Thank you for your continued affiliation with UnityPoint Health!

The UnityPoint Health Credentials Verification Office (CVO) will send the applicant the online portal application invites via e-mail based on your re-credentialing due date.

If the CVO has been previously made aware of a Delegate Credentialing Contact, a person who can assist with completing the portal, the delegate will also receive an invitation via e-mail.

The e-mails and logins for the Practitioner and Delegate Credentialing Contacts are NOT interchangeable.

The application will slightly vary dependent upon if the applicant has hospital membership/privileges or if the applicant only has PHO (Medimore Payors) participation. Applicants are responsible for the final review, signing and submitting of the portal application.

If you have any questions please contact the CVO:

UPH_CVO@unitypoint.org

Provider Assistance Line available from 7:00am-5:00pm CST: 515-241-7977

https://www.unitypoint.org/cvo

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Invitation E-mail

You, and if applicable the Delegate Credentialing Contact, will receive two (2) email notices from the CVO requesting that you complete your recredentialing. The e-mails and logins for the Practitioner and Delegate Credentialing Contacts are NOT interchangeable.

One email will outline your instructions and provide your direct link to your portal.

The second email will provide you the password to be used for your portal.

We recommend that you copy and paste the password to assure capitalization and proper letters are used. Make sure to not grab extra spaces before or after the password.
Credentialing Information to have on hand

The following information is provided to assist you in ensuring you have all of the information needed on your Application for quick credentialing turnaround. Please contact the CVO for any clarification needed.

**UPH_CVO@unitypoint.org**

Provider Assistance Line available from 7:00am-5:00pm CST: 515-241-7977

Prior to starting the application completion process via the UnityPoint Health Practitioner Portal you will need to gather the following information/documents.

For recredentialing applications the CVO Requests all of your information **within the past 4 years**, if anything has been previously supplied to the CVO it should be prepopulated in your portal application for you.

**Information:**
- Current and prior state license number(s), effective and expiration date(s)
- Current and prior DEA number(s) and expiration date(s)
- Current and prior Controlled Substance Registration number(s) and expiration date(s)
- Current and prior malpractice insurance policy(ies) information including carrier name, policy number, effective and expiration date, per incident and aggregate amount
- Any new Medical and Training Program information and date(s) of attendance
- Board/National Certification number(s), date(s), and/or eligibility status/exam date(s), if applicable
- Hospital/Ambulatory Surgery Center Affiliation information and date(s), if applicable
- Work History and Gap Explanations
- Back-Up/Covering Provider information
- Be prepared to answer questions regarding your professional history such as non-renewed Hospital privileges, financial investments/relationships, malpractice claims filed, criminal history, health and vaccine status, etc.

**Documents:**
- A PDF copy of your Current Malpractice Insurance Certificate(s)
  - **NOTE:** You are not required to provide a copy of this if you have already supplied a recent copy to the CVO, but providing a current copy is always appreciated
Applicant Portal - Basic Info & Troubleshooting

Note the compatibility requirements.

The UnityPoint Health Practitioner Portal is located here:

Practitioner Portal

To access the Practitioner Portal as a delegated (credentialing contact) user:

Delegate Cred Contact - Practitioner Portal

Upon clicking on your portal link in the email you will arrive at the log in page. Enter your email address that your portal invitation was sent to and enter the password provided in the second email.

If the applicant cannot get the password to work try the “Forgot your password” feature, see below for troubleshooting tips. If you are still unable to access your application please contact the CVO: UPH_CVO@unitypoint.org
Password troubleshooting:

If your password does not appear to work, you can click on the “Forgot your password?” option and you will be prompted to the following screen. Last name and first name must match with our names in the credentialing software system.

Successful matching of last name and first name to our system will be confirmed with this message stating a new temporary password has been sent to the original email where the portal invitation was sent.
The password email will ONLY give you the new password. You will use your original recredentialing portal email for the portal link.

We recommend that you copy/paste the password, making sure to not grab extra space prior or after the password.
Please be aware the application will timeout and could cause portal issues if left open for an extended length of time without activity.

If this occurs, be sure to completely close your internet browser and then retry entering the portal. Sometimes when there has been too long of inactivity, you get locked out – this closing of the browser is necessary to reset it. You may also need to clear your browser history/cache and/or restart your computer.

Once logged into the portal the main screen outlines all the required information that will be needed for application completion. The portal will walk the applicant through all the sections, providing instructions along the way.
Information will be populated in the portal if we have the information in our credentialing software system already from prior information supplied by the applicant. This information needs to be reviewed by the applicant for accuracy by clicking on the down arrow next to each entry and “Edit” to review all information loaded. Recredentialing information is based on the last 4 years of information.

Green highlighted sections have been added throughout the portal in areas that we have identified providers/delegates are not addressing information required.

and update data as needed.

Do NOT delete Offices. Provide an end date at the location if no longer practicing at the location.

You are REQUIRED to provide the name of providers or practice group that covers your patients when unavailable at each practice location.

Please note:
Fields with Red Asterisk* are required fields. If they are not filled in the portal will place a Red Flag next to the section header where a field need addressed.

