Expiration Date: ______________________

Accept Medicare Assignment Yes _____ No_____ Medicare No.: ______________________________

UPIN No. _______________ CLIA No. _______________ Medicaid No. ______________________________

NPI No. _______________ CAQH No. _______________

INSURANCE INFORMATION

Provide names of all carriers used during the past ten years

Insurance Carrier	Policy No.	Name of Insured	Coverage Dates (mm/dd/yy) From	To	Per Occur Limit	Aggregate Limit

PRACTICE HISTORY

Please present your professional work history, starting with the present, including office practice, military experience, and teaching appointments. Use an additional page if needed. Please include work history since graduation from medical/graduate school:

Name of Organization or Office Practice	Military Yes____ No_____		Phone No.		From (M/Y)	To (M/Y)
Mailing Address	City	State	Zip	Country	Position	
Name of Organization or Office Practice	Military Yes____ No_____		Phone No.		From (M/Y)	To (M/Y)
Mailing Address	City	State	Zip	Country	Position	
Name of Organization or Office Practice	Military Yes____ No_____		Phone No.		From (M/Y)	To (M/Y)
Mailing Address	City	State	Zip	Country	Position	

PROFESSIONAL PEER REFERENCES

Please list three peer references (MD: MD; DC:DC, DPM:DPM) with whom you have worked or who have observed your work and can comment on your quality of care and rapport with patients, staff and colleagues. *Do not include relatives, current partners or associates in your practice*.

Name	Address	City	St.	Zip	Phone Number	Fax Number
Name	Address	City	St.	Zip	Phone Number	Fax Number
Name	Address	City	St.	Zip	Phone Number	Fax Number

PERSONAL / PROFESSIONAL INFORMATION

If you answer YES to any of the following questions, please provide a full and objective statement of the details on a separate sheet of paper, including the relevant dates. For purposes of these questions, "Healthcare entity" means any type of entity including the medical staff of any such entity (e.g. hospitals, surgery centers, HMOs); "clinical privileges" means any arrangement under which you are or were authorized by healthcare entity to provide patient care services; "affiliation" means membership, contract employment, or any other type of professional relationship; and "official" means an officer, department or committee chairman, medical director, administrator, or any other individual having the authority to make recommendations or take action regarding your clinical privileges and/or your participation in providing patient care services

PROFESSIONAL LICENSES			
1.	Have you ever been denied a professional license by any state licensing board or agency?	Yes	No
2.	Has your license to practice in any state ever been reduced, suspended, limited, revoked, canceled or otherwise diminished in any manner?	Yes	No
3.	Have you ever voluntarily or involuntarily relinquished your license or agreed to have your license limited, suspended, revoked, canceled, restricted or otherwise diminished in any manner?	Yes	No
4.	Have you ever been the subject of any disciplinary action or proceeding by any licensing or regulatory agency or state board including, but not limited to, reprimands, probation, monitoring (other than routine), limitation of practice or procedures or mandatory second opinions?	Yes	No
5.	Are there any pending actions, proceedings or investigations related to your professional license?	Yes	No
CONTROLLED SUBSTANCES PERMITS AND CERTIFICATES			
6.	Have you ever been denied a state or federal permit or certificate related to controlled substances?	Yes	No
7.	Have any of your permits or certificates related to controlled substances ever been challenged, suspended, limited, revoked, canceled, relinquished, or otherwise diminished in any manner?	Yes	No
8.	Have you ever voluntarily relinquished or agreed to restrictions or limitations upon any permit or certificate related to controlled substances?	Yes	No
9.	Have you ever been the subject of any disciplinary action or proceeding by any state or federal agency responsible for regulating controlled substances?	Yes	No
10.	Are there any pending actions, proceedings or investigations related to your controlled substances permits or certificates?	Yes	No
APPOINTMENTS/CLINICAL PRIVILEGES/MEMBERSHIPS			
11.	Has your membership, staff status, request for clinical privileges, or any other type of affiliation at any healthcare entity ever been voluntary or involuntarily limited, suspended, revoked, not renewed, subjected to probationary condition, reduced, or otherwise diminished, or have proceedings toward any of those ends ever been instituted or recommended by an official, committee, or governing body of any healthcare entity?	Yes	No
12.	Have you ever been denied clinical privileges or affiliation with any healthcare entity, or has any official, committee or governing body of any healthcare entity ever recommended such denial?	Yes	No
13.	Has your request for any specific clinical privilege(s) ever been denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship), or have you ever been placed on probation, concurrent or retrospective review, or been subject to monitoring, mandatory consultations or second opinions (other than for utilization review) by a hospital, healthcare entity, health maintenance organization, preferred provider organization or other managed care organization?	Yes	No
14.	Have you ever voluntarily or involuntarily surrendered any clinical privileges or medical/dental staff memberships?	Yes	No
15.	Has any health maintenance organization, preferred provider organization or other managed care organization ever terminated you as a provider of professional services?	Yes	No
16.	Have you ever failed to re-apply for medical or dental staff appointment or clinical privileges at any hospital or other health care facility?	Yes	No
17.	Have you ever been required to obtain additional education/training as a result of peer review or quality assurance activities?	Yes	No
18.	Are there any pending actions, proceedings or investigations related to any of your medical or dental staff appointments or clinical privileges?	Yes	No
19.	Have you ever been denied membership or renewal in any medical organization, or been subject to disciplinary action in any medical organization?	Yes	No
20.	Are you aware of any actions contemplated or pending against you by any hospital, licensing board, law enforcement agency, managed care organization, or professional group or society that could impact upon the accuracy of your answers to these questions?	Yes	No

