

Applicant's Name:	Degree:				
Mailing Address: Is this: ___ Work ___ Home					
Phone Number:	Work:				Home:
Fax Number:	Work:				Home:
Cell Phone/Pager:	Cell Phone:				Pager:
E-mail Address:					Connection Type: ___ High Speed ___ Dial Up
Contact Person in your office to confirm receipt of faxes and give status reports.	Name:	Phone:			Extension:
	Office Title:				
Tax I.D. # or Social Security # (Must be provided to be reimbursed) Name of Corporation if used for reimbursement					
Professional License(s): Please list ALL states in which you HAVE BEEN licensed, the license number and expiration date. Also, please submit a copy of your Medical License Certificate for EACH state in which you are currently licensed.	State	License #	Expiration Date	Active	Inactive
	1. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
	2. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
	3. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
	4. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
	<i>If more, please submit on separate page and attach to the application</i>				
Appeal level Reviewers must be Board Certified. (M.D.'s / D.O.'s must be certified by ABMS or ABOS) Please list ALL specialties in which you are Board Certified and submit a copy of your Board Certification for each specialty.	Specialty	Board Certified?	Board Eligible?	Name of Board:	Expiration Date:
	1. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____	_____
	2. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____	_____
	3. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____	_____
	4. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____	_____
Major Professional Activity (<u>focus</u> within your specialty)	Age Groups: <input type="checkbox"/> Adult <input type="checkbox"/> Pediatric <input type="checkbox"/> Teen				
	Anatomical Specialties: _____				
	Treatment Specialties (i.e. arthritis, joint replacement): _____				
Briefly name your professional achievements (suitable for including in a summary of experience)					
Some States require Reviewers to be in active practice a minimum number of hours per week. IMPORTANT – Please answer <u>all</u> portions of these three questions.	1) Do you regularly treat patients in a clinical setting? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ # hours per week				
	2) What other activity do you engage in that you consider "active practice": _____ # hours per week _____				
	3) Have you had a minimum of 5 years experience providing health care? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Organizations for which you currently provide utilization review services:					
List any areas which may pose a conflict of interest for you in the performance of reviews for PRN:					

Participating Reviewer Application (Physicians), Page 2 of 3

Are there any past, present or pending actions against your professional license? <u>Include:</u> Malpractice Suits, Investigations of Wrongdoing, Disciplinary Actions such as Reprimands, Probation, License Limitations, Suspensions or Revocations, Fines or Penalties	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please provide a full explanation on Page 3 and attach copies of any legal documents related to the incident(s), including but not limited to the initial complaint or charges, findings and orders.
Have you ever been convicted of a felony?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide an explanation on a separate sheet.
Hospital Affiliation(s)	Name Address Medical Staff Status
Professional Reference #1: References must currently not be related to you by family or current/pending professional partnership/financial arrangement (Not an Associate.)	Name: _____ Specialty: _____ Phone _____ Street Address: _____ City State, Zip: _____
Professional Reference #2:	Name: _____ Specialty: _____ Phone _____ Street Address: _____ City State, Zip: _____

Please mail or fax your completed application with copies of the following documents to the Credentialing Department. To expedite processing of your application, please fax all documents to: (602) 944-2028.

1. Curriculum Vitae (Work History for past 5 years in month/year to month/year format. Please explain any gaps in excess of 6 months)
2. Medical or Professional License(s) for all states in which you are licensed
3. Board Certification(s) for all specialties in which you are board certified

NOTICE: You have the right, upon request, to review information we have obtained to evaluate your credentialing application, attestation or CV. You also have the right to correct erroneous information and to receive the status of your credentialing or re-credentialing application upon request.. For further details regarding your rights please refer to the separate Physician Orientation Manual, under the heading: "Reviewer Rights".

CERTIFICATION - By signing below, I certify/attest to the following:

- 1) No physical, mental, or substance abuse problems exist that could, without reasonable accommodation, affect my professional judgment or impede my ability to participate in utilization review activities.
- 2) That Physicians' Review Network is authorized to investigate and evaluate my application, and consult with any person, organization, or entity that has, or could have, any information, data, or documents regarding my background, competence and credentials.
- 3) That any individual, organization or entity providing information regarding my background, competence and credentials is authorized to release such information to Physicians' Review Network and I release from liability Physicians Review Network and any individual, organization or entity for any act or omission related to the collection or release of information provided in good faith.
- 4) That the information contained in this application and supporting documents is true, complete, and accurate to the best of my knowledge.

DATE: _____

Reviewer Signature (Will be used as electronic signature, Please stay within box)

Revised 02/2011

CONFIDENTIAL INFORMATION REPORT

If you answered “Yes” to the question on page 2 regarding past or present actions against your professional license, please copy and complete the following form for each incident reported. Please attach any legal documents available. *PLEASE PRINT*

Month / Year of Incident _____ County/State Recorded _____

Summary describing nature of incident (complaint, allegation) _____

What was your response to the allegation(s)? _____

Disposition of Claim: Dropped Dismissed Pending Settled, Amount: _____

With prejudice Without prejudice

Verdict for you, Amount: _____ Verdict for plaintiff, Amount: _____

Reviewer Signature: _____ **Date:** _____