Example of when answering a question may open up another required field:

U.S. Citizen = No Visa information required
Not a U.S. Citizen = Visa information required

Screen sample of a Red Flag that must be addressed or the portal will not let you submit.
Credentials Verification Office  
Recredentialing Tip Sheet – Updated April 2023

You are REQUIRED to provide the name of providers or practice group that covers your patients when unavailable at each practice location.

Please note:
Only one (1) office can be checked as Primary
Only one (1) office can be checked as Mailing
You must have at least one (1) office marked as a billing office
One office can have all 3 identifications checked.

Please select the down arrow then the edit (pencil) tool for each practice office in this section to review and update data as needed.

<table>
<thead>
<tr>
<th>Practice Location</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osceola Vision Center, 147 S Main ST, Osceola, IA</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>UnityPoint Clinic Pediatric Gastroenterology At Galesburg, 834 N Seminary ST STE 301, Galesburg, IL</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>
If you miss a required field, you will receive a warning to go back and fix.

If you do not address the required field a Red Flag will appear – this must be addressed, or the application will not allow you to submit the portal application. Be sure to use the “Save and Continue” button to be sure your changes are saved, and your flags are cleared.
Additional tips have been added throughout the system. They are identified with the italics symbol.

If the applicant has recently submitted other portals, they will show at the bottom of the main Welcome page.

NOTE: A Delegate Credentialer (office personnel who assist with credentialing applications) can ASSIST with the completion of the application but ONLY THE PRACTITIONER IS ALLOWED TO SUBMIT THE COMPLETED FORM AND PRIVILEGES. The Delegate will receive a separate portal invitation to complete their work.

For questions regarding packet completion and submission, email the CVO at UPH_CVO@unitypoint.org

Prior submitted applications

| UPH ReCredentialing & Privileges Portal 2022 - Complete |  
| Submitted: 5/19/2022 |

If the applicant has other applications to complete there will be an option at the bottom of the main Welcome page to switch to the other application. Such as a Recredentialing application instead of an Initial application.

PRACTITIONER IS ALLOWED TO SUBMIT THE COMPLETED FORM AND PRIVILEGES. The Delegate will receive a separate portal invitation to complete their work.

For questions regarding packet completion and submission, email the CVO at UPH_CVO@unitypoint.org

Not the application you were looking for? Choose another active application here:  

---

Credentials Verification Office
Recredentialing Tip Sheet – Updated April 2023
You can use the search feature in our Lookup lines, in the example below it shows how to look up a Hospital or Ambulatory Surgery center. Click on the italics symbol for additional search tips.

IF the facility or entity is not in the drop-down listing, simply type in the required data field information.

**Healthcare Organization Affiliations**

You are REQUIRED to list ALL Current, Pending, and Prior Hospital affiliations you have had in the last 4 years.

If you no longer have membership and/or privileges at a listed hospital, note status of “Inactive” and provide an end date.

**EACH affiliation must be REVIEWED and EDITED to answer required question.**

Select the down arrow then the edit (pencil) tool for each Healthcare Organization Affiliation listed in this section to review, update and answer the required question.

**MEDIMORE PHO REQUIREMENT:**

MD/DO, ARNP and PA practitioners (excluding Allergy/Immunology, Anesthesiology, Dermatology, Emergency Medicine, Genetics, Occupational Medicine, Physical Medicine, Palliative Medicine, Pathology, Public Health, Radiology, and Radiology/Oncology) requesting participation with Medimore PHO are required to have either admitting privileges or a way to admit patients at a Medimore participating hospital.

I do not have hospital privileges but have the following arrangement for my patients to be admitted

Current or Prior Affiliation

Organization Lookup

Organization Name

Address

Suite #

Primary?
Basic Information Section

Remember, information will be populated in the portal if we have the information in our credentialing software system already from prior information supplied by the applicant. This information needs to be reviewed by the applicant for accuracy by clicking on the down arrow next to each entry and “Edit” to review all information loaded.
Vital & Contact –

The Primary e-mail and alternate e-mail listed must be for the Applicant, we cannot accept a Delegate Cred Contact in the primary or alternate e-mail fields. Use the Delegated Credentialing Contact section further into the application to list the person who will assist you in completing your credentialing.

If the applicant is relocating, and their current home address will be changing at a later date or during application processing, the new local address must be passed along to the CVO for system updating.

Personal History –

Birth Country and Citizenship must be provided
**Alias Information** –

Please provide any former or alternate names.

If you have married and had a name change since your last recredentialing cycle we must have appropriate documentation of your name change. The Credentialing Coordinator processing your application will contact you for a marriage certificate, etc. or may ask you to submit a service now request to get that updated in our system.
Delegated Credentialing Contact –

If someone will be assisting you in the completion of your application their information will be populated here, if you wish to add someone to assist in your application processing please list them here. This person will then be added to your profile and will receive future messages for recredentialing, licensure expirations, etc. They can NOT submit your portal application or privilege requests.

If you do not have such a person in your office, enter the email and phone number you want to be contacted at for recredentialing and expiration notices.

Sample of screen to identify REQUIRED fields identified by Asterisks.
Practice Locations -

Remember information will be populated in the portal if we have the information in our credentialing software system already from prior information supplied by the applicant. This information needs to be reviewed by the applicant for accuracy by clicking on the down arrow next to each entry and “Edit” to review all information loaded.

