Molina Healthcare of Wisconsin, Inc.
Practitioner Application

1. INSTRUCTIONS

This form should be:

- **Typed or legibly printed in black or blue ink.**
- Keep a copy of the application on file for future requests.
- If more space is needed than provided on original, attach additional sheets and reference the question being answered.
- *Please do not use abbreviations*.
- If a section does not apply to you, please check the provided box at the top of the section.
- If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- **Please sign and date page 12**

Please attach c**urrent copies of the following documents with this application:**

- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

**** All sections must be completed in their entirety. ****

2. PRACTITIONER INFORMATION

Last Name: (include suffix; Jr., Sr., III)	First:	Middle:	Degree(s):
List any other name(s) under which you have been known by reference, licensing and or educational institutions:			
Home Mailing Address:	City:	State:	Zip Code:
Home Telephone Number: ( )	Pager Number/Cell Phone Number: ( )	E-Mail Address:	
Birth Date: (mm/dd/yyyy)	Birth Place (city, state, country):	Citizenship:	
Social Security Number	☐ Male ☐ Female	Languages spoken by Practitioner	
NPI:	Medicaid Number:	Medicare Number:	
Primary Practicing Specialty:	Other specialties:		
Other Professional Interests in Practice, Research, etc.:			

PRACTITIONER NAME:_____

3. PRIMARY PRACTICE INFORMATION

Effective Date at Primary Practice location (MM/YY) _____

Practice Type (Please check all that apply)	**Accepting New Patients?**
☐PCP ☐Specialist ☐Urgent Care ☐Obstetrics ☐PCP and Obstetrics	☐Yes ☐No
Practice Setting	**Practice Limitations? (e.g. 18 years or older?)**
☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐Other _____	☐Yes ☐No If yes, please explain:

Name of Practice / Affiliation or Clinic Name:	Department Name (if hospital based):	
Primary Office Street Address:	City:	
	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	
Mailing Address: (if different from above)		
Billing Address: (if different from above)		Taxonomy Code:
Office Manager / Administrator Name:	Administration Telephone Number: ( )	
E-mail Address:	Fax Number: ( )	
Credentialing Contact (if different from above):	Telephone Number: ( )	
E-mail Address:	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Please list languages spoken by office staff:		
Office Hours: Mon: _____ Tue: _____ Wed: _____ Thu: _____ Fri: _____ Sat: _____ Sun: _____		

Covering Providers/Call Group **Does Not Apply** ☐

Do you provide 24-hour, after-hours coverage for patients in case of emergency? ☐Yes ☐No

If **no**, please explain how your patients obtain advice and care after hours: _____

_____

Covering Provider Name & Degree	Specialty	Address	Phone Number

PRACTITIONER NAME:_____

4. ADDITIONAL PRACTICE INFORMATION

*****Please make a copy of this page and complete for each additional location in which you practice**

Practice Type (Please check all that apply)	**Accepting New Patients?**
☐PCP ☐Specialist ☐Urgent Care ☐Obstetrics ☐PCP and Obstetrics	☐Yes ☐No
Practice Setting	**Practice Limitations? (e.g. 18 years or older?)**
☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐Other _____	☐Yes ☐No If yes, please explain:

Name of Secondary Practice / Affiliation or Clinic Name:	Department Name (if hospital based):	
Primary Office Street Address:	City:	
	State:	Zip Code:
Patient Appointment Telephone Number: ( )	Fax Number: ( )	
Mailing Address: (if different from above)		
Billing Address: (if different from above)		
Office Manager / Administrator Name:	Administration Telephone Number: ( )	
E-mail Address:	Fax Number: ( )	
Credentialing Contact (if different from above):	Telephone Number: ( )	
E-mail Address:	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Please list languages spoken by office staff:		
Office Hours: Mon: _____ Tue: _____ Wed: _____ Thu: _____ Fri: _____ Sat: _____ Sun: _____		

Covering Providers/Call Group **Does Not Apply** ☐

Do you provide 24-hour, after-hours coverage for patients in case of emergency? ☐Yes ☐No

If no, please explain how your patients obtain advice and care after hours: _____

_____

Covering Provider Name & Degree	Specialty	Address	Phone Number

PRACTITIONER NAME:_____

5. PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS

(Attach Additional Sheet if Necessary)

