

MCC Health Care  
Systems  
**311 N Pecos Road**  
Ste 100  
Henderson, NV 89074  
Ph: (702) 792-2994

MCC Health Care  
Provider Relations  
Provider Network  
Fax: (702) 933-6659



Horizon Health  
PO Box 98218  
Las Vegas NV 89193  
Ph: (702) 367-222  
Horizon Toll Free  
(800) 884-6875

**Re: Re-Credentialing Application**

Dear Provider:

Horizon Health  
Provider Relations  
Provider Network  
Fax: (702) 933-6656

We thank you for your participation with Managed Care Consultants, Inc., AlterNet PPO and/or Horizon Health Care, Inc. network(s).

Please find the enclosed Provider Re-Credentialing Application to complete, sign and return to our office as soon as possible.

In order for credentialing to be processed quickly, it is imperative that the credentialing application be completed thoroughly. Please attach a copy of the following:

- Copy of Current Primary License
- Copy of Current DEA (as applicable)
- Copy of Current State Pharmacy Certificate
- Copy of Current Malpractice Insurance Certificate
- Signed and Dated Questionnaire
- Explanations for all "Yes" answers on the Questionnaire
- Current Curriculum Vitae (CV)
- **Completed W-9 form**
- **CMS 1500 (HCFA) form with box 25 and 33 completed**

Prior to starting the credentialing process, all required elements listed above must be received.

**Please be advised that the credentialing process may take 60 to 120 days to complete once the minimum requirements have been received. Provider will be notified in writing when the process is completed.**

If you have any questions or concerns, please call me directly at (702) 792-2994.

Thank you,

*Provider Relations Department*

**Personal Data**

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Name \_\_\_\_\_  
Last First Middle Suffix Title

Maiden/Former/Other Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthplace (City/State/Country) \_\_\_\_\_

Social Security Number \_\_\_\_\_ UPIN or NPI \_\_\_\_\_

Medicaid Number \_\_\_\_\_ State \_\_\_\_\_ Medicare Number \_\_\_\_\_ State \_\_\_\_\_

Current Home Address \_\_\_\_\_  
Street City State Zip Code

Local Home Address \_\_\_\_\_  
(if different than above) Street City State Zip Code

Pager Number \_\_\_\_\_ Cell Number \_\_\_\_\_ Home Number \_\_\_\_\_

Do you speak a language other than English with sufficient fluency to treat patients who speak only that language Yes No

If yes specify languages: \_\_\_\_\_

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**Primary or Pending Practice Location**

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Primary Practice Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Office Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Federal Tax ID Number \_\_\_\_\_ E-mail Address \_\_\_\_\_

Credentialing Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

Expected Start Date \_\_\_\_\_ Do you intend to practice as: Primary Care Specialist Urgent Care

Primary Specialty \_\_\_\_\_ Subspecialty \_\_\_\_\_

Specialty/Subspecialty in which care will be provided \_\_\_\_\_

Provide a narrative description of your clinical practice including special interests (if additional space is required, attach a separate sheet) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Billing Information**

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Billing Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Office Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Billing Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

**Additional Practice Location(s)**

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Primary Practice Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Office Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Federal Tax ID Number \_\_\_\_\_ E-mail Address \_\_\_\_\_

Specialty/Subspecialty in which care will be provided \_\_\_\_\_

**Other Practice Name** \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Office Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Federal Tax ID Number \_\_\_\_\_ E-mail Address \_\_\_\_\_

Specialty/Subspecialty in which care will be provided \_\_\_\_\_

**Other Practice Name** \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Office Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Federal Tax ID Number \_\_\_\_\_ E-mail Address \_\_\_\_\_

Specialty/Subspecialty in which care will be provided \_\_\_\_\_

**Other Practice Name** \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Office Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Federal Tax ID Number \_\_\_\_\_ E-mail Address \_\_\_\_\_

Specialty/Subspecialty in which care will be provided \_\_\_\_\_

**Other Practice Name** \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Office Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Federal Tax ID Number \_\_\_\_\_ E-mail Address \_\_\_\_\_

Specialty/Subspecialty in which care will be provided \_\_\_\_\_

**Medical/Graduate/Professional Education**

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From \_\_\_\_/\_\_\_\_/\_\_\_\_ Institution Name \_\_\_\_\_  
To \_\_\_\_/\_\_\_\_/\_\_\_\_ Degree Received \_\_\_\_\_ Completed Yes No  
Address \_\_\_\_\_  
Street City State Zip Code  
Phone Number (if known) \_\_\_\_\_

**ECFMG – Applicable to International Medical Graduates**

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ECFMG Number \_\_\_\_\_ Date Issued \_\_\_\_\_ Valid Through \_\_\_\_\_

