NHealth
Norman Regional Health System

Provider Membership Application
NHealth Care Network

Thank you for your interest in becoming a participating member of the NHealth Clinically Integrated Network (CIN). Consideration for membership is based upon a provider's commitment to improve the health of patients, qualifications, practice history in the community, and the geographic and specialty needs of NHealth at the time of enrollment. Membership in NHealth will become effective only after credentials verification and approval of the NHealth Board of Directors. If you are a member of a medical group, please note that all members of your group practice must be eligible for membership and that all members must participate in NHealth in order for you to participate.

Step 1- Participating Provider Requirements (All Applicants) - Please review the following participation requirements and attest to your eligibility.

- I am currently credentialed and a member in good standing on the Medical Staff of Norman Regional Health System, or
    - I have begun the credentialing process with Norman Regional Health System Medical Staff Services
    - I currently am not a member of the Medical Staff of Norman Regional Health System, I understand that I must complete the secondary NHealth credentialing process prior to full acceptance to NHealth. Every effort will be made to submit information within 60 days.
- I am committed to improving quality of care and clinical outcomes, improving coordination and continuity of care, improving efficiency of care, eliminating unnecessary clinical care variation, applying evidence-based medical interventions, and supporting comprehensive clinical care with use of an information integration technology platform.
- I will meet and abide by the terms outlined in the NHealth Participation Agreements
- I agree to participate in all of the contracts of NHealth
- I agree to comply with the clinical performance standards, guidelines, and objectives to be defined by the NHealth Committees.
- I agree to actively promote, gather and report evidence-based clinical outcome measures as required by NHealth with third party payers and NHealth policies and procedures
    - Upon request of NHealth, I agree to provide information in a timely manner in order to allow for analysis of clinical outcomes by NHealth.
    - I agree to comply with all requirements and deadlines as defined by NHealth for aggregation and reporting of clinical outcomes.

By my signature, I attest that I meet, or that I will meet, the Participating Provider Requirements listed above. All information and documentation contained in this application is true, correct and complete to my best knowledge and belief. I further agree, that any material misstatements in or omissions from this application may constitute cause for denial of my application for participation. Additionally, if I am accepted as a Participating Provider, I will continue to meet all the participating Provider Requirements during the term of my membership.

Provider Signature: _____

Provider Printed Name: _____ Date: _____

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Step 2- Applicant Information (All Applicants)

Please Indicate What Type of Provider You Are:

- ☐ **Physician**
- ☐ **Physician's Assistant**
- ☐ **Advanced Practice Nurse**
- ☐ **Physical Therapist**
- ☐ **Occupational Therapist**
- ☐ **Psychologist**
- ☐ **Licensed Professional Counselor**
- ☐ **Licensed Clinical Social Worker**
- ☐ **Licensed Marital and Family Therapist**
- ☐ **Licensed Behavioral Practitioner**
- ☐ **Dentist**
- ☐ **Optometrist**
- ☐ **Podiatrist**
- ☐ **Audiologist**
- ☐ **Other (Please Specify):_____**

General Information: Enter all information, when applicable, EXACTLY as it appears in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). All fields marked with an asterisk (*) are required.				
Last Name	First Name	M.I.	SS#	Birth Date
Primary Practice Specialty	Board Certification Date	Supervising Physician (If Applicable)		
Tax ID # (TIN)	Individual NPI#	Group NPI #		EMR Product/ Version
Practice Name (If more than one practice site, please report additional site information on a separate page)				
Practice Street Address		Suite #		CAQH#
City	State	Zip		Practice Phone #
Practice Fax #	Personal Phone #	Preferred Email		
Billing Address		Suite #		
City	State	Zip		Primary Language
In-Office Contact Name	Title	Email		
DEA Number and expiration date	OBNDD Number	Provider's Personal Email		
Medicare Number	Medicaid Number	OK Medical License Number		
Provide copy of Malpractice Insurance Coverage				

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Required Documents: This documentation must be received before the NHealth credentialing process can begin.

- ☐ Copy of Drivers License
- ☐ Copy of DEA
- ☐ Copy of OBNDD
- ☐ Copy of State License
- ☐ Copies of Malpractice Certificates of Insurance (COI) for the past 5 years
- ☐ Copy of Current CV
- ☐ Copy of Board Certification
- ☐ Oklahoma Uniform Credentialing Application

Please send completed form and requested documentation to Aryn Sherfield, Supervisor Medical Staff Services, Payer

Phone: (405) 307-1075 Ext 73026 Fax: (405) 515-5114 Email: asherfield@nrh-ok.com

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As a requirement, to completing the Credentialing Application for Membership in the NHealth CIN, the following information must be answered. Please note that additional information may be requested in order to complete the application process. If it is discovered that the information you supplied on the application questionnaire or application form is false, this may result in ineligibility for membership.

Please answer the questions listed below. For any "Yes" or "N/A" responses, provide an explanation in the comments area below or include additional pages as needed.

Disclosure Questions	Yes	No	N/A
License			
Do you currently hold an unrestricted Oklahoma State License in one of the provider disciplines listed at the top of page 2?			
Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions of limitations by any state or professional licensing, registration or certification board?			
Hospital Privileges and Other Affiliations			
Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?			
Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?			
Medicare, Medicaid or Other Governmental Program Participation			
Are you currently eligible to participate in federally funded health care programs such as Medicare and Medicaid?			
Are you currently participating in Medicare?			
Board Certification			
Are you currently board certified in your primary area of expected specialty practice?			
DEA or State Controlled Substance Registration			
Do you have a current and unrestricted DEA registration?			
Have your Federal DEA and /or State Controlled Dangerous Substances (CDS) certificate (s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?			
Professional Liability Insurance Information and Claims History			
Do you currently have malpractice liability coverage with minimum coverage of $1,000,000 per occurrence/ $3,000,000 aggregate?			
Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated)?			
Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?			

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Ability to Perform Job			
Are you currently engaged in the illegal use of drugs?			
Do you use any chemical substance 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?			
Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?			
Criminal / Civil History			
Have you ever been convicted or, pled guilty to, or pled nolo contendere to any felony?			

Comments:

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Please send completed form to Aryn Sherfield

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