



## EMI HEALTH PHYSICIAN AND MID-LEVEL FORM

EMI Health • 852 East Arrowhead Lane • Murray, Utah 84107-5298 • 801-262-7975

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
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PRACTICE STATUS:    INDIVIDUAL       GROUP       OTHER: \_\_\_\_\_

PLEASE CHECK BOX OF NPI NUMBER USED FOR BILLING:       INDIVIDUAL: \_\_\_\_\_       GROUP: \_\_\_\_\_

PRINCIPAL OFFICE LOCATION	SECONDARY OFFICE LOCATION
STREET _____	STREET _____
CITY _____ STATE _____ ZIP _____ COUNTY _____	CITY _____ STATE _____ ZIP _____ COUNTY _____
TELEPHONE _____ TAX ID NUMBER _____	TELEPHONE _____ TAX ID NUMBER _____
FAX _____ EMAIL ADDRESS _____	FAX _____ EMAIL ADDRESS _____

INDIVIDUAL NPI: _____	GROUP NPI: _____ NPI USED FOR BILLING: <input type="checkbox"/> YES <input type="checkbox"/> NO
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BILLING ADDRESS (if different than above)	CORRESPONDENCE ADDRESS (if different than above)
PAY TO NAME _____	CORRESPONDENCE NAME _____
ADDRESS _____	ADDRESS _____
CITY _____ STATE _____ ZIP _____ COUNTY _____	CITY _____ STATE _____ ZIP _____ COUNTY _____
TELEPHONE _____ CONTACT NAME _____	TELEPHONE _____ CONTACT NAME _____

PROVIDER'S DATE OF BIRTH _____	OFFICE MANAGER'S NAME _____
PRIMARY STATE OF LICENSURE / LICENSE # (PLEASE ENCLOSE COPY) _____	SECONDARY STATE OF LICENSURE / LICENSE # (PLEASE ENCLOSE COPY) _____
DEA NUMBER (PLEASE ENCLOSE COPY) _____	PA'S AND NP'S LIST SUPERVISING PHYSICIAN _____

Primary Hospital Affiliation (Please check one)       Active     Provisional     Consulting     Courtesy

Location: \_\_\_\_\_

**IF YOU DO NOT ADMIT PATIENTS, PLEASE INCLUDE DOCUMENTATION ON WHAT TYPE OF ADMITTING ARRANGEMENTS YOU HAVE**

Other Hospital Affiliation (Please check one)       Active     Provisional     Consulting     Courtesy

Location: \_\_\_\_\_

MEDICAL PRACTICE

Please check your principal fields of specialization (up to two) in which you are board certified or eligible to take boards, or credentialed at your primary hospital. Note that some subspecialties are combined for presentation purposes.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Allergist                              | <input type="checkbox"/> Internal Medicine       | <input type="checkbox"/> Pediatric Radiology      |
| <input type="checkbox"/> Anesthesia                             | <input type="checkbox"/> Maxillofacial Surgery   | <input type="checkbox"/> Pediatric Surgery        |
| <input type="checkbox"/> Cardiology                             | <input type="checkbox"/> Neonatology             | <input type="checkbox"/> Pediatrics               |
| <input type="checkbox"/> Cardiovascular Disease                 | <input type="checkbox"/> Nephrology              | <input type="checkbox"/> Perinatology             |
| <input type="checkbox"/> Certified Nurse Midwife                | <input type="checkbox"/> Neurological Surgery    | <input type="checkbox"/> Physician Assistant      |
| <input type="checkbox"/> Certified Registered Nurse Anesthetist | <input type="checkbox"/> Neurology               | <input type="checkbox"/> Plastic Surgery          |
| <input type="checkbox"/> Certified Surgical Technician          | <input type="checkbox"/> Neurosurgery            | <input type="checkbox"/> Proctology               |
| <input type="checkbox"/> Critical Care                          | <input type="checkbox"/> Nurse Practitioner      | <input type="checkbox"/> Psychiatry               |
| <input type="checkbox"/> Dermatology                            | <input type="checkbox"/> Obstetrics              | <input type="checkbox"/> Pulmonary Disease        |
| <input type="checkbox"/> Emergency Medicine                     | <input type="checkbox"/> Obstetrics & Gynecology | <input type="checkbox"/> Radiation Therapy        |
| <input type="checkbox"/> Endocrinology                          | <input type="checkbox"/> Oncology                | <input type="checkbox"/> Radiologist              |
| <input type="checkbox"/> Family Practice                        | <input type="checkbox"/> Oncology / Hematology   | <input type="checkbox"/> Radiology Oncology       |
| <input type="checkbox"/> Gastroenterology                       | <input type="checkbox"/> Ophthalmology           | <input type="checkbox"/> Registered Nurse         |
| <input type="checkbox"/> General Surgery                        | <input type="checkbox"/> Oral Surgeon            | <input type="checkbox"/> Rehab Physician Medicine |
| <input type="checkbox"/> Genetics                               | <input type="checkbox"/> Orthopedic Surgery      | <input type="checkbox"/> Respiratory Disease      |
| <input type="checkbox"/> Geriatrics                             | <input type="checkbox"/> Orthopedics             | <input type="checkbox"/> Rheumatology             |
| <input type="checkbox"/> Gynecological Endocrinology            | <input type="checkbox"/> Osteopathic Physician   | <input type="checkbox"/> Sports Medicine          |
| <input type="checkbox"/> Gynecology Only                        | <input type="checkbox"/> Otorhinolaryngology     | <input type="checkbox"/> Thoracic Surgery         |
| <input type="checkbox"/> Hand Surgery                           | <input type="checkbox"/> Pathology               | <input type="checkbox"/> Podiatry                 |
| <input type="checkbox"/> Urology                                | <input type="checkbox"/> Hematology              | <input type="checkbox"/> Pediatric Allergy        |
| <input type="checkbox"/> Vascular Surgery                       | <input type="checkbox"/> Hepatology              | <input type="checkbox"/> Pediatric Cardiology     |
| <input type="checkbox"/> Immunology                             | <input type="checkbox"/> Pediatric Endocrinology | <input type="checkbox"/> Infectious Diseases      |
| <input type="checkbox"/> Pediatric Neurology                    | <input type="checkbox"/> Other: _____            |   |