**Internship/Post-Graduate/Professional Training (If Applicable)**

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From \_\_\_\_/\_\_\_\_/\_\_\_\_ Institution Name \_\_\_\_\_  
To \_\_\_\_/\_\_\_\_/\_\_\_\_ Internship Type/Specialty (Transitional, rotating, 5<sup>th</sup> pathway, etc) \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip Code  
Phone Number (if known) \_\_\_\_\_  
Completed Training Yes No If no, expected completion date \_\_\_\_\_  
If not successfully completed, explain \_\_\_\_\_  
Program Director \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip Code  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**Residency/Post-Graduate/Professional Training (If additional space is required, attach a separate sheet.)**

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From \_\_\_\_/\_\_\_\_/\_\_\_\_ Institution Name \_\_\_\_\_  
To \_\_\_\_/\_\_\_\_/\_\_\_\_ Residency Type/Specialty \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip code  
Phone Number (if known) \_\_\_\_\_  
Completed Training Yes No If no, expected completion date \_\_\_\_\_  
If not successfully completed, explain \_\_\_\_\_  
Program Director \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip Code  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**Residency/Post-Graduate/Professional Training - Continued**

From \_\_\_/\_\_\_/\_\_\_ Institution Name \_\_\_\_\_

To \_\_\_/\_\_\_/\_\_\_ Residency Type/Specialty \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code

Phone Number (if known) \_\_\_\_\_

Completed Training Yes No If no, expected completion date \_\_\_\_\_

If not successfully completed, explain \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**Fellowship/Post-Graduate/Professional Training (If additional space is required, attach a separate sheet).**

From \_\_\_/\_\_\_/\_\_\_ Institution Name \_\_\_\_\_

To \_\_\_/\_\_\_/\_\_\_ Fellowship Type/Specialty \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code

Phone Number (if known) \_\_\_\_\_

Completed Training Yes No If no, expected completion date \_\_\_\_\_

If not successfully completed, explain \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**Primary Hospital Affiliation (Pertinent to Practice Location(s) (If additional space is required, use a separate sheet).**

From \_\_\_/\_\_\_/\_\_\_ Facility Name \_\_\_\_\_

To \_\_\_/\_\_\_/\_\_\_ Department/Specialty/Privilege Affiliation \_\_\_\_\_

Application Pending Address \_\_\_\_\_

Street City State Zip Code

Admit Plan Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

From \_\_\_/\_\_\_/\_\_\_ Institution Name \_\_\_\_\_

To \_\_\_/\_\_\_/\_\_\_ Department/Specialty/Privilege Affiliation \_\_\_\_\_

Application Pending Address \_\_\_\_\_

Street City State Zip Code

Admit Plan Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

From \_\_\_/\_\_\_/\_\_\_ Institution Name \_\_\_\_\_

To \_\_\_/\_\_\_/\_\_\_ Department/Specialty/Privilege Affiliation \_\_\_\_\_

Application Pending Address \_\_\_\_\_

Street City State Zip Code

Admit Plan Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**Chronological Employment/Practice History**

Chronological listing [month/year] of employment/practice history for the previous 5 years. List all experience, including armed service and public health, time out of medical practice in pursuit of other business or professional activities, sabbaticals, parenting, personal travel, personal crisis, etc. LEAVE NO GAPS IN CHRONOLOGY. If additional space is required, attach a separate sheet.

From \_\_\_\_/\_\_\_\_/\_\_\_\_ Organization Name/Activity \_\_\_\_\_

To \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason for Leaving \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

From \_\_\_\_/\_\_\_\_/\_\_\_\_ Organization Name/Activity \_\_\_\_\_

To \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason for Leaving \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

From \_\_\_\_/\_\_\_\_/\_\_\_\_ Organization Name/Activity \_\_\_\_\_

To \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason for Leaving \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

From \_\_\_\_/\_\_\_\_/\_\_\_\_ Organization Name/Activity \_\_\_\_\_

To \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason for Leaving \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

From \_\_\_\_/\_\_\_\_/\_\_\_\_ Organization Name/Activity \_\_\_\_\_

To \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason for Leaving \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**Explain gaps/interruptions of greater than three (3) months to practice of medicine/professional practice (if additional space is required, use separate sheet.)**

From \_\_\_\_/\_\_\_\_/\_\_\_\_ Organization Name/Activity \_\_\_\_\_

To \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason for Leaving \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

From \_\_\_\_/\_\_\_\_/\_\_\_\_ Organization Name/Activity \_\_\_\_\_

To \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason for Leaving \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**Specialty/Subspecialty Certification**

Certifying Board	Specialty/Subspecialty	Date Certified	Date Re-Certified	Expiration Date
_____	_____	___/___/___	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___	___/___/___

If not certified, please state your intent for certification and describe the status of your efforts and eligibility, including scheduled date of exam, past failures of exams, if any. \_\_\_\_\_

**Licensure – List all past, current and pending professional licenses**

State	License Number	Date Certified	Date Re-Certified	License Status
_____	_____	___/___/___	___/___/___	Active Inactive
_____	_____	___/___/___	___/___/___	Active Inactive
_____	_____	___/___/___	___/___/___	Active Inactive
_____	_____	___/___/___	___/___/___	Active Inactive

