NorthCare Network is a regional entity formed under Section 1204b of the Michigan Mental Health Code. The Network includes five Member CMHSPs: Copper Country Mental Health Authority, Gogebic County Community Mental Health Authority, Hiawatha Behavioral Health, Northpointe Behavioral Healthcare Systems, and Pathways Community Mental Health Authority.

INDIVIDUAL PRACTITIONER / INDIVIDUAL CONTRACT PROVIDER CREDENTIALING & RECREDENTIALING APPLICATION

INSTRUCTIONS: Individual Practitioners/Individual Contract Providers seeking authorization to practice in the NorthCare Provider Network will complete this application in full. Print or type all responses. Attach additional sheets if there is insufficient space on this form for your response.

I wish to apply for the provider panel of:

☐ Copper Country CMH – www.cccmh.org; 901 W. Memorial Dr., Houghton, MI 49931
☐ Gogebic CMHSP Authority – www.gccmh.org; 103 West U.S. 2, Wakefield, MI 49968
☐ Hiawatha Behavioral Health – www.hbhcmh.org; 125 N. Lake St., Manistique, MI 49854
☐ Northpointe Behavioral Healthcare System – www.nbhs.org; 715 Pyle Dr., Kingsford, MI 49802
☐ Pathways CMHSP – www.up-pathways.org; 200 W. Spring St., Marquette, MI 49855
☐ NorthCare Network – www.northcare-up.org; 200 W. Spring St., Suite 2, Marquette, MI 49855

Name	
Any other name(s) by which you have been known	
Citizenship:	

LICENSING/CERTIFICATION: (Attach copies)
List all past and present professional licenses/certifications. Please attach valid certification of all licenses and certifications.

Type of Licensure/ Certification	
Michigan License #	
Expiration Date	
Other Jurisdiction # -include name of state or jurisdiction	
Expiration Date	
Type of Licensure/ Certification	
Michigan License #	
Expiration Date	
Other Jurisdiction # -include name of state or jurisdiction	
Expiration Date	
Type of Licensure/ Certification	
Michigan License #	
Other Jurisdiction # -include name of state or jurisdiction	
Expiration Date	

PHYSICIANS, NURSE PRACTITIONERS, PHYSICIAN'S ASSISTANTS:

DEA Registration #	
Expiration Date	
Michigan Controlled Substance #	
Supervising MD,DO Michigan Controlled Substance # (if NP or PA)	
Expiration Date	
USMLE exam (if foreign graduate)-attach copies of report cards for Step I,2,3& Clinical Skills Assessment	
ECFMG# (if foreign graduate)-attach copy	
Expiration Date	
Nurse Practitioner Certification Exam(attach copy)	
Physician's Assistant Certification Exam(attach copy)	

BOARD CERTIFICATION:

List all present and past specialty Board certifications. Please attach valid verification of all licenses and certifications, including an original letter of verification from the conferring body.

Name of Board: _____Date Certified: _____Date(s) Re-certified: _____

Name of Board: _____Date Certified: _____Date(s) Re-certified: _____

Have you ever taken and failed a certification examination? Yes No If yes, please provide explanation on separate sheet.

PROFESSIONAL LIABILITY COVERAGE:

Attach a copy of your certificate of insurance. (If an employee of CMHSP or NorthCare this is not required)

MINIMUM COVERAGE - $1,000,000 per occurrence; $3,000,000 aggregate

Insurance Carrier	
Address	
Duration Period	
Amount of Coverage	
Insurance Carrier	
Address	
Duration Period	
Amount of Coverage	

EDUCATIONAL BACKGROUND*

Undergraduate Education

College/University	
Address	
Dates Attended	
Degree Received	
College/University	
Address	
Dates Attended	
Degree Received	

Clinical Graduate Education

College/University	
Address	
Dates Attended	
Degree Received	

Medical Education/Advanced Education

College/University	
Address	
Dates Attended	
Degree Received	

Internship/Practicum/Residency/Fellowship/Field Placement

Type	
Placement Setting	
Address	
Dates Attended	
Contact Person	
Type	
Placement Setting	
Address	
Dates Attended	
Contact Person	
Type	
Placement Setting	
Address	
Dates Attended	
Contact Person	
Type	
Placement Setting	
Address	
Dates Attended	
Contact Person	
Type	
Placement Setting	
Address	
Dates Attended	
Contact Person	

**By signing this application, primary verification of education in the form of an official transcript issued by the institution conferring your most advanced degree will be obtained by the Provider.*

PROFESSIONAL WORK EXPERIENCE:

All applicants must attach a current resume with educational and professional work experience.

Have you been practicing continuously since obtaining your professional license? Yes ☐ No ☐

If No, please explain.

Physicians Only: HOSPITAL AFFILIATIONS

Hospital Name	
Address	
Dates of Affiliation	
Category of Membership	
Hospital Name	
Address	
Dates of Affiliation	
Category of Membership	
Hospital Name	
Address	
Dates of Affiliation	
Category of Membership	

PROFESSIONAL CLINICAL REFERENCES: *Necessary for Initial Credentialing only*

List two (2) professional clinical references that have personal knowledge of your clinical abilities in a health care organization/capacity. One (1) professional reference must be someone who provided direct supervision.