For each specialty indicated, indicate if you are board certified or eligible to take boards and specify the name of the certifying board (please enclose a copy.)

_____ Primary Specialty	<input type="checkbox"/> Board Certified	<input type="checkbox"/> Eligible	Certifying board: _____
			Date of Exam: _____ <input type="checkbox"/> Written <input type="checkbox"/> Oral
_____ Secondary Specialty	<input type="checkbox"/> Board Certified	<input type="checkbox"/> Eligible	Certifying board: _____
			Date of Exam: _____ <input type="checkbox"/> Written <input type="checkbox"/> Oral

Medical School	Location	Year Graduated
Internship	Location	Dates: From / to
Residency	Location	Dates: From / to
Fellowships		
Teaching Appointments	Name while attending school	
If Applicable: Foreign Medical Graduate Number	If you are fluent in languages other than English, please list:	

- Do you have any other partners / associates in your practice?  Yes  No
- Do you use physicians assistants, nurse practitioners, and / or physical therapists?  
(If yes, please attach names and license numbers)  Yes  No
- Have you been subject to any of the following:
- Suspensions or limitations to your practice?  Yes  No
  - Suspensions as a Medicare or Medicaid provider?  Yes  No
  - Professional liability insurance cancellation in the past five years?  Yes  No
  - Denied membership in any organization or health care institution, HMO, or PPO?  Yes  No
  - State licensing investigations or actions?  Yes  No
  - DEA licensing investigations or actions?  Yes  No
  - Conviction of a felony, fraud, moral, or ethical crime?  Yes  No
  - Chronic illness or physical defect that would impair your ability to practice your specialty?  Yes  No
  - Ownership in any facility or joint ownership of a facility to which you might refer patients?  Yes  No

**Please attach an explanation of any questions answered "yes."**

- Are you accepting new patients?  Yes  No
- Are you routinely available for patient care at least four full days per week?  
If not, what are your office hours?: \_\_\_\_\_  Yes  No

What, if any, limitations do you have on the age range of your patients?  
\_\_\_\_\_

Approximately how many patients do you see per day, when you are in your office?  
\_\_\_\_\_

What, if any, limitations do you have on accepting new patients?  
\_\_\_\_\_

What arrangements do you have to provide 24-hour, 7-day-per-week coverage for your patients?  
\_\_\_\_\_

Briefly describe the general levels of care that you currently offer:  
\_\_\_\_\_  
\_\_\_\_\_

Liability Carrier	Policy Number
Amount of Coverage per Occurrence	Aggregate
Malpractice Action:	
Number of Malpractice Claims: _____ (if none, please write "none.")	
Number of prior malpractice judgements or settlements within the last ten years: _____ (if none, please write "none.")	
<p><b>For each malpractice action, please attach a detailed explanation to this application in order to expedite the credentialing process.</b></p>	

Please submit the following with your application:

- 1. A copy of your current state license(s)
- 2. Proof of malpractice coverage (the policy face sheet or certificate of insurance, with effective dates)
- 3. Any explanations requested elsewhere in this application
- 4. A copy of your board certificate and board specialties
- 5. A copy of your certificate if you have a subspecialty
- 6. Additional mailing, billing, or office addresses or additional active staff hospital affiliations
- 7. A copy of your DEA certificate
- 8. Release form
- 9. Five year work history
- 10. W-9 tax form

All information is complete and accurate to the best of my knowledge. We understand that this application does not entitle us to continued participation with EMI Health. We authorize EMI Health to consult with, and inspect all documents from individuals and organizations having information bearing on our qualifications. We agree that EMI Health, its representatives, and any individuals or entities providing information to EMI Health in good faith pursuant to this release shall not be liable for any act or omission related to the evaluation or verification or information in this application. We further agree to notify EMI Health of any change to the information requested by this application.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

EMI.PROV.PHYS-APP.0611.0060



**PLEASE NOTE THAT THIS INFORMATION WILL BE TREATED AS CONFIDENTIAL**