State Professional License/Registration/Cert Number:	Issue Date:	Expiration Date:
Name of Sponsor if required by licensure, (e.g. Physician's Assistant).		
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued:

6. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS

State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:

7. UNDERGRADUATE EDUCATION (*Do not abbreviate*)

Does Not Apply ☐

College or University Name:	Degree Received(be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:
College or University Name:	Degree Received(be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:

8. MEDICAL/PROFESSIONAL EDUCATION (*Do not abbreviate*)

Does Not Apply ☐

Medical/Professional School:	Start Date: (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:
Medical/Professional School:	Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:

9. MASTER DEGREE PROGRAM OR POST GRADUATE EDUCATION

Does Not Apply ☐

Institution:	Address	City	State	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Program or Course of Study:	Faculty Director:		

PRACTITIONER NAME:_____

10. INTERNSHIP/PGYI (Attach Additional Sheet if Necessary)			Does Not Apply ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Internship:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

11. RESIDENCIES (Attach Additional Sheet if Necessary)			Does Not Apply ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

12. FELLOWSHIPS (Attach Additional Sheet if Necessary)			Does Not Apply ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

13. BOARD CERTIFICATION — Does Not Apply ☐

Are you board or otherwise professionally certified?

☐ **Yes** If "Yes", please complete below: ☐ **No** If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.

Issuing Board/Entity and State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)

Have you applied for certification other than those indicated above? ☐ Yes ☐ No

If so, list certification and date:

If you participate in a specialty which does not have board certification, please indicate specialty:

14. PROFESSIONAL AFFILIATIONS (*Do not abbreviate*) — Does Not Apply ☐

Please List Membership In All Professional Societies Complete Name of Society:	Date Joined	Current Member
	/ / .	☐ YES ☐ NO
	/ / .	☐ YES ☐ NO

15. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (e.g., Fluoroscopy, Radiography, etc.) (Attach Certificate if Applicable)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

16. HOSPITAL AFFILIATIONS — Does Not Apply ☐

Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) have current affiliations, (B) applications in process, (C) previous hospital affiliations, (D) in-patient coverage plan **(for those without admitting privileges).** List only affiliations here, list employment in section XVI, Work History.

A. CURRENT HOSPITAL AFFILIATIONS (*Do not abbreviate*)

Name of **Primary** Admitting Hospital:	Department:
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:

Can you admit / follow patients at this hospital? ☐Yes ☐ No

Name of **Secondary** Admitting Hospital:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:

PRACTITIONER NAME:_____

Status:	Appointment Date:
Can you admit / follow patients at this hospital? ☐Yes ☐ No	
Name of **Other** Institutions:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date:
Can you admit / follow patients at this hospital? ☐Yes ☐ No	

B. HOSPITAL APPLICATIONS IN PROCESS (*Do not abbreviate*)

Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:

D. INPATIENT COVERAGE PLAN (for those without admitting privileges)	**Does Not Apply** ☐
Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

18. WORK HISTORY (*Do not abbreviate*)

Chronologically list the most recent 5 years of work history. (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient.

Name of Current Practice / Employer:	Contact Name:			Telephone Number: ( )	
	Email:			Fax Number: ( )	
Mailing Address	City:	State:	Zip:	From (mm/yyyy)	To (mm/yyyy)
Name of Practice / Employer:	Contact Name:			Telephone Number: ( )	
Reason for Leaving:	Email:			Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):
Name of Practice / Employer:	Contact Name:			Telephone Number: ( )	
Reason for Leaving:	Email:			Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

PRACTITIONER NAME:_____

Name of Practice / Employer:	Contact Name:			Telephone Number: ( )	
Reason for Leaving:	Email:			Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

19. Please account for all gaps between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable:

	From (mm/yyyy):	To (mm/yyyy):

20. PEER REFERENCES

List at least **two** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. If you have been out of residency for a period of less than three years, one reference must be from the Program Director. Allied Health Provider must provide at least one reference from the same discipline.

Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	

21. PROFESSIONAL LIABILITY (*Do not abbreviate*)

A. CURRENT INSURANCE CARRIER:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: $	Aggregate amount: $	Date Began:	Expiration Date:

PRACTITIONER NAME:_____

22. PRACTITIONER ATTESTATION QUESTIONS - *To be completed by the practitioner*

(Answer all questions. For any "YES" response, provide an explanation in the Supplemental Disclosure section at the bottom of page 10.)

