UnityPoint Health

Credentials Verification Office

Recredentialing Application Portal Tip Sheet

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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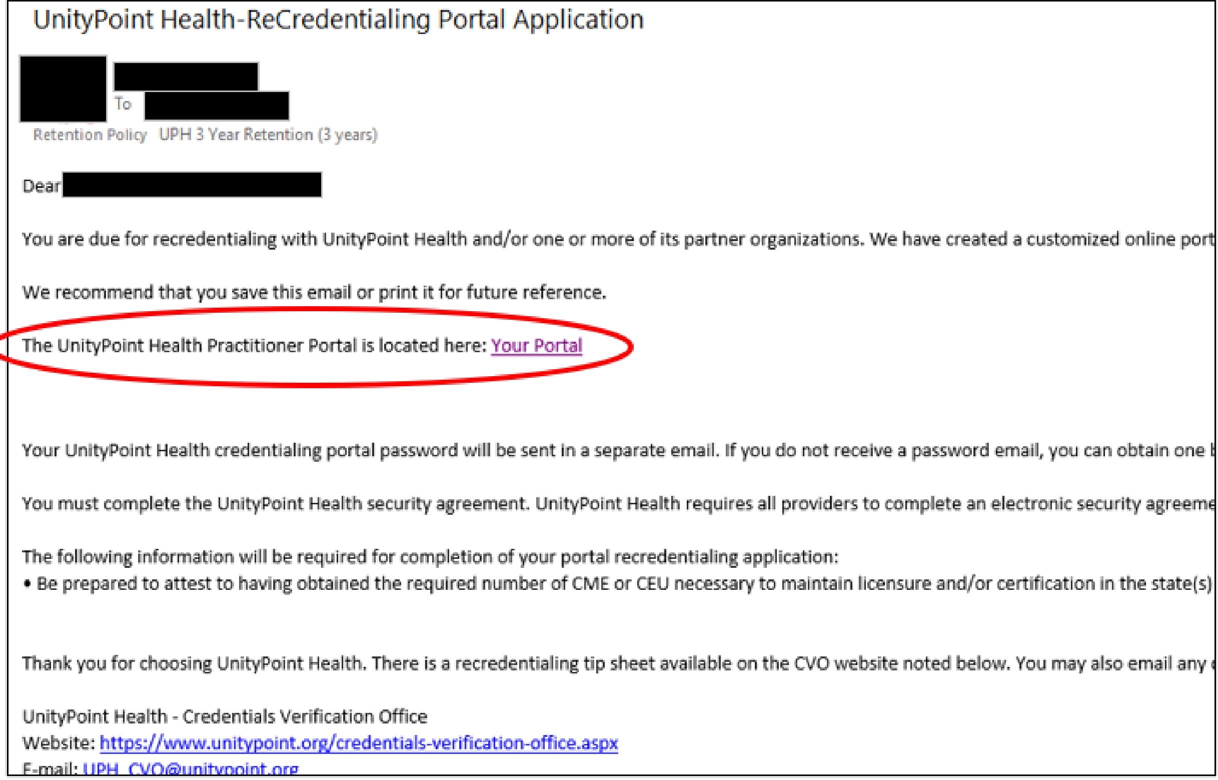
Invitation E-mail

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.



UnityPoint Health-ReCredentialing Portal Application

To

Retention Policy UPH 3 Year Retention (3 years)

Dear

You are due for recredentialing with UnityPoint Health and/or one or more of its partner organizations. We have created a customized online port

We recommend that you save this email or print it for future reference.