SANCTIONS OR NOTICES BY GOVERNMENT THIRD-PARTY PAYORS			
21.	Have you ever been sanctioned/disciplined by a professional standards review organization (PSRO) or by a utilization and quality control peer review organization (PRO)?	Yes	No
22.	Have you ever received a notice of termination or been sanctioned, monitored (excluding random monitoring), or excluded from status as a supplier of services under a Medicare/Medicaid/CHAMPUS/ or government program?	Yes	No
CRIMINAL HISTORY			
23.	Have you ever been prosecuted for or been convicted of a felony or a misdemeanor (excluding minor traffic violations but including driving while intoxicated or under the influence)? Include information related to any deferred adjudication, deferred prosecution or pleas of nolo contendere.	Yes	No
24.	Are any felony or misdemeanor (excluding minor traffic violations but including driving while intoxicated or under the influence) investigations of you currently underway?	Yes	No
25.	Are there any misdemeanor or felony charges (excluding minor traffic violations but including driving while intoxicated or under the influence) currently pending against you?	Yes	No
PROFESSIONAL LIABILITY			
26.	Are there any claims or cases presently filed against you?	Yes	No
27.	Have you ever been denied malpractice coverage or has your coverage ever been limited, reduced or canceled?	Yes	No
28.	Has a claim for professional liability ever been asserted against you that resulted in a lawsuit, judgment or a settlement without judgment (includes any payment made by you or by a malpractice carrier on your behalf)?	Yes	No
29.	Have you ever been the subject of a report to the National Practitioner Data Bank based upon medical malpractice payments, including settlement payments made on your behalf?	Yes	No
HEALTH STATUS			
31.	Are you currently taking any medications that may affect your ability to provide health care services with or without reasonable accommodations?	Yes	No
32.	Are you currently in counseling or treatment or suffer the symptoms of any medical or emotional condition, including, but not limited to alcohol or drug dependence problems or are you currently using any type of illegal substance/drug?	Yes	No
33.	Do you currently have any conditions that could compromise your current ability to perform any of the mental and physical functions, with or without reasonable accommodation, to safely and appropriately provide health care services to enrollees in accord with the participating provider services agreement?	Yes	No
34.	Are you currently using any illegal drug?	Yes	No

COMPLETED APPLICATIONS REQUIRE THE FOLLOWING ITEMS: *(Please indicate which items are attached)*	√ if attached
Copy of current Board of Certification Certificate	☐
Copy of current State License	☐
Copy of current DEA certificate	☐
Copy of ECFMG/USMLE certificate, if applicable	☐
Copy of current CV, including complete work history in M/Y format	☐
Copy of current malpractice insurance coverage declaration sheet, including name of insured and amounts and date of coverage	☐
Copy of State Excess Fund Letter, if applicable	☐
A detailed explanation for each question answered "Yes" in the Personal/Professional and Heath Status sections	☐
Signed and dated Attestation and Release from Liability statement form (stamped signatures will not be accepted)	☐

ATTESTATION AND RELEASE FROM LIABILITY

I, the undersigned Applicant, present the information included on the foregoing pages as part of this credentialing process in the expectation that its confidentiality and privacy will be preserved to the extent permitted by law, and that this information will be released or disclosed only as part of current and future medical peer review, credentialing and quality assurance processes, or otherwise when required by law or by any court or administrative agency.

In order for **Credentials*OnLine*** designated agent for primary source verification of my credentials, to prepare a complete personal credentials portfolio for the evaluation of my credentials, I hereby give permission to **Credentials*OnLine***, agent of FirstSight Vision Services, Inc. to request information regarding my professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) or medical staff or other officials of the hospital(s), or surgery centers at which I currently have or formerly have had staff privileges, professional certification boards, state and federal regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers or contracting entities.

The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I release and agree to hold harmless **Credentials*OnLin***e and its affiliates to which this information is given, and the representatives, employees and agents of each of them, from any and all liability for any damages, costs and expenses which may result from the gathering or use of such information, so long as such release or use of information is done in good faith and without malice.

I hereby authorize the educational facilities, the chief(s) of the clinical department(s) or medical staff or other officials of the hospital(s) or surgery center(s) at which I currently have or formerly have had staff privileges, professional certification boards, state and federal regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers or contracting entities to submit information requested by **Credentials*OnLin***e on behalf of FirstSight including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and lawsuit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I hereby further release and agree to hold harmless all such entities, their representatives, employees and agents from any and all liability for any damages which may result from providing this information as long as such information is released in good faith and without malice.

Any release of liability above is in addition to, not in limitation of, any limitations of liability or immunities available under applicable state or federal law.

I agree that a photocopy or facsimile of this document with my signature may be accepted by any entity or person from which information is sought, with the same authority as the original, and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I understand that I have the right to review and correct erroneous information that I personally submitted with my application, via the organization for which I am applying for participation and/or privileges, in support of my request. I further understand that information submitted by outside primary sources is considered peer review protected and may not be reviewed.

I represent that the information provided in or attached to this application is accurate and complete. I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application by FirstSight. I further understand that any misrepresentation, misstatement or omission from this Application, if discovered after staff privileges or network participation has been awarded to me, may lead to immediate suspension or termination of those privileges or network participation. I agree to inform the organization to which I am applying for participation and/or privileges in writing within 15 days (15 days from the notice to the applicant) if there is any change in any information provided or the answers to questions on the Application as a result of any occurrence subsequent to my signing this Application.

______________________________________ ____________________________
Signature *(stamped signatures are unacceptable)* **Date**

____
Please print name