LICENSURE			
1.	Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?	YES ☐	NO☐
2.	Has there been any challenge to your licensure, registration or certification?*	YES ☐	NO☐
HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS			
3.	Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*	YES ☐	NO☐
4.	Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*	YES ☐	NO☐
5.	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, PHOs)?*	YES ☐	NO☐
EDUCATION, TRAINING AND BOARD CERTIFICATION			
6.	Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*	YES ☐	NO☐
7.	Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*	YES ☐	NO☐
8.	Have any of your board certifications or eligibility ever been revoked?*	YES ☐	NO☐
9.	Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*	YES ☐	NO☐
DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION			
10.	Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*	YES ☐	NO☐
MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION			
11.	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 program, or in regard to other federal or state governmental healthcare plans or programs?*	YES ☐	NO☐
OTHER SANCTIONS OR INVESTIGATIONS			
12.	Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*	YES ☐	NO☐
13.	To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*	YES ☐	NO☐
14.	Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*	YES ☐	NO☐
15.	Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*	YES ☐	NO☐
16.	Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*	YES ☐	NO☐
PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY			
17.	Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*	YES ☐	NO☐

PRACTITIONER NAME:_____

18.	Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*	YES ☐	NO☐
MALPRACTICE CLAIMS HISTORY			
19.	Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?* If yes, provide information for each case.	YES ☐	NO☐
CRIMINAL/CIVIL HISTORY			
20.	Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*	YES ☐	NO☐
21.	In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*	YES ☐	NO☐
22.	Are there any such claims being asserted against you now?	YES ☐	NO☐
ABILITY TO PERFORM JOB			
23.	Are you currently engaged in the illegal use of drugs?* ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)	YES ☐	NO☐
24.	Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*	YES ☐	NO☐
25.	Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*	YES ☐	NO☐
26.	Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*	YES ☐	NO☐

22. Supplemental Disclosure

Does Not Apply ☐

Provide detailed explanations for any "YES" answers from Section 22 "Practitioner Attestation Questions"

Question #:_____

Explanation:

Question #:_____

Explanation:

Question #:_____

Explanation:

Question #:_____

Explanation:

PRACTITIONER NAME:_____

23. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL

Does Not Apply ☐

Practitioner Name:(print or type)

Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected PHI. Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.

Date and clinical details of the incident, with preceding events:
Date: Details:

Your role and specific responsibility in the incident:

Subsequent events, including patient's clinical outcome:

Date suit or claim was filed:

Name and Address of Insurance Carrier that handled the claim:

Your status in the legal action (primary defendant, co-defendant, other):

Current status of suit or other action:

Date of settlement, judgment, or dismissal:

If case was settled out-of-court, or with a judgment, settlement amount attributed to you? **$**

24. ATTESTATION AND RELEASE OF INFORMATION FORM

Modifications Will Not Be Accepted

By submitting this authorization and release of information form, I understand and agree as follows:

I understand and acknowledge that, as an applicant for participating status with Molina Healthcare of Wisconsin, Inc. for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications.

I further understand and acknowledge that Molina Healthcare of Wisconsin, Inc. or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of Molina Healthcare of Wisconsin, Inc. as part of the verification and credentialing process.

I authorize all individuals, institutions and entities of organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to Molina Healthcare of Wisconsin, Inc., their staffs and agents.

I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of Molina Healthcare of Wisconsin, Inc. or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.

I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations and policies of Molina Healthcare of Wisconsin, Inc.

I agree to abide by the policies, procedures, and or contractual agreements of Molina Healthcare of Wisconsin, Inc. from whom I am seeking initial or recredentialing.

I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of Molina Healthcare of Wisconsin, Inc. where I have membership and/or participation status before initiating judicial action.

I understand that completion and submission of this application/Attestation/Authorization and Release does not automatically grant me membership or participating status with Molina Healthcare of Wisconsin, Inc.

I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

ATTESTATION/RELEASE FORM
I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here: _____

Signature: _____

(Stamped signature is not acceptable)

Date: _____

PRACTITIONER NAME:_____