

Premier Health Networks of Alabama



Preferred Provider Networks

CONFIDENTIAL
PROVIDER INFORMATION

	YES	NO
1. A. ARE YOU NOW OR HAVE YOU EVER BEEN INVOLVED IN ANY MALPRACTICE SUIT, INCLUDING ARBITRATION?		
B. HAS ANY MALPRACTICE CLAIM SETTLEMENT, NOT INVOLVING LITIGATION OR ARBITRATION, EVER BEEN PAID BY YOU OR PAID ON YOUR BEHALF?		
IF THE ANSWER TO EITHER OF THE ABOVE QUESTIONS IS YES, PLEASE ATTACH THE FOLLOWING INFORMATION FOR EACH SUIT OR SETTLEMENT: DATE AND DETAILS OF THE INCIDENT(S) LEADING TO THE SUIT OF SETTLEMENT DATE OF SUIT OR SETTLEMENT PROFESSIONAL LIABILITY INSURER INVOLVED YOUR ROLE IN THE INCIDENT(S) YOUR STATUS IN ANY SUIT OR OTHER LEGAL ACTION (PRIMARY DEFENDANT, CODEFENDANT, OTHER) CURRENT STATUS OF SUIT OR OTHER LEGAL ACTION AMOUNT RESERVED BY CARRIER FOR EACH CLAIM, OR AMOUNT PAID AS AN OUT-OF-COURT SETTLEMENT, OR AMOUNT OF JURY AWARD OR COURT AWARD (PLEASE OBTAIN THIS INFORMATION FROM YOUR INSURER IF NECESSARY)		
2. HAS YOUR PROFESSIONAL LIABILITY INSURANCE EVER BEEN DENIED, SUSPENDED, CANCELLED, OR NOT RENEWED? IF THE ANSWER IS YES, PLEASE EXPLAIN IN AN ATTACHMENT.		
3. A. DO YOU NOW HAVE OR WITHIN THE LAST FIVE YEARS HAVE YOU HAD ANY PHYSICAL CONDITION, MENTAL CONDITION OR CHEMICAL DEPENDENCY CONDITION (ALCOHOL OR OTHER SUBSTANCE DEPENDENCY) THAT DOES OR HAS INTERFERED WITH YOUR ABILITY TO PRACTICE MEDICINE?		
B. HAVE YOU EVER RECEIVED TREATMENT OR BEEN ADVISED TO RECEIVE TREATMENT FOR ALCOHOL OR OTHER SUBSTANCE DEPENDENCY?		
IF THE ANSWER TO EITHER OF THE ABOVE QUESTIONS IS YES, PLEASE EXPLAIN IN AN ATTACHMENT.		
4. HAVE YOU EVER HAD ANY OF THE FOLLOWING ITEMS DENIED, REVOKED, SUSPENDED, NOT RENEWED, PLACED UNDER PROBATION, SUBJECTED TO DISCIPLINARY ACTION, OR OTHERWISE LIMITED OR CURTAILED; OR HAVE YOU VOLUNTARILY RELINQUISHED ANY ITEM IN ANTICIPATION OF ANY OF THESE ACTIONS; OR ARE ANY OF THESE ACTIONS PENDING WITH RESPECT TO ANY OF THE FOLLOWING ITEMS?		
STATE LICENSE		
DEA REGISTRATION OR OTHER NARCOTIC LICENSE		
HOSPITAL OR OTHER HEALTH CARE FACILITY STAFF MEMBERSHIP OR PRIVILEGES		
PROFESSIONAL ORGANIZATION MEMBERSHIP		
MEDICARE, MEDICAID, OR OTHER GOVERNMENT PROGRAM PARTICIPATION		
HMO, PPO, OR OTHER PREPAID HEALTH PLAN PARTICIPATION		
IF THE ANSWER TO ANY OF THE ABOVE ITEMS IS YES, PLEASE EXPLAIN IN AN ATTACHMENT		
5. IF YOU HAVE EVER BEEN EMPLOYED AS A PHYSICIAN BY A MILITARY SERVICE, A HOSPITAL, AN HMO OR ANY OTHER HEALTH CARE ORGANIZATION, WAS YOUR EMPLOYMENT EVER TERMINATED BY THE EMPLOYER? <input type="checkbox"/> N/A (NOT APPLICABLE)		
6. HAVE YOU EVER BEEN CONVICTED OF A CRIME (OTHER THAN A TRAFFIC OFFENSE), OR ARE YOU CURRENTLY UNDER INDICTMENT FOR AN ALLEGED CRIME? IF THE ANSWER IS YES, PLEASE EXPLAIN IN AN ATTACHMENT.		

I authorize Premier Health Networks of Alabama (referred to as NAMCI and Comp1One) to consult with members of hospital medical staffs, professional liability carriers and other persons or entities to obtain information concerning my professional qualifications, including competence, ethics, and other qualifications. I release Premier Health Networks of Alabama and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my application. I consent to the release, by any person to Premier Health Networks of Alabama, of all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions or other confidential or privileged information. I release, from any and all liability, anyone providing this information in good faith and without malice. I understand that any misstatement in this application may constitute grounds for denial of this application or for summary dismissal as a participating Premier Health Networks of Alabama Provider. If any material changes occur affecting my professional status, it is my obligation to notify Premier Health Networks of Alabama as soon as possible. I consent to the release of this information, as well as other quality assurance data relating to me, to health plans owned or managed by Premier Health Networks or to medical groups, IPAs, or other similar entities contracting with those plans.

NAME (PLEASE PRINT)	SIGNATURE	DATE
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PLEASE BE SURE TO ENCLOSE WITH THIS APPLICATION
ANY EXPLANATORY STATEMENTS REQUESTED RELATED TO CONFIDENTIAL QUESTIONS

PLEASE DO NOT SEPARATE