- All current and prior practice locations in the last 4 years must be listed on the application.
- You will need start dates for each location.
- You will need end dates for locations where you are no longer practicing – do NOT delete prior locations. Practice locations that are listed but you no longer practice at MUST have an end date entered. This information is needed to make payer enrollment and provider directory listing updates.
You must identify if you are currently working at the location. If you say No – you are REQUIRED to provide an end date for the location.

---

**Practice Location(s)**

Please select the down arrow then the Edit (pencil) tool for each office in this section to review and update data as needed.

Do Not Delete Offices: Provide an end date at the location if no longer practicing at the location.

You are REQUIRED to provide the name of providers or practice group that covers your patients when unavailable at each practice location.

Please note:

- Only one (1) office can be checked as Primary
- Only one (1) office can be checked as Mailing
- You must have at least one (1) office marked as a billing office

Beginnign Practice Date at This Primary Location: *

Are You Still Practicing At This Primary Location: *

Add a New Practice Location By Lookup: Use A=to search by address; N=to search by Office Name; C=to search by City; T=to search by TIN. If your practice location is not in the drop down listing, enter in the required field information.

To look for a location use A=Enter address, N=Enter Office Name, C=Enter City Name or T=Enter Office TIN

<table>
<thead>
<tr>
<th>Office name</th>
<th>Discotta Vision Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address 1</td>
<td>147 S Main ST</td>
</tr>
</tbody>
</table>
The type of office is to identify the primary practice location for payer enrollment purposes.

- **Primary** = Main office
- **Additional** = Additional practice location under the same billing tax identification number (TIN)
- **Secondary** = A second billing TIN
- **Tertiary** = A third billing TIN
- **Billing Office** = If your practice locations have separate billing offices, they need to be listed
- **Mailing** = If your practice locations have separate mailing offices, they need to be listed

You will need to identify the type of office – Primary, Additional, Secondary, etc. Click on the symbol for additional tips throughout the system.

An example of a Provider with two separate employers, one of which has multiple clinical office locations

- **Primary** = UnityPoint Health Express Care Moline
- **Additional** = UnityPoint Health Express Care Rock Island
- **Billing and Mailing** = UnityPoint Health Billing Office
- **Secondary and Mailing** = Private Family Medicine Practice, LLC
- **Billing** = Private Family Medicine Practice, LLC Billing Office
We must have covering Physicians/Practitioners listed for your clinical practice locations that will manage your patients when you are unavailable. Covering/Back-up Providers are Providers who will provide coverage for you when you are out of the office and unable to provide continuation of care to patients.

Your Covering/Back-up Practitioners can be a group or individual and should be listed as “GROUP NAME” or “FIRST/LAST NAME, DEGREE” to satisfy this requirement.

This requirement is applicable to Locums as well as although your role is to cover for another Physicians/Practitioner, your Locum Company or the Practice you are covering for should be able to provide another Practitioner to cover your role in your absence.

If you are applying for privileges the covering Physicians/Practitioners you utilize must have privileges at the same UPH location you are applying for.
You may need to inform us of new practice locations. You will click the gray “Add Another Office Location” button.

Do NOT delete Offices—Provide an end date at the location if you are no longer practicing at a location.

You are REQUIRED to provide the name of providers or practice group that covers your patients when unavailable at each practice location.

You will need to identify the type of office – Primary, Additional, Secondary, etc. Click on the symbol for additional tips throughout the system.
Practice Location(s)

Please select the down arrow then the Edit (pencil) tool for each office in this section to review and update data as needed.

Do NOT delete Offices—Provide an end date at the location if no longer practicing at the location.

You are REQUIRED to provide the name of providers or practice group that covers your patients when unavailable at each practice location.

Please note:
Only one (1) office can be checked as Primary
Only one (1) office can be checked as Mailing
You must have at least one (1) office marked as a billing office

Beginnin\text{g Practice Date at This Additional Location:}

Add a New Practice Location By Lookup: Use A=to search by address; N=to search by Office Name; C=to search by City; T=to search by TIN. If your practice location is not in the drop down listing-enter in the required field information.

To look for a location use A=Enter address; N=Enter Office Name; C=Enter City Name or T=Enter Office TIN

Office name *
Address 1 *
Address 2

* Indicates a required field.
Provider Languages –

We welcome providers to inform us of languages they may read, speak, or write. If you do not speak/write other languages, this section can be skipped by clicking the “Save and Continue” button.

Provider Languages
Please specify all languages that you claim working-level proficiency.

Portuguese

Language: Portuguese
Read ✔️ Speak ✔️ Write ✔️

Add a language
Professional History

EACH license, registration and certification must be reviewed and edited.

Select the down arrow then the edit (pencil) tool for each license, registration and certification listed in this section to review and update data as needed.

To ADD licenses, DEA or CSA, click on the gray button "Add License NP/PL/PE Certifications" and then use the ID Number Type drop down list to select the type of additional license you are adding.
Licensure, Registrations and Certifications Section

All current, pending, and prior licenses, registrations, and certifications held within the last 4 years must be provided. If we have information in our system already it will populate, and you will need to review those lines for accuracy.