Name	
Organization/Title	
Address	
Contact Number	
Dates of Affiliation	
Name	
Organization/Title	
Address	
Contact Number	
Dates of Affiliation	

DISCLOSURE QUESTIONS	Yes	No
Has your professional license or certification to practice in your profession ever been denied, suspended or restricted?	☐	☐
Have you ever been subject to a fine, reprimand or limitations by any state of professional licensing, registration or certification board?	☐	☐
Has your Federal DEA and/ or your State Controlled Dangerous Substance certificates or authorizations ever been challenged, denied, suspended, restricted, revoked, or denied renewal?	☐	☐
Have you ever been disciplined, excluded from, debarred, suspended reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid programs, or in regard to other federal or state governmental health plans or programs or state licensing Boards within the past 5 years or since last credentialed?	☐	☐
Are you presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or PIHP?	☐	☐
Have you, within a three-year period preceding this agreement, been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property?	☐	☐
Are you presently indicted or otherwise criminally or civilly charged by a government entity (federal, state or local) with commission of a felony charge of any of the offenses enumerated in the above section?	☐	☐
Have you, within a three-year period preceding this agreement, had one or more public transactions (federal, state or local) terminated for cause or default.	☐	☐
Have you ever had professional liability insurance denied, canceled, issued on special terms or renewal refused?	☐	☐
Do you have a history of professional liability claims?	☐	☐
Have there been, or are there currently pending, any malpractice claims, suits, settlements, or arbitration proceedings involving your professional practice within the past 5 years?	☐	☐
Have your clinical privileges or medical staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affect) or have proceedings toward any of those ends been instituted or recommended by any hospital, healthcare institution or medical staff, committee or governing board?	☐	☐
Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action by any managed care organizations including HMOs, PPOs or provider organizations such as IPAs and PHOs?	☐	☐
If you answered yes to any of the above questions you must include an explanation. If you have a history of professional liability claims attach complete history (attach an additional sheet if necessary):		

CRIMINAL HISTORY	Yes	No
In the last ten- (10) years have you been convicted of a felony criminal offense?	☐	☐
In the last ten- (10) year have you pled guilty to any felony criminal charges?	☐	☐
Are there any felony criminal charges currently pending against you?	☐	☐
In the last ten- (10) years have you been charged with offenses of a sexual nature?	☐	☐
If you answered yes to any of the above, please explain the nature of the charges, relevant dates, and how the matter was disposed (attach an additional sheet if necessary):		

MENTAL AND PHYSICAL HEALTH	YES	NO
Do you presently have a physical or mental health condition, including alcohol/drug dependence, which would affect your ability to provide professional or medical staff duties as requested/required?	☐	☐
Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify that the use of drugs may have an ongoing impact and that it has occurred recently enough to indicate the individual is actively engaged in such conduct.)	☐	☐
Do you have any reason to believe that you would pose a risk to the safety or the wellbeing of individuals served?	☐	☐
Are you unable to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation?	☐	☐
If you answered yes to any of the above questions you must include an explanation. (attach an additional sheet if necessary):		

ACKNOWLEDGEMENT & AGREEMENT

In making this application, I agree to the following:

1. I have been informed the applicable policies and procedures of the organization in force at the time of my application are available at the respective website noted on the first page of this application and I agree to be bound by the terms thereof in all matters relating to consideration of my application.
2. I am aware of my rights as an applicant to be informed about the status of my application; my right to submit additional material if there are questions regarding the application; and my appeal rights of a negative decision by the Credentialing Committee.
3. I hereby declare that I shall not engage in the practice of the division of fees under any guise whatsoever. In complying with this principle, I understand that I am not to collect fees for others referring customers to me, nor permit others to collect fees for me, nor permit any agent or associate of mine to do so.
4. I acknowledge my obligation to provide continuous care and supervision to all individuals for whom I have responsibility and that I will seek clinical consultation whenever necessary and as directed by applicable policies and procedures.
5. I acknowledge the ongoing responsibility to notify the agency in a timely manner of any adverse change in licensure or certification status. I understand this is to be done as soon as I am aware or should have been aware of the change.
6. I am willing to appear for personal interviews, as requested, with regard to my application.

I understand that failure to comply with the agreements specified above or providing inaccurate, incorrect or withholding information on this application will automatically terminate my appointment.

I realize that certification of my credentials and/or license does not necessarily qualify me to perform certain clinical or medical procedures/treatment modalities without the written consent of the Credentialing Committee(s).

I understand the respective Credentialing Committee(s), or designee shall review all applications for inclusion on the provider panel. Further, I understand that as an employee or contract provider, my participation must have final approval of the NorthCare Credentialing Committee.

I understand that this application is not an employment application, and that it does not create an employment relationship or any co-employment relationship.

By signing this, I attest that the information provided within the application is complete and accurate to my knowledge. All information submitted by me in this application is warranted to be true, correct and complete. I give consent for the verification of the information provided in this application.

_____ _____

Signature of Applicant Date

RELEASE OF INFORMATION

I fully understand that if any matter stated in this application is or becomes false, it will be considered a material breach and my provider agreement will be terminated. All information submitted by me in this application is warranted to be true, correct and complete. I authorize Credentialing staff to verify the information contained within the Credentialing application.

I authorize Credentialing staff to consult with the National Practitioners Data Bank, state licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, Educational Council for Foreign Medical Graduates, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competence, character, moral and ethical qualifications, and I also authorize all of them to release such information to authorized Credentialing staff. I release NorthCare and its employees and all those with whom NorthCare contracts, from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____