GREAT FALLS PHYSICIANS

Dear Provider,

Great Falls Physicians IPA (GFMD) would like to invite you to participate in our growing network of Central Montana independent medical professionals. We work with employers throughout the state to assist your patients in maximizing their health benefit dollars, as more patients have benefit incentives for using network providers.

GFMD offers many benefits to our member physicians: reduced malpractice insurance costs and access to legal and managed care consultants. GFMD IPA has also developed a Physician Hospital Organization with Benefis. Currently this PHO offers a Preferred Provider Organization (PPO) called Treasure State Healthcare Network to community employers.

There are two types of memberships available in GFMD IPA. A full membership fee is $3000 and allows full voting privileges to the member. An Associate membership is $800 and does not provide voting privileges, however the Associate member is entitled full access to all GFMD programs and other membership benefits.

For credentialing purposes we will require the following items returned to our office for all providers.

1. **Completed GFMD application**
2. **Copy of Insurance Certificate.**
3. **Curriculum Vitae or Resume**

We hope that you are interested in becoming a member of Great Falls Physicians IPA. If you have any questions, please call our office at (406) 756-8617.

Sincerely,

Kelli D. Meuchel
Executive Officer
GFMD, IPA

GREAT FALLS PHYSICIANS

GREAT FALLS PHYSICIANS IPA
APPLICATION FORM

REQUIRED DOCUMENTS: APPLICATION, RESUME, MALPRACTICE CERT.

PERSONAL IDENTIFICATION DATA

Last Name | First Name | Initial | Professional Degree

Address of Office | City | State | Zip | (____)_____ Telephone

Office Hours | Monday | Tuesday | Wednesday | Thursday | Friday

Residence Address | City | State | Zip | Telephone

Birthdate | Birthplace | Citizenship | If not a citizen of the US, please indicate the status of your visa at the present time.

Are you applying to Great Falls Physicians IPA as a member of a medical group or as a partner to a current GFMD IPA member? If so, please identify:

_____ _____
Group Name/GFMD IPA Member Name | Telephone Number

MEDICAL SPECIALTIES:

	BOARD CERTIFIED (circle one)	American Board of Medical Specialties Board	Year Certified
Primary _____	**Yes/No**	_____	_____
Secondary _____	**Yes/No**	_____	_____

Have you ever been examined by a specialty board but failed to pass the examination? Yes/No

If not certified, have you applied for certification examination? Yes/No

Have you been accepted to take the certification examination? Yes/No
If yes, what dates are you scheduled to take the examination?_____

STATISTICAL INFORMATION:

MT Professional License # *Exp. date* Federal Tax Identification # Social Security #

Please indicate all states, license numbers and exp. dates in which you have had, or currently have, a medical license

National Provider Identifier (NPI) Federal Narcotics Registration Number (DEA)

EDUCATIONAL DATA:

Premedical Education - College or University, Complete Address Degree/Honors Date of Grad.

Medical School Attended Complete Address Degree/Honors Date of Grad.

Internship Complete Address of School/ Hospital Dept.Chief Type of Internship From To

Residency Complete Address of School/Hospital Dept. Chief Type of Residency From To

Fellowship Complete Address of School/Hospital Dept. Chief Type of Fellowship From To

Continuing Medical Education:

1. On a separate sheet, list all postgraduate activities which you have attended, or for which you have received credit in the past two years.

2. Furnish a list of scientific papers or essays you have written, and a list of scientific meetings you have attended during the previous three years (include reprints).

PROFESSIONAL DATA:

Name others with whom you are associated in practice and the nature of the association:

Please answer each of the following questions in full. If the answer if yes, please provide full explanation of the details on a separate sheet.