- You will use the ID Type drop down to add licenses, registrations, and certifications
- Advanced Practice Practitioners (ARNP, PA-C) must identify a supervising provider for their licensure unless a waiver has been approved. For additional information on waivers, contact the CVO, UPH_CVO@unitypoint.org
- All current and prior licenses within the requested time period need to be listed on your Application. For Licenses that are no longer active, please review the Disclosure Questions and complete associated Disclosure Forms if applicable.
  - If you have reported Training Programs, Hospitals, and Work History in a certain state, have you also provided us that State License, CSA, and DEA information?
  - If your employer is based in a state that you do not work in please add a comment to that employment history entry to explain. For example, you work for a locums company based in Texas, but you only work in Nebraska, Illinois, and Iowa.
- You must verify the status and limitations of all your licensure.
  
  Regarding the question “Is this license unlimited?”
  - A “Yes” answer is appropriate if your licensure has no limitations beyond the regular scope of practice. For example, a mid-level provider practicing under the supervision of a Physician is not a limitation if that falls under the regular scope of practice. Or a Controlled Substance or DEA certificate that does not include schedule I drugs, substances, or chemicals; Schedule I are defined as drugs with no currently accepted medical use and as such this schedule is not typically issued.
  - A “No” answer is required if there are any limitations to your licensure. For example, a license issued only for public agency or non-profit employment, or a DEA issued only for a University.
- Enter “NA” for the state if it is not a state specific ID number such as NPI, ECFMG, or a CPR certificate
Licensure,Registrations and Certification Information
EACH license, registration and certification must be reviewed and edited.

Select the down arrow then the edit (pencil) tool for each license, registration and certification listed in this section to review and update data as needed.

Do NOT delete listed licenses. If you have not renewed, enter the expiration date and select the option “Not Renewed” in the drop down list.

<table>
<thead>
<tr>
<th>License Type</th>
<th>State/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>State License, IL</td>
<td></td>
</tr>
<tr>
<td>DEA Registration, IA</td>
<td></td>
</tr>
<tr>
<td>NPI, NA</td>
<td></td>
</tr>
<tr>
<td>Controlled Substance, IL</td>
<td></td>
</tr>
</tbody>
</table>
New to the portal is a required field identifying the status of the licensures.
For NPI – Enter NA into the State Field

If you add a new CSA or DEA, you will be required to enter in the prescribing schedule.

If you need to add more licensures, CSA, DEA, life certifications, etc. you will click on the gray button labelled, “Add License/NPI/Life Certifications.”

If you do not have any additions, click on the option, “I do not have a State License”
Example of where to use the drop down to find the new item you are adding in this section.
Healthcare Organization Affiliations -

You must enter all hospital and ambulatory surgery center affiliations within the past 4 years – current, pending, and prior.

Do NOT delete facilities that you no longer hold membership/privileges. We must have your end date at the location. For affiliations that are no longer active, please review the Disclosure Questions and complete associated Disclosure Forms if applicable.

We need to know the status of your membership/privileges at each facility.

If you no longer have membership and/or privileges at a listed hospital, select status of “inactive” and provide an end date.

Each affiliation must be REVIEWED and EDITED to answer required question.

Select the down arrow and then the edit (pencil) tool for each healthcare organization affiliation listed in this section to review, update and answer the required question.

Medimore PHO Requirement:

MD/DO, ARNP and PA practitioners (excluding Allergy/Immunology, Anesthesiology, Dermatology, Emergency Medicine, Genetics, Occupational Medicine, Physical Medicine, Palliative Medicine, Pathology, Public Health, Radiology, and Radiology/Oncology) requesting participation with Medimore PHO are required to have either admitting privileges or a way to admit patients at a Medimore participating hospital.

If you do not require admitting privileges, please select Save and Continue.
Screen shots of information needed for each affiliation.

If your membership is pending, you must identify it in the Status field and check the appropriate box. Use the date you applied to satisfy the “Start Date” requirement if needed.

<table>
<thead>
<tr>
<th>Healthcare Organization Affiliations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You are REQUIRED to list ALL Current, Pending, and Prior Hospital affiliations you have had in the last 4 years.</strong></td>
</tr>
</tbody>
</table>

If you no longer have membership and/or privileges at a listed hospital, select status of “Inactive” and provide an end date:

**EACH affiliation must be REVIEWED and EDITED to answer required question.**

Select the down arrow and then the edit (pencil) tool for each Healthcare Organization Affiliation listed in this section to review, update and answer the required question.

**MEDMORE PHO REQUIREMENT:**

MD/DO, ARNP and PA practitioners (excluding Allergy/Immunology, Anesthesiology, Dermatology, Emergency Medicine, Genetics, Occupational Medicine, Physical Medicine, Palliative Medicine, Pathology, Public Health, Radiology, and Radiology/Diagnostic Imaging) requesting participation with Medimore PHO are required to have either admitting privileges or a way to admit patients at a Medimore participating hospital.

If you do not require admitting privileges, please select Save and Continue.

I do not have hospital privileges but have the following arrangement for my patients to be admitted

<table>
<thead>
<tr>
<th>Current or Prior Affiliation</th>
<th>Current Healthcare Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization Lookup</td>
<td>Organization Name</td>
</tr>
</tbody>
</table>

* Indicates a required field
To add in new facilities, you will selecting the Gray box circled in red below, and then on the following screen you need to identify them as Current or Prior in the drop down box.

