

# Physician Application

## Instructions

In order to complete the physician credentialing process, Raytel Imaging Network requires the following **CURRENT** information/documentation for each Radiologist who reads at your facility. **An application, which is not accompanied by all required documents noted in the checklist below, will cause a delay in the credentialing process.** Raytel Imaging Network has an established standard of 180 days to complete the entire credentialing process from receipt of completed application through final credentials decision.

- Complete the Physician Application in its entirety.
- Please type or print application in legible writing – prefer typed.
- Review your application before signing and mailing. **Incomplete applications will not be processed and will be returned to you resulting in a delay in the credentialing process.**
- Sign and date application.
- Keep a copy of your application for your own file.
- **A Physician Application must be completed for each Radiologist that reads at your facility. If necessary, please reproduce this application, as needed.**

Failure to accurately answer and/or falsifying any of the responses on this application will constitute cause for immediate and automatic denial of affiliation and/or termination of affiliation with Raytel Imaging Network.

The following items must accompany all applications.

- Physician Application completed in its entirety with Attestation and Release signed/dated
- Current Curriculum Vitae, which includes complete education and work history (**include explanation of gaps**)
- Copy of Fellowship Training Certificate (if applicable)
- Evidence of continuing medical education activities (i.e. Certificates of completion)
- Copy of Current State Medical License(s)
- Copy of all applicable Board Certification(s) from ABMS or AOA Board
- Copy of Current Drug Enforcement Administration (DEA) Certificate(s)
- Copy of Current Controlled Dangerous Substance (CDS) Certificate(s) (if applicable)
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) (if applicable)
- Hospital Affiliations and Hospital Affiliation – Consent to Release Form (A separate form must be completed and returned for each hospital affiliation.)
- Current face sheet of Malpractice Insurance Policy showing policy #, coverage limitations and expiration date
- Malpractice Claims History – attach all documentation
- Disciplinary actions, convictions, sanctions; Medicare/Medicaid sanctions - attach all documentation

If you have any questions or need clarification regarding this application, please call the Provider Relations/Credentialing Department at 1-800-453-0574, extension 125.

**Please mail completed Physician Application with all documentation to:**

Raytel Imaging Network  
Attn: Provider Relations/Credentialing  
101 West Fourth Avenue  
Collegeville, PA 19426

# Physician Application

## I. Physician/Facility Information: *(A Separate Application Must Be Completed for Each Physician)*

Physician Name: \_\_\_\_\_

Prof. Suffix:  MD  DO      Sex:  M  F      DOB (Mo/Day/Yr): \_\_\_\_\_ SS#: \_\_\_\_\_

Any other name under which you have been known: \_\_\_\_\_ NPI #: \_\_\_\_\_

Name of Primary Practice: \_\_\_\_\_

Corporate Name of Practice: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Tax ID #: \_\_\_\_\_ Facility License #: \_\_\_\_\_

### Facility Contact Person:

Name/Title: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ e-mail: \_\_\_\_\_

**Remittance Name** *(complete even if same as facility name):*

\_\_\_\_\_

**Remittance Address** *(complete even if same as facility address):*

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Credentialing Contact:

Name/Title: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ e-mail: \_\_\_\_\_

## Additional Medical Practice Affiliations: *(Attach separate sheet if needed)*

**2<sup>nd</sup> Affiliation** - Practice Name: \_\_\_\_\_ Tax ID#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ e-mail: \_\_\_\_\_

**3<sup>rd</sup> Affiliation** - Practice Name: \_\_\_\_\_ Tax ID#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ e-mail: \_\_\_\_\_

### ***The following two questions must be answered:***

**How many years of experience do you have in interpreting MRI films?** \_\_\_\_\_

**How many years of experience do you have in interpreting CT films?** \_\_\_\_\_

**II. License Information:** *(Copy of all Current Licenses must be attached)*

List all current licenses along with restrictions or conditions. *(Attach separate sheet if needed)*  
*(W-9 and copies of all licenses must be attached)*

State – License	License #	Expiration Date	Restrictions/Conditions <i>(Attach separate sheet if needed)</i>

List states in which you have had a license within the last ten (10) years: \_\_\_\_\_  
\_\_\_\_\_

**III. Controlled Substance Information:** *(Copy of all Current Certificates must be attached)*

List current federal DEA registrations and state CDS registrations (if applicable) *(Attach separate sheet if needed)*

Controlled Substance	Certificate #	Expiration Date	Limitations
DEA			
CDS			

**IV. Professional Liability Insurance Information:** *(Copy of face sheet of policy must be attached)*

Please list your current insurance carrier, as well as any other carriers you have been insured within the last five (5) years. Provide the carrier name, policy number and current expiration date.

