



**PHYSICIAN  RE-CREDENTIALING FORM**

Practice Name: \_\_\_\_\_  
 Practice Tax ID: \_\_\_\_\_

Physician Name: \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_ NPI: \_\_\_\_\_

Board Certification \_\_\_\_\_ Certified  Eligible  Other \_\_\_\_\_

I would like a secondary specialty to appear on the website \_\_\_\_\_

Hospital Privilege at: \_\_\_\_\_  Active  Courtesy  Other

\_\_\_\_\_  Active  Courtesy  Other

\_\_\_\_\_  Active  Courtesy  Other

**Instructions:** Please answer the following sections. If you answer "Yes" to any question, reference in the space provided or on a separate sheet, giving full details and attach.

**Have any of the following in the last 2 years been, or are they currently in the process of being, denied, revoked, not renewed, suspended, limited, restricted, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state?**

	Yes	No
1) Medical or professional license	<input type="checkbox"/>	<input type="checkbox"/>
2) DEA or CDS/BNDD registration	<input type="checkbox"/>	<input type="checkbox"/>
3) Hospital medical staff membership	<input type="checkbox"/>	<input type="checkbox"/>
4) Clinical privileges or other rights on any hospital medical staff	<input type="checkbox"/>	<input type="checkbox"/>
5) Employment by any hospital, institution or the military	<input type="checkbox"/>	<input type="checkbox"/>
6) Professional society memberships	<input type="checkbox"/>	<input type="checkbox"/>
7) Participation in private, federal or state health insurance (i.e. Medicare, Medicaid)	<input type="checkbox"/>	<input type="checkbox"/>
8) Participation in an HMO, PPO or any other managed care organization	<input type="checkbox"/>	<input type="checkbox"/>
9) Board Certification	<input type="checkbox"/>	<input type="checkbox"/>

**At any time, have you ever been**

	Yes	No
10) Convicted of a criminal offense	<input type="checkbox"/>	<input type="checkbox"/>
11) Convicted of a felony	<input type="checkbox"/>	<input type="checkbox"/>
12) Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of trial, or an accelerated rehabilitation disposition in the disposition of felony charges in any state, territory or country	<input type="checkbox"/>	<input type="checkbox"/>

**Have you ever at any time or are you currently**

	Yes	No
13) Under indictment for any crime	<input type="checkbox"/>	<input type="checkbox"/>
14) The subject of an investigation by any private, federal or state health insurance program or state licensing board	<input type="checkbox"/>	<input type="checkbox"/>
15) Under investigation by any state licensing board or federal agency	<input type="checkbox"/>	<input type="checkbox"/>
16) The subject of any adverse action reports to a state or federal databank	<input type="checkbox"/>	<input type="checkbox"/>

**Have you ever either voluntarily or involuntarily**

	Yes	No
17) Withdrawn your application for medical staff membership at any facility	<input type="checkbox"/>	<input type="checkbox"/>
18) Withdrawn your request for any clinical privileges at any facility	<input type="checkbox"/>	<input type="checkbox"/>

**Health Status**

	Yes	No
19) Are you able to perform the professional duties of the position with or without reasonable accommodation? (A "Yes" answer does not require additional documentation)	<input type="checkbox"/>	<input type="checkbox"/>
20) Are you currently using illegal substances or illegally using substances?	<input type="checkbox"/>	<input type="checkbox"/>

**Professional Liability History. In the past 2 years -**

	Yes	No
21) Has your liability insurance ever been canceled or denied?	<input type="checkbox"/>	<input type="checkbox"/>
22) Do you have any malpractice judgments against you including arbitration?	<input type="checkbox"/>	<input type="checkbox"/>
23) Have you had any claim settlements not involving litigation or arbitration paid by you or on your behalf?	<input type="checkbox"/>	<input type="checkbox"/>
24) Are you now a defendant in a pending malpractice suit?	<input type="checkbox"/>	<input type="checkbox"/>

**If you answered "Yes" to any question (except 19) please provide the following for each case –**

Date of occurrence of alleged malpractice \_\_\_\_\_ Plaintiff name \_\_\_\_\_  
Name of insurer involved \_\_\_\_\_  
Status of Case \_\_\_\_\_ You were  Primary Defendant  Codefendant  
The case is:  Pending  Found for Plaintiff  Found for Defendant  Dismissed  
 Settled (Give amount \_\_\_\_\_) Relationship to Patient \_\_\_\_\_  
Alleged harm to Patient \_\_\_\_\_  
Circumstances of Patient's Illness \_\_\_\_\_  
Any other Pertinent Details \_\_\_\_\_

**Please attach copies of the following:**  Current State License(s)  Current DEA Certification  
 Evidence of Board Certification or Eligibility  Proof of Liability Insurance Coverage  Signed Authorization for Release of Information (found at [www.ehpservices.com](http://www.ehpservices.com) Provider Forms)

By signing below you: 1) represent and warrant that all information provided herein is complete and accurate to the best of your knowledge and belief; 2) understand Significa should be promptly informed of any material change in this information as it occurs, whether before or after you enter into an agreement with Significa for provision of services; 3) understand that any misstatement in this application may constitute grounds for denial or for summary dismissal; and, 4) agree your signature on this form when communicated by facsimile transmission or as a scanned document sent via email shall be binding if transmitted in either fashion with electronically reproduced signatures treated as original.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please send completed form to: Manager of Credentialing, Significa Benefit Services  
PO Box 8737  
Lancaster, PA 17604-8737

Fax 717-399-1693 or email scanned document(s) to [providerrelations@ehpservices.com](mailto:providerrelations@ehpservices.com)