The UnityPoint Health Practitioner Portal is located here: Your Portal

Your UnityPoint Health credentialing portal password will be sent in a separate email. If you do not receive a password email, you can obtain one

You must complete the UnityPoint Health security agreement. UnityPoint Health requires all providers to complete an electronic security agreeme

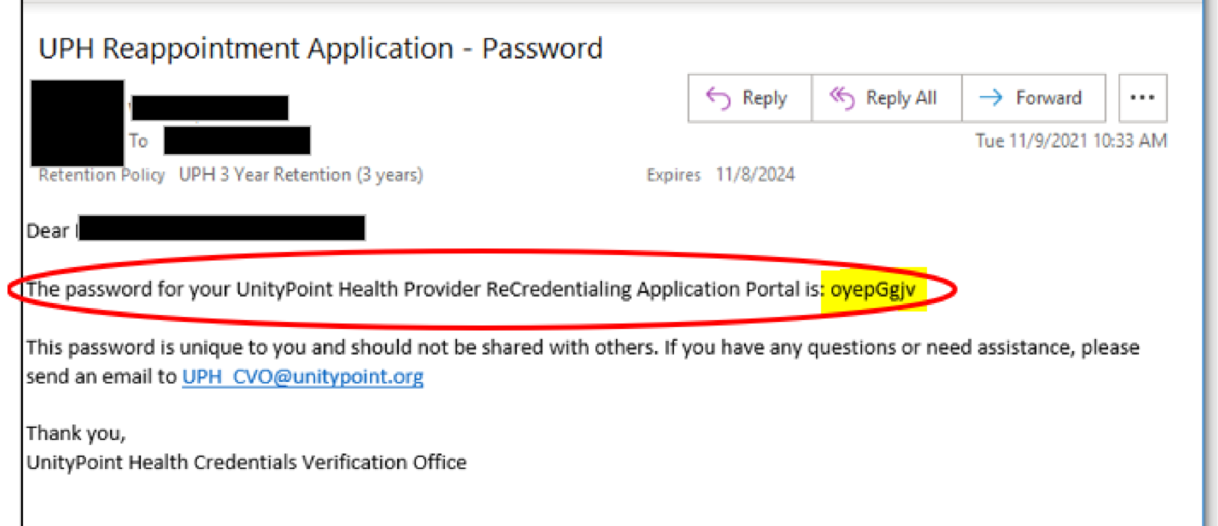
The following information will be required for completion of your portal recredentialing application:
• Be prepared to attest to having obtained the required number of CME or CEU necessary to maintain licensure and/or certification in the state(s)

Thank you for choosing UnityPoint Health. There is a recredentialing tip sheet available on the CVO website noted below. You may also email any

UnityPoint Health - Credentials Verification Office
Website: https://www.unitypoint.org/credentials-verification-office.aspx
E-mail: UPH_CVO@unitypoint.org

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.



UPH Reappointment Application - Password

Reply | Reply All | Forward | ...

To

Tue 11/9/2021 10:33 AM

Retention Policy UPH 3 Year Retention (3 years) Expires 11/8/2024

Dear

The password for your UnityPoint Health Provider ReCredentialing Application Portal is: oyepGgjv

This password is unique to you and should not be shared with others. If you have any questions or need assistance, please send an email to UPH_CVO@unitypoint.org

Thank you,
UnityPoint Health Credentials Verification Office

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 includingcarrier 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.