**Insurance Carrier:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

**Policy Limits:** Occurrence: \_\_\_\_\_ Aggregate: \_\_\_\_\_ **Policy Type:** Claims Made: \_\_\_\_\_ Occurrence: \_\_\_\_\_

**Address:** \_\_\_\_\_

**Effective Date:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_ **Retroactive Date:** \_\_\_\_\_

**Past Carrier(s) for last 5 years:**

**Insurance Carrier:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

**Policy Limits:** Occurrence: \_\_\_\_\_ Aggregate: \_\_\_\_\_ **Policy Type:** Claims Made: \_\_\_\_\_ Occurrence: \_\_\_\_\_

**Address:** \_\_\_\_\_

**Effective Date:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_ **Retroactive Date:** \_\_\_\_\_

**Insurance Carrier:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

**Policy Limits:** Occurrence: \_\_\_\_\_ Aggregate: \_\_\_\_\_ **Policy Type:** Claims Made: \_\_\_\_\_ Occurrence: \_\_\_\_\_

**Address:** \_\_\_\_\_

**Effective Date:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_ **Retroactive Date:** \_\_\_\_\_

- Has your professional liability insurance ever been cancelled?  Yes  No
- Are any specific medical procedures excluded from your coverage?  Yes  No
- Have any professional judgments or claims settlement, including those in arbitration, been paid by you or on your behalf?  Yes  No
- Is any formal or informal professional liability claim or lawsuit now pending against you?  Yes  No
- Have any claims not involving litigation or arbitration been paid by you or on your behalf?  Yes  No
- Have you had any liability cases against you dropped or dismissed?  Yes  No

**Please provide detailed information on “Malpractice History Information” page to any of the questions to which you answered yes (attach separate sheet if needed).**

**V. Medical Education Information** *(Copy of CV, ECFMG and Fellowship Training Certificate must be attached. Also attach copies of CME's/Degrees)*

**Medical School:**

Name of Medical School: \_\_\_\_\_

City/State/Country: \_\_\_\_\_

Dates Attended: \_\_\_\_\_ Degree: \_\_\_\_\_

ECFMG (Graduates of Foreign Medical Schools): Certificate #: \_\_\_\_\_ Date Issued: \_\_\_\_\_

**Graduate Training:**

**Internship:**

Institution: \_\_\_\_\_ Post-Graduate Med. Ed. Director Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Dates Attended: \_\_\_\_\_

**Residencies:**

Institution: \_\_\_\_\_ Residency Director Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Dates Attended: \_\_\_\_\_ Specialty: \_\_\_\_\_ Board Certification Date: \_\_\_\_\_

**Fellowships:**

Institution: \_\_\_\_\_ Program Director Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Dates Attended: \_\_\_\_\_ Specialty: \_\_\_\_\_ Board Certification Date: \_\_\_\_\_

**CME Requirements**

Have you met your Board Certification or State Licensure mandatory CME requirements, as applicable?  Yes  No

**VI. Board Certification/Specialties** *(Copy of all Board Certifications must be attached)*

Area of Specialty: \_\_\_\_\_ Area of Sub-Specialty: \_\_\_\_\_

Board Certification Specialty	Board Title (Name of Certifying Board)	Date Certified	Date Recertified

**If not Board Certified:**

- Are you currently Board eligible?  Yes  No
- Have you been accepted by the Board to take an exam and are you actively in the Board Certification process?  Yes  No
- If yes, note year you must complete the process according to Board's requirements: \_\_\_\_\_
- If no, when do you plan to take the Board Certification exam? \_\_\_\_\_

## VII. Academic Appointments

Please list all teaching/university positions held to date. (*Attach separate sheet if needed*)

---



---



---

## VIII. Hospital Affiliations (*Attach separate sheet if needed*)

*Hospital Affiliation – Consent to Release Form must be submitted for each Hospital Affiliation listed. Make additional copies as needed – form is at back of application.*

Institution: \_\_\_\_\_ Department: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Type of Privileges (i.e., full & unrestricted; consultant): \_\_\_\_\_

Institution: \_\_\_\_\_ Department: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Type of Privileges (i.e., full & unrestricted; consultant): \_\_\_\_\_

## IX. Work History (*Please complete if curriculum vitae is not attached*)

Please list complete work history from college graduation to present place of employment. (*Attach separate sheet if needed*)

Date From	Date To	Position Held	Facility or Company Name	Street Address	City	State	Zip

## X. Competency

*Please answer the following questions. If you answer 'yes' to any, please provide a detailed explanation with dates and circumstances on an attached sheet.*