You will need to identify your current status at each facility.
If you do NOT have hospital privileges, you must have an admitting arrangement and you will need to identify who the admitting provider or group you will be using. This is a requirement for the UnityPoint Health PHO, Medimore, participation. You will enter the start date that the admitting arrangement was made for the hospital location.

Non-direct patient care providers (Social Workers, Physical/Occupational Therapists, etc.) can enter N/A in the pop-up boxes.

If you have questions on this requirement, please submit your question to uph_medimorecred@unitypoint.org
If you do not require admitting privileges, please select Save and Continue.

I do not have hospital privileges but have the following arrangement for my patients to be admitted:

- Current or Prior Affiliation
- Organization Lookup
- Organization Name
- Address
- City
- Enter Membership Status (Active, Pending, or Inactive)
- Start Date at Hospital

Click Box if Membership/Privileges are Currently Pending or Active at this Hospital or if you have an admitting arrangement with a covering group:

End Date of Membership/Privileges at Hospital

* Indicates a required field.
When adding in new facilities, you can use the search feature in the Organization Lookup line identified below. Click on the italics symbol for additional search tips.

IF the facility is not in the drop-down listing, simply type in the required data field information.

Healthcare Organization Affiliations

**You are REQUIRED to list ALL Current, Pending, and Prior Hospital affiliations you have had in the last 4 years.**

**If you no longer have membership and/or privileges at a listed hospital, note status of “Inactive” and provide an end date.**

Each affiliation must be REVIEWED and EDITED to answer required questions.

Select the down arrow then the **edit (pencil) tool** for each Healthcare Organization Affiliation listed in this section to review, update and answer the required question.

Medmore PHO Requirement:

MD/DO, ARNP and PA practitioners (excluding Allergy/Immunology, Anesthesiology, Dermatology, Emergency Medicine, Genetics, Occupational Medicine, Physical Medicine, Palliative Medicine, Pathology, Public Health, Radiology, and Radiology/Oncology) requesting participation with Medmore PHO are required to have either admitting privileges or a way to admit patients at a Medmore participating hospital.

I do not have hospital privileges but have the following arrangement for my patients to be admitted

- [ ]
  - Current or Prior Affiliation
  - Organization Lookup:
    - Organization Name
      - Address
        - City
        - State
        - Zip

* indicates a required field

Save and Continue
**Employment History**

You are REQUIRED to list all employment engagements for the last 4 years.

All work engagements must be entered, including explanation of any gaps in your employment greater than 30 or 60 days as requested in your portal.

If you are no longer employed with an entity, you must enter an end date. A current employer is required to be listed, if you end your employment with a location ensure you have entered a new employer if they are not already reported on your application, this includes future employment.

**NOTE** – Practice locations that are under the same employer do not get listed here. Only enter your primary location with that employer in this section, and any additional locations you practice at or billing/mailing locations under your employer should be listed under the Practice Locations section of the portal application. See some common examples below:

**Employer with multiple clinic locations**

If you are employed by an entity that has multiple clinical locations we only need the primary location listed in your employment history, we do not need all of the various clinic office locations you may see patients at under that employment history.

For example, UnityPoint Health/UnityPoint Clinic Providers will often go to multiple clinics or work in multiple emergency departments as part of their employment. It is unnecessary to list all UnityPoint locations that you may see patients at under employment history as all those locations are for the same employer, you will just list UnityPoint Health once with your original start date.

**Locum Work History**

If you are employed by a locums agency we only need the agency listed in your employment history, we do not need all of the clinical assignments and locations you were assigned to with that agency under work history.
Employment History

List chronologically (most recent first) all employment engagements, including employment, self-employment, service as an independent contractor, and military service in the last 4 years. If there is any gap of greater than 30 days in the chronology, explain using Gap Explanation option.

Do not duplicate internship, residency, and fellowship information reported in Medical School & Training Programs section.

Do not duplicate or list practice locations sites in this section if they are with the same employer. You should only list your practice offices in the prior application section called Practice Location Section.

Type of Employment: Work History

* Indicates a required field
In order for the “Thru Date” to populate you must check “No” for “Currently Employed?”, even for Gap Explanations.
Current and Past Insurance Carriers –

You must list all insurance carrier information for the past 4 years. Including those associated with training programs and termed employment engagements. For insurances that are no longer active, please review the Disclosure Questions and complete associated Disclosure Forms if applicable.

If you are unaware of the current and past insurance carriers that afford(ed) your coverage then you and/or your delegate credentialing contact will need to contact your prior employers, training programs, and/or possibly prior medical staff offices to obtain this information.

We do not require copies of prior certificates of insurance but if you have copies or are able to obtain those it may expedite the credentialing process.

UnityPoint Health (UPH) applicants – Please collaborate closely with your delegate credentialing contact to validate the entity providing current malpractice coverage for you.

Reminder to click the down arrow next to the listed carrier to edit the entry.

