

**SOUTH CAROLINA UNIFORM MANAGED CARE PRACTITIONER  
CREDENTIALS UPDATE FORM**

(Note: The following information will be held strictly confidential)

**I. DEMOGRAPHIC DATA:**

A. Name in full: \_\_\_\_\_ Date of birth: \_\_\_\_\_

B. Practice Name:

PCP:      Yes                  No                                  Specialty: \_\_\_\_\_

C. Social Security Number: \_\_\_\_\_ NPI: \_\_\_\_\_

Tax ID: \_\_\_\_\_ Group NPI: \_\_\_\_\_

D. Address:

Office (appointment) Phone #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_

Office Credentialing Contact Person: \_\_\_\_\_ Contact #: \_\_\_\_\_

a) New Office Address: \_\_\_\_\_

b) New Telephone #: \_\_\_\_\_ New Fax #: \_\_\_\_\_

E. Primary Admitting Facility:

If incorrect, please update:

Are your hospital privileges active and in good standing?      Yes      No

If you do not admit, please list below the physician that covers your hospitalized patients:

Are you accepting new patients?      Yes      No

Describe any limitations (other than gender listed below):

Male only:

Female only:

Both/No restrictions:

Please indicate the amount of your malpractice coverage, ie, \$ 1,000,000/\$ 3,000,000?

Carrier Name \_\_\_\_\_ JUA and PCF:      Yes      No

Effective Dates: From \_\_\_\_\_ To \_\_\_\_\_

F. Office e-mail address (if any):

G. Practice Web site address (if any):

**II. CERTIFICATION/EDUCATION UPDATE:**

A. Board Status: \_\_\_\_\_ If incorrect, please update:

Certified by American Board of: \_\_\_\_\_ Date certified: \_\_\_\_\_ Re-Certified: \_\_\_\_\_

B. Medical School: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

C. Professional License number where currently in practice: \_\_\_\_\_

III. PLEASE ANSWER THE FOLLOWING QUESTIONS (This section must be completed by practitioner):

Managed Care Organizations must have updated liability information and written explanations to begin the recredentialing process.

*(If you answer "Yes" to any of the questions listed below, please enclose a detailed explanation.)*

- |  |     |    |
|--|-----|----|
| 1. Do you have any pending misdemeanor or felony charges?  | Yes | No |
| 2. In the past three years have you been convicted of a felony?  | Yes | No |
| 3. In the past three years has your license to practice medicine in any jurisdiction been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited?   | Yes | No |
| 4. In the past three years and up to and including the present, have you had any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodations, to perform the essential functions of a practitioner in your areas of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? | Yes | No |
| 5. Considering the essential functions of a practitioner in your area of practice, in the past three years and up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients?  | Yes | No |
| 6. In the past three years have you been publicly reprimanded or disciplined by a professional licensing agency or board?  | Yes | No |
| 7. In the past three years has your DEA certification or state controlled drug permit been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?  | Yes | No |
| 8. In the past three years have any of your privileges or memberships at any hospital or institution been denied, suspended, reduced, revoked, not renewed or otherwise limited?   | Yes | No |
| 9. In the past three years has your participation in Medicare, Medicaid, or any other government program been limited or curtailed, or have you voluntarily excluded yourself from any of these programs?  | Yes | No |
| 10. In the past three years has your participation in an Insurance Company network been limited or terminated?   | Yes | No |
| 11. In the past three years and up to the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?   | Yes | No |
| 12. In the past three years and up to and including the present, have you had or do you have any mental or physical condition or do you take any medications that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?  | Yes | No |
| 13. In the past three years has any malpractice carrier made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf, or are any medical malpractice suits pending against you?  | Yes | No |
| 14. In the past three years has your professional liability insurer placed conditions or restrictions on your coverage or ability to obtain coverage?  | Yes | No |

**(THE ABOVE INFORMATION WILL BE HELD STRICTLY CONFIDENTIAL)**

**Signature:**

**Date:**

**Please print name:**

*Must be signed in ink*

*EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE.*

*Rubber Stamped and Electronic Signatures Are Not Acceptable*

**Practitioners have the right to review information obtained to evaluate their credentialing and recredentialing applications.**

V. AUTHORIZATION:

I CERTIFY THAT ALL INFORMATION CONTAINED IN THIS CREDENTIALS UPDATE FORM AND ALL ITS ATTACHMENTS ARE ACCURATE, COMPLETE AND TRUE.

I understand that:

- A. Any misrepresentation, misstatement or omission of a relevant fact in connection with this application may result in denial of my application or termination of my participation in the Managed Care Organization;
- B. It is my responsibility to promptly advise the Managed Care Organization in writing within 30 days of any changes or additions to the information contained in this application;
- C. All the information contained in this application or attachments is subject to the Managed Care Organization's investigation and review and;

**NOTICE:** The National Practitioner Data Bank will be queried. If you are not recredentialed for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating, or omitting a relevant fact in connection with your credentials, the rejection may be reported to The National Practitioner Data Bank.

I authorize the Managed Care Organization to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been or am currently associated, and with others, including, without limit, past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further consent to the inspection by agents, employees, contractors, affiliates or other representatives of the Managed Care Organization of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications.

I release from liability the Managed Care Organization and all representatives of the Managed Care Organization for their acts performed in good faith and without malice or negligence in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations who provide information to the Managed Care Organization in good faith and without malice or negligence concerning my professional competence, character and ethics. I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension, or curtailment or participation status, membership and/or privileges of any type to or from the Managed Care Organization.

**SIGNATURE:**

**DATE:**

***EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE.  
ELECTRONIC AND RUBBER STAMPED SIGNATURES ARE NOT ACCEPTABLE***