1. Has your license to practice medicine in this state or any other state been denied, restricted, limited, suspended or revoked?  Yes  No
2. Has your DEA and/or CDS to prescribe medications in this state or any other state been denied, restricted, limited, suspended or revoked?  Yes  No
3. Are there any investigatory or disciplinary actions pending with respect to your license, DEA or CDS?  Yes  No
4. In the case where you have hospital privileges, have they ever been denied, suspended or revoked?  Yes  No
5. Have you ever had, or are there now pending, any disciplinary proceedings against you by a hospital?  Yes  No
6. Have you ever voluntarily surrendered your license, DEA, CDS, or any professional status?  Yes  No
7. Have you ever been denied membership or renewal thereof, or been subject to any disciplinary action by any professional organization?  Yes  No
8. Has your participation in Medicare, Medicaid, or any other government program ever been denied, restricted, limited, suspended or revoked?  Yes  No
9. To the best of your knowledge are you, or have you ever been, investigated with regard to Medicare, Medicaid, or any other government program?  Yes  No
10. Have you ever been subject to any disciplinary actions or have you ever been terminated for cause, or not renewed for cause, by any managed care organizations, health maintenance organizations, or preferred provider organizations, or any other managed care program?  Yes  No
11. Have you ever been convicted, pled guilty, or pled nolo contendere to a criminal offense?  Yes  No
12. Do you currently use illegal drugs?  Yes  No
13. Do you use chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?  Yes  No
14. Have you ever been convicted of, pled guilty, or pled nolo contendere to any administrative, civil, or criminal complaint or investigation regarding sexual misconduct?  Yes  No
15. Are you prevented in any way from performing the essential functions of your job with or without reasonable accommodation?  Yes  No
16. Have you had any gaps of greater than six months in your professional education or work history?  Yes  No

**\*Application must be signed and dated –Page 6 \***

**ALL questions must be completed in order to process application. Any applications with incomplete information will be returned resulting in delay in credentialing approval.**

## Attestation and Release

### ***PLEASE READ CAREFULLY BEFORE SIGNING***

By signing this application, I attest that all of the information submitted in this application is true, correct and complete to the best of my knowledge and belief. I understand that any misstatement or omissions from this application may constitute cause for denial of my application, or if subsequently discovered, to terminate my participation with Raytel Imaging Network (RIN).

By applying for membership in RIN, I hereby signify my willingness to discuss information contained in my application. I hereby authorize RIN to consult with administrators and members of the medical staffs of hospitals, institutions, or facilities, with which I have been associated and with others, including past and present malpractice carriers, who may have further information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by representatives of RIN of all documents that may be material to an evaluation of my professional qualifications and competence and consent to RIN's query of such services as the National Practitioner Data Bank, Federation of State Medical Boards, American Board of Medical Specialties, and other agencies.

I hereby release from liability all RIN representatives for their acts performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I hereby release from any liability any and all individuals and organizations that provide information to RIN in good faith and without malice concerning my professional competence, ethics, character and other qualifications. I hereby consent to the release and exchange of information relating to any disciplinary action, suspension, or curtailment of medical privileges to RIN.

I understand and agree that I, as an applicant, have the burden of producing adequate information that is true, correct and complete to the best of my knowledge and belief, for proper evaluation of my professional competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications. I understand that I have the right to correct erroneous information and the right to review information obtained to evaluate my credentialing application unless disclosure is prohibited by law or the information is protected by peer review.

***I understand that approval of this application is contingent upon review and acceptance of this application by the Raytel Imaging Network Review Committee and receipt of the signed Preferred Provider Contract and all information/documents referenced in the Physician Credentialing Checklist, which is attached.***

---

*Physician Signature*

---

*Date*

---

*Print Name*

***ALL questions must be completed in order to process application. Any applications with incomplete information will be returned resulting in delay in credentialing approval.***

### Malpractice History Information

Please provide information regarding any malpractice history question to which you answered "yes" using a separate sheet for each case.

**Insurance Carrier** \_\_\_\_\_

**Date of Occurrence:** \_\_\_\_\_ **Date of Claim:** \_\_\_\_\_

**Provide detailed factual description of the case:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Provide a detailed description of your role and specific involvement in the case or care of the patient:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Primary Defendant:**  Yes  No      **List Name(s):** \_\_\_\_\_

\_\_\_\_\_

**Other Parties to the Suit:** \_\_\_\_\_

**Current status of this case:**  Dropped       Dismissed       Settled       Pending

Found for Plaintiff       Found for Defendant

**Patient care outcome:** \_\_\_\_\_

\_\_\_\_\_

**Standard of care outcome:** \_\_\_\_\_

**Dollar amount settled, reserved, or submitted as a result of judgment in this case:** \_\_\_\_\_

**Hospital Affiliation - Consent to Release Form**

Hospital Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Attention: Credentials Department

Please be advised that I am seeking membership in Raytel Imaging Network (RIN). In this regard, I give my consent to have documentation of the status of my credentials forwarded to RIN. Please provide RIN documentation that I am a member in good standing with full and unrestricted privileges in the specialty of \_\_\_\_\_.

Please send or fax this information to the following address:

Raytel Imaging Network  
101 West Fourth Avenue  
Collegeville, PA 19426

Attention: Lily Cao, Credentialing Manager

FAX: 610-831-9125

Please contact RIN at 800-453-0574, with any questions you may have.

Thank you in advance.

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

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_