You can add additional carriers by clicking on the “Add Another Malpractice Carrier” and enter required data fields.
All coverage must be accounted for each training program and employer, there is a field for you to identify the education program or employer associated with each coverage entry you add.
Peer References -

There are various requirements for who we need a peer reference form completed by, carefully review the type of references that are required.

- **Advanced Practice Providers** – you MUST list your supervising physician as one of the two peers.
Education and Training Section

Information must be entered for the past 4 years to inform us of any updates in your Education and Training.

If you have completed the Education and Training within the last 4 years and the information has already been reported to us, you do not need to duplicate the information.

Medical Education/Clinical Training Update

Please provide an update of your medical education and/or clinical training over the last 4 years.

Do not duplicate internship, residency, and fellowship information previously reported.
Medical Education/Clinical Training Update -

There is a drop down table to search for education and training. If the location is not found, manually enter the contact information.

Medical Education/Clinical Training Update

Please list ALL your applicable Medical Education, including all internships, residencies and fellowships and/or clinical training, including training not completed.

Any gaps in training greater than 30 days, as well as information on any programs started but not completed must be included.
Medical Education/Clinical Training Update

Please list ALL your applicable Medical Education, including all internships, residencies and fellowships and/or clinical training, including training not completed.

Any gaps in training greater than 30 days, as well as information on any programs started but not completed must be included.

- [ ] What type of education? *Medical Education
- [ ] University Lookup
- [ ] University Name
- [ ] Address
- [ ] City, State, Zip
- [ ] Suite #
- [ ] Country
- [ ] Specialty
- [ ] Program Director
- [ ] Program Office Email
- [ ] Address
- [ ] Program Office Phone #
- [ ] Program Office Fax #
- [ ] From Date
- [ ] Thru Date

Were you the subject of any disciplinary action during your attendance at this institution? *
- [ ] Yes
- [ ] No

Did you successfully complete this program? *
- [ ] Yes
- [ ] No
Board Certifications/National Certifications Section

Sample of fields to be completed in this section. Review the existing information for any needed updates, and add any additional Certifications obtained.

Board/National Certification is a threshold requirement for application processing. Board eligibility information must be completed if you are not currently Board certified.

Advanced Practice Providers you will list your national certifications in this section.

For certifications that are no longer active, please review the Disclosure Questions and complete associated Disclosure Forms if applicable.

Board/National Certification

Please provide information about the Specialty in which you are Board Certified or may become Board Certified.

You will be asked to enter any scheduled or recently completed exam dates.

Are you Board certified? ☐ Yes ☐ No
Specialty of Board Certification: Family Medicine
Practicing this specialty? ☐ Yes ☐ No
Expiration Date: 7/4/2019
If not certified, are you eligible to take Boards? ☐ Yes ☐ No
Have you taken the specialty boards certification? ☐ Yes ☐ No
Are you scheduled to take the specialty board exam? ☐ Yes ☐ No
Board eligibility information must be completed if you are not currently Board certified.

**Board/National Certification**

Please provide information about the Specialty in which you are Board Certified or may become Board Certified.

You are **REQUIRED** to enter any scheduled or recently completed exam dates.

- Are you Board certified? *(Yes or No)*
  - Find Specialty Look Up
    - Board Certification Specialty
      - Practicing this Specialty? *(Yes or No)*
      - Certification Number:
    - If not certified, are you eligible to take Boards? *(Yes or No)*
    - Have you taken the specialty boards certification? *(Yes or No)*
    - Are you scheduled to take the specialty board exam? *(Yes or No)*
Disclosure Question Section

These questions are required to be completed reflecting on your last 4 years of history. Providing the answer to these questions gives the CVO a complete picture of your professional history.

Any questions answered “YES” will need the associated supplemental information field or form completed. If the form is not completed, the CVO will return the application for completion, causing delays in processing.

The disclosure questions and forms will vary based on where you will be credentialed.

- If you are strictly being credentialed for Iowa you will be asked the exact questions from the Iowa state credentialing application.

- If you are being credentialed for Illinois you will be asked the exact questions from the Illinois state mandated credentialing application.
Iowa:

Please carefully review the following questions as the CVO commonly needs to request clarification or correction to applications regarding. Provided are some examples of when it may be appropriate to answer these questions yes if it occurred within the past 4 years:

4. Have you ever voluntarily or involuntarily withdrawn from a clinical, medical, dental or professional staff?
   - Voluntarily resigned hospital or other healthcare affiliation privileges while in good standing due to a change in practice, employment, moving, etc.
   - Involuntarily resigned hospital or other healthcare affiliation while under investigation or to avoid investigation or due to disciplinary action

5. Have you ever voluntarily or involuntarily withdrawn a request for an increase in privileges?
   - Voluntarily withdrew due to a change in practice, employment, moving, etc.
   - Involuntarily withdrew to avoid investigation or reporting to a database

16. Has your malpractice insurance ever been denied, suspended, limited, not renewed or terminated by a carrier? (If yes, explain on Addendum C/Addendum A)
   - Carrier chose not to renew or terminated your malpractice insurance coverage due to no longer meeting criteria for coverage such as high risk procedures, frequency and severity of claims, payout amount of claims, and similar situations
   - This would not apply to a situation where an employer changes insurance carriers for employed providers, coverage changes due to a change in employment, or similar situations

17. Have you ever had a malpractice case filed against you? (If yes, explain on Addendum C/Addendum A)
   - If you have any malpractice claims filed against you

18. Have you ever had a malpractice judgment entered against you? (If yes, explain on Addendum C/Addendum A)
   - If you have any malpractice claims filed against you where a settlement did not occur, and a judgement payment was made against you instead

19. Have any malpractice settlements ever been made on your behalf? (If yes, explain on Addendum C)
   - If you have any malpractice claims filed against you that resulted in settlement payments being made

20. Are there any open claims or pending malpractice cases presently filed against you? (If yes, explain on Addendum C/Addendum A)
   - If you have any open malpractice claims filed against you

21. Has/have any adverse action(s) or malpractice report(s) about you been made to the National Practitioner Data Bank, or any other databank?
   - If you have any reports made to the NPDB or any other databanks
REMEMBER – If any of the Disclosure Section questions were answered “YES” the matching Disclosure Field or Form MUST be added and filled out with additional details.

For Questions #1-#15 and #21-#24 you will have a field to fill in for each “YES” answer

4. Have you voluntarily or involuntarily withdrawn from a clinical, medical, dental or professional staff?

* ☐ Yes  ☐ No

Please provide an explanation *Voluntarily resigned Hospital privileges when moving out of State due to employment change

For Questions #16-#20 you will need to “Add Professional Liability Incident” and then select “YES” when presented the option to be directed to fill out the Liability Claims Information – Addendum A. You can add as many forms as needed.

If all of the Disclosure Section questions were answered “NO”, you will still need to select “Add Professional Liability Incident” and then select “NO” when presented the option in order to continue to the Investments, CME/CEU, and Flu Vaccine questions.

Even if you have no Claims to report, please select “Add Professional Liability Incident” and then select “NO” to proceed to the next section.
Special Note for Question #16: You will need to “Add Professional Liability Incident” and then select “YES” to fill out the Liability Claims Information – Addendum A on the following page and complete the following fields:

- Which disclosure question is the explanation associated with?: 16
- **Insurance Carrier Name:** Name of the carrier that denied, suspended, limited, not renewed or terminated coverage
- **Describe your involvement with the patient’s care. Your narrative must include the following at a minimum:** 1. Condition and diagnosis at time of incident, 2. Dates and description of treatment rendered, 3. Condition of patient subsequent to treatment: The explanation of the circumstances surrounding the yes answer to this question.

Example of the Liability Claims Information – Addendum A for Question #16

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any Claims activity to report?</td>
<td>* Yes □ No</td>
</tr>
<tr>
<td>Which disclosure question is the explanation associated with?</td>
<td>▲ 16 ▼</td>
</tr>
<tr>
<td>Description of Allegation or Action taken</td>
<td>▼</td>
</tr>
<tr>
<td>Date of Incident</td>
<td>▲ Date of Claim or Suit filed ▼</td>
</tr>
<tr>
<td>Location of incident</td>
<td>▼</td>
</tr>
<tr>
<td>Insurance Carrier Name</td>
<td>Insurance Company, Co</td>
</tr>
<tr>
<td>Insurance Carrier</td>
<td>▼</td>
</tr>
<tr>
<td>Address</td>
<td>▼</td>
</tr>
<tr>
<td>City</td>
<td>▲ State ▼ Zip Code</td>
</tr>
<tr>
<td>Phone Number</td>
<td>▼</td>
</tr>
<tr>
<td>Describe your involvement with the patient’s care. Your narrative must include the following at a minimum: 1. Condition and diagnosis at time of incident, 2. Dates and description of treatment rendered, 3. Condition of patient subsequent to treatment: The explanation of the circumstances surrounding the yes answer to this question.</td>
<td>▼</td>
</tr>
<tr>
<td>Insurance coverage was not renewed by insurance carrier due to ▼ reason</td>
<td>▼</td>
</tr>
<tr>
<td>Your Status:</td>
<td>▼</td>
</tr>
<tr>
<td>Claim Status:</td>
<td>▼</td>
</tr>
</tbody>
</table>
Illinois:

Please carefully review the following questions as the CVO commonly needs to request clarification or correction to applications regarding. Provided are some examples of when it may be appropriate to answer these questions yes if it occurred within the past 4 years:

Adverse or other Action - 3. Have you lost any board certification(s), and/or failed to recertify?
- If you have voluntarily decided not to renew your boards for any reason, such as only maintaining your subspeciality or a change in practice
- If you failed your recertification requirements
- If you have a lapse in certification
- If your certification was revoked by the specialty board

Adverse or other Action - 5. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank?
- If you have any reports made to the NPDB or any other databanks

Adverse or other Action - 8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason?
- Voluntarily resigned hospital or other healthcare affiliation while in good standing due to a change in practice, employment, moving, etc.
- Involuntarily resigned hospital or other healthcare affiliation while under investigation or to avoid investigation or due to disciplinary action

Professional Liability - 1. Have any professional liability judgments ever been entered against you?
- If you have any malpractice claims filed against you where a settlement did not occur, and a judgement payment was made against you instead

Professional Liability - 2. Have any professional liability claim settlements ever been paid by you and/or paid on your behalf?
- If you have any malpractice claims filed against you that resulted in settlement payments being made

Professional Liability - 3. Are there any currently pending professional liability suits, actions and/or claims filed against you?
- If you have any open malpractice claims filed against you

Liability Insurance - Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled, non-renewed or limits reduced?
- Voluntarily non-renewing carriers due to employer choice to change insurance carriers, coverage changes due to a change in employment, or similar situations
- Carrier denied, cancelled, reduced, non-renew or terminated your malpractice insurance coverage due to no longer meeting criteria for coverage such as high risk procedures, frequency and severity of claims, payout amount of claims, and similar situations
REMEMBER – If any of the Disclosure Section questions were answered “YES,” the matching Disclosure Field or Form MUST be added and filled out with additional details.