1. Has your license to practice medicine in any jurisdiction ever been revoked, suspended, or subject to probation or any conditions or limitations? Yes/No

2. Have any disciplinary actions or investigations been initiated, or are any pending against you, by any state licensure board? Yes/No

3. Have you ever been asked to surrender your licensure/certification? Yes/No

4. Have any complaints been filed against you with the Board of Medical Examiners or the Medical Society? Yes/No

5. Has your DEA license ever been voluntarily or involuntarily relinquished, limited, suspended or revoked? Yes/No

6. Is your narcotics registration certificate currently being challenged? Yes/No

7. Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (e.g. Medicare, Medicaid)? Yes/No

8. Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program? Yes/No

9. Have you ever been named as a defendant in any criminal proceeding? Yes/No

10. Have you ever been convicted of a felony, moral, or ethical crime? Yes/No

11. Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings in any professional organization? Yes/No

12. Do you presently have any physical or mental health problems which would interfere with your ability to provide high quality professional services? Yes/No

AFFILIATIONS AND WORK HISTORY:

List in chronological order all institutional affiliations since completion of postgraduate education. This includes all hospitals, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet. **Complete addresses and telephone numbers must be included.**

Name and complete address and phone number of institution **Capacity** **Dates**

_____

_____

_____

_____

_____

If the answers to any of the following questions is yes, please provide a full explanation of the details on a separate sheet and attach.

Has your employment, Medical Staff appointment, or clinical privileges ever been voluntarily diminished, relinquished or limited at any institution, hospital, or other health care facility? Yes/No

Has your employment, Medical Staff appointment. or clinical privileges ever been involuntarily suspended, revoked, refused, relinquished, or limited at any institution, hospital or other health care facility? Yes/No

Have you ever withdrawn your application for appointment, reappointment, or clinical privileges, or resigned from the Medical Staff before a decision was made by a hospital or health care facility's governing board? Yes/No

Have you ever been the subject of disciplinary proceedings or investigations at any hospital or health care facility? Yes/No

Are any such investigations pending? Yes/No

PROFESSIONAL LIABILITY DATA:

Please provide a copy of your current malpractice insurance certificate that lists $1,000,000/$3,000,000 individual limits per claim/aggregate limits.

A. Insurance

1. Has your professional liability insurance coverage ever been terminated by action of the insurance company? Yes/No
2. Have you ever been denied professional liability insurance coverage? Yes/No
3. If the answer to question 1 or 2 above is yes, state when and by what company._____
4. Has your present professional liability insurance carrier excluded any specific area of practice from your coverage (i.e. obstetrics, surgery, etc)? Yes/No

If yes, list the clinical activities which have been excluded and provide a full explanation on a separate sheet, including the name of the carrier, the date, and specific information concerning any limitation.

B. Legal Actions

1. Have any professional liability claims or suits ever been filed against you? Yes/No
2. Have any professional liability suits been filed against you which are presently pending? Yes/No
3. Have any judgments or settlements been made against you in professional liability cases? Yes/No

If the answer to any of the above questions is yes, please provide a full explanation of the details of each and every matter on the Confidential Professional Liability Information Form attached to include the number of pending claims. The explanation must include the name of the court in which the suit was filed, the caption and docket number of the case, and the name and address of the attorney defending you, and all other relevant details.

Include suits in which a judgment or settlement was made against a professional corporation of which you are/were a member, shareholder, or employee in which you were involved in the patient's care.

All information submitted by me in this Application is true and accurate to the best of my knowledge and belief. I fully understand that any misleading statement or material omissions in this application may constitute cause for denial of eligibility.

By signing this Authorization to Release Information, I, the undersigned, hereby consent to the inspection by North Central Montana Physicians or its representative and SourceOne CVO of all records and documents that may be material to an evaluation of my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter that may be considered material to my qualifications. I understand that this may include the inspection and/or verification of educational records, professional organization and/or association records, court records, licensing board or certification records, professional liability insurance records, as well as inspection of a personal credit report, query of the National Practitioner Data Bank, contact with personal and/or professional references and any other records or third parties that may have a direct bearing upon my being considered for a position.

Additionally, I, the undersigned, hereby release from liability all representatives and agents of aforementioned organization for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from liability any and all individuals and organizations who provide information to this facility's representative, in good faith and without malice and I hereby consent to the release of such information.

I certify that all of the information contained on the attached North Central Montana Physicians data form is complete and accurate.

_____ _____

Signature of Applicant Physician Date