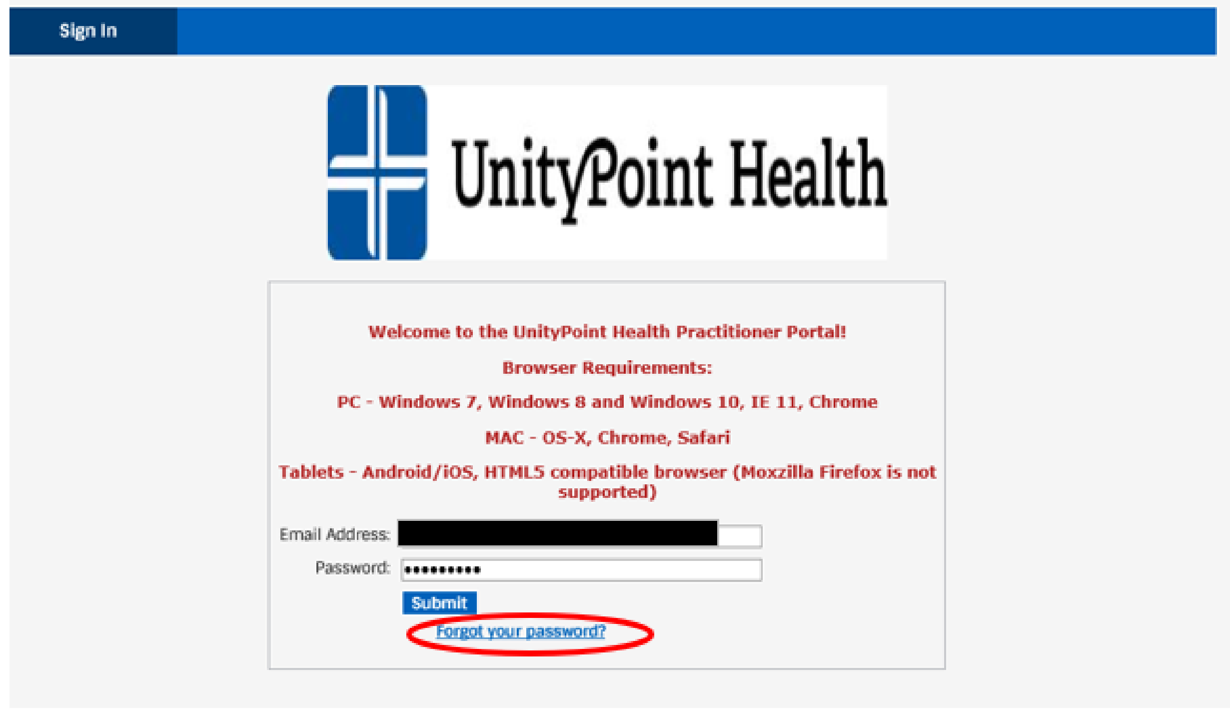
The UnityPoint Health Practitioner Portal is located here:

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



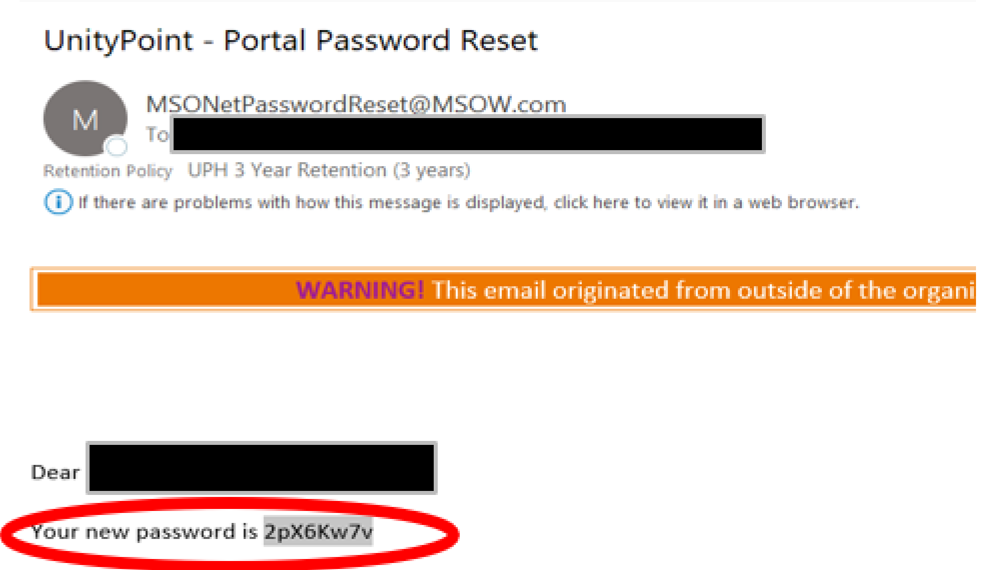
Password troubleshooting:

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.