- For **Adverse or other actions** please complete a Form A
- For **Professional Liability Action** please complete a Form B
- For **Criminal Action** please complete a Form C
- For **Medical Conditions** please complete a Form D
- For **Chemical Substances or Alcohol Abuse** please complete a Form E

Select “Add a form” and you will be presented with the Disclosure Form Drop Down, you can add as many forms as needed. If you have no questions answered yes and have no forms to complete select “Save and Continue” instead.
Example of the Adverse and Other Actions Form A for Question #8 when you have resigned privileges due to a change in employment
Privileges Section (N/A for PHO only enrollment)

This section is only in the portal utilized for applicants seeking hospital membership/privileges.

Providers who are needing to be recredentialed at hospitals for membership/privileges, you will see a section called “Privileges” on the top of the portal page.

To view and complete the privilege forms you must click on the words “Request Privileges” on the left side of the screen.

You will need to click on EACH privilege set name to open the form for requesting the privileges.

At the end of the privilege request form, you MUST click the “Submit” button.
Once successfully submitted, the main Privilege Section screen changes to show you have requested the privileges with a date noted.
You may be prompted to add your Date of Birth before the portal privileges will fully submit. If you are using two (2) monitors, watch for this message to appear on your second screen.
Required Documents Section

Upload Documents -

Documents must be in jpeg or pdf format for uploading. Please ensure your Practitioner Photo is in JPEG. Documents uploaded as a word, excel, or other file type may delay application processing.

You can click on the upload icon next to the document you want to upload to the CVO.
**Forms**

The forms will populate with the information supplied thus far in the portal and are viewable by clicking on the blue “View Form” button.

You will not download and sign these forms - they are available for your review. As soon as you hit the submission button on your application your electronic signatures will be populated on the forms.

Your electronic signature does not appear on the forms until the portal application is submitted.

You will need to click the box below View Form for the forms for your electronic signature and date stamp to be placed on the forms.

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**Portal ReCredentialing Application APP 4-23-21**

- **View Form**

I represent and warrant that all of the information provided and the responses given are correct and complete to the best of my knowledge and belief.

- **Previous**
**Review and Submission Section**

All portal sections must have a blue check mark underneath their headers.

You must have all sections of the portal checked off in order for the application to successfully submit.

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**Submit**

In order to submit your completed application, please make sure all required fields have been populated and accepted. All sections of the portal should have blue check marks. If you are seeing red flags appearing in any section, you must click into the area and address the item flagged. Make sure all required documents have been uploaded and/or signed.

**NOTE:** Only the Practitioner is allowed to submit the application. If you are a delegate user and the application is complete, please inform the practitioner to submit the application via their portal.

Click Continue when you are ready to submit.
If you see a missing checkmark, return to the section, and look for a Red Flag.

Below is an example of a portal that has two (2) sections that are not complete.

You can click into the section and a Red Flag will identify the item that is need further completion. Look for the red Asterisk fields in the sections.
Once all sections are successfully complete the portal is now eligible for submission.

Disclosure Questions

Please provide information on your professional history over the past four years.

The questions are divided up in the following categories:

- Adverse or Other Actions
- Professional Liability Actions
- Liability Insurance
- Criminal Actions
- Medical Condition
- Chemical Substances or Alcohol Abuse
- CME Attestation
- Flu Vaccine Attestation

Please note: If you need to report multiple incidents, please complete all questions then complete additional incidents on appropriate form(s) in the Additional Forms section. You will need to complete a separate form for each incident.
Click the “Submit” Button

You will be prompted to add your Date of Birth before the portal will fully submit. If you are using two (2) monitors, watch for this message to appear on your second screen.
Upon successful submission the main page of the portal will show a submission message.

NOTE: If the submission message notes a problem occurred, please reach out to the CVO, UPH_CVO@unitypoint.org

Your application is being processed. This may take some time to complete. Please check back later to access your completed application.
Next Steps

The application will then begin processing by the CVO. The Applicant will be contacted by a Credentialing Coordinator should anything additional be needed to process the application. The applicant may be asked to return to the portal for corrections on the application or they may be asked to provide those corrections via e-mail.

You can access the Portal to download a copy of your completed application once you have hit submit.

If you have any questions please contact the CVO:

UPH_CVO@unitypoint.org

Provider Assistance Line available from 7:00am-5:00pm CST: 515-241-7977

https://www.unitypoint.org/cvo

You can check status of your application using the CAT (Credentialing Application Tracker) on the CVO service now website: Credentials Verification Office Portal (service-now.com)