**Drug Enforcement Administration Registration**

DEA Number \_\_\_\_\_ State \_\_\_\_\_ Expiration Number \_\_\_\_\_

Approved for all schedules? Yes No, Please Explain \_\_\_\_\_

DEA Number \_\_\_\_\_ State \_\_\_\_\_ Expiration Number \_\_\_\_\_

Approved for all schedules? Yes No, Please Explain \_\_\_\_\_

If you do not maintain a DEA certificate, please explain \_\_\_\_\_

Not applicable to Practice DEA Pending Date application sent to DEA \_\_\_/\_\_\_/\_\_\_ Other \_\_\_\_\_

**State Controlled Substance Certification Registration**

CDS Number \_\_\_\_\_ State \_\_\_\_\_ Expiration Number \_\_\_\_\_

**Liability Insurance – Insurance Carrier for Primary and or pending location (s)**

Enclose a copy of professional liability insurance coverage (face sheet Verification of self-Insurance) to include effective dates, insurance carrier, expiration dates, coverage limits, and name of each provider covered.

Coverage Dates \_\_\_\_\_ Insurance Carrier Name \_\_\_\_\_

From \_\_\_/\_\_\_/\_\_\_ Address \_\_\_\_\_

To \_\_\_/\_\_\_/\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Policy Number \_\_\_\_\_ Expiration Date \_\_\_/\_\_\_/\_\_\_

Amount of Coverage \_\_\_\_\_

## **Disclosure Questions for Re-Credentialing**

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Please provide complete explanations if any of the following questions are answered in the affirmative. Please use a separate sheet, include question number when answering.

1. **Yes No**      **Has your professional license or registration ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished, investigated or is currently being investigated by any licensing board or any health-related agency or organization, and, if so, what were the results?**
  
2. **Yes No**      **Has your DEA or CDS registration ever been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your DEA/CDS registration, or is there a review pending?**
  
3. **Yes No**      **Has your membership, participation with peer review organizations, third party payers, clinical privileges, medical staff, board certification, or employment ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed, or is there a review pending?**
  
4. **Yes No**      **Have you ever voluntarily relinquished your membership, participation, clinical privileges or request for privileges, participation with peer review organizations, third party payers, employment, professional license, board certification or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency?**
  
5. **Yes No**      **Has your certificate or participation in any private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to such action presently underway?**
  
6. **Yes No**      **Are there any charges pending or are you currently charged with or have you ever been indicted or found guilty of a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation), or other offense?**
  
7. **Yes No**      **Have you ever been found liable, guilty or responsible for sexual impropriety or misconduct or sexual harassment with a patient, co-worker, or other?**
  
8. **Yes No**      **Have you ever had any professional liability claims or lawsuits brought against you, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments? If yes, please complete the enclosed malpractice Litigation and Professional Complaints Addendum.**
  
9. **Yes No**      **Has your professional liability carrier ever refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?**
  
10. **Yes No**      **Have you ever practiced within your profession without professional liability insurance?**
  
11. **Yes No**      **Do you have a physical or mental condition that would affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions of a practitioner in you area of practice without posing a health or safety risk to you patients?**
  
12. **Yes No**      **Does your use or past use (or have you been told that your use or past use of alcohol or drugs), affect, or has affected, your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions in your area of practice with out posing a health risk to your patients?**

13. Yes No

**Are you currently using illegal 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. “Illegal use of drugs” refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec 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 their provision of Federal Law” The term does include, however, the unlawful use of prescription controlled substances.)**

### Notice of Applicant’s Rights

You may review your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy, state or federal laws, or Managed Care Consultants, Inc. and/or Horizon Health Care, Inc. policies. If there are discrepancies in the information received during the process, you will be notified and allowed an opportunity to add information to you application.

### Attestation Signature and Date

I hereby certify that all the information on this application from is complete, true and accurate. I further agree to update this information as necessary so that it remains complete, true and accurate while my application is being processed. Any misrepresentation, false or misleading information may result in denial of application for participation and/or termination of my participation with Managed Care Consultants, Inc. and/or Horizon Health Care, Inc.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Update Attestation Signature and Date

I have reviewed and updated all the information on this application, including the Disclosure Questions, and I certify it is complete True and accurate.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



## CREDENTIALING CONSENT AND RELEASE

I \_\_\_\_\_ hereby release Managed Care Consultants, Inc. and/or Horizon Health Care, Inc. from liability the Entity and its Agents, state licensing board(s), health care organizations, including, with out limitation, hospitals, clinics, and third party payers, medical malpractice insurance carriers(s), and any staff, and all individuals, institutions and entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be addition to any other applicable immunities provided by law for peer review activities.

All information provided by me in the Application is true, accurate and complete. I understand and agree that any material misstatements in or omission from the Application may constitute grounds for denial or revocation of Participation. I understand and acknowledge that the Entity shall be solely responsible for all decisions concerning the granting of Participation.

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.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Printed Name: \_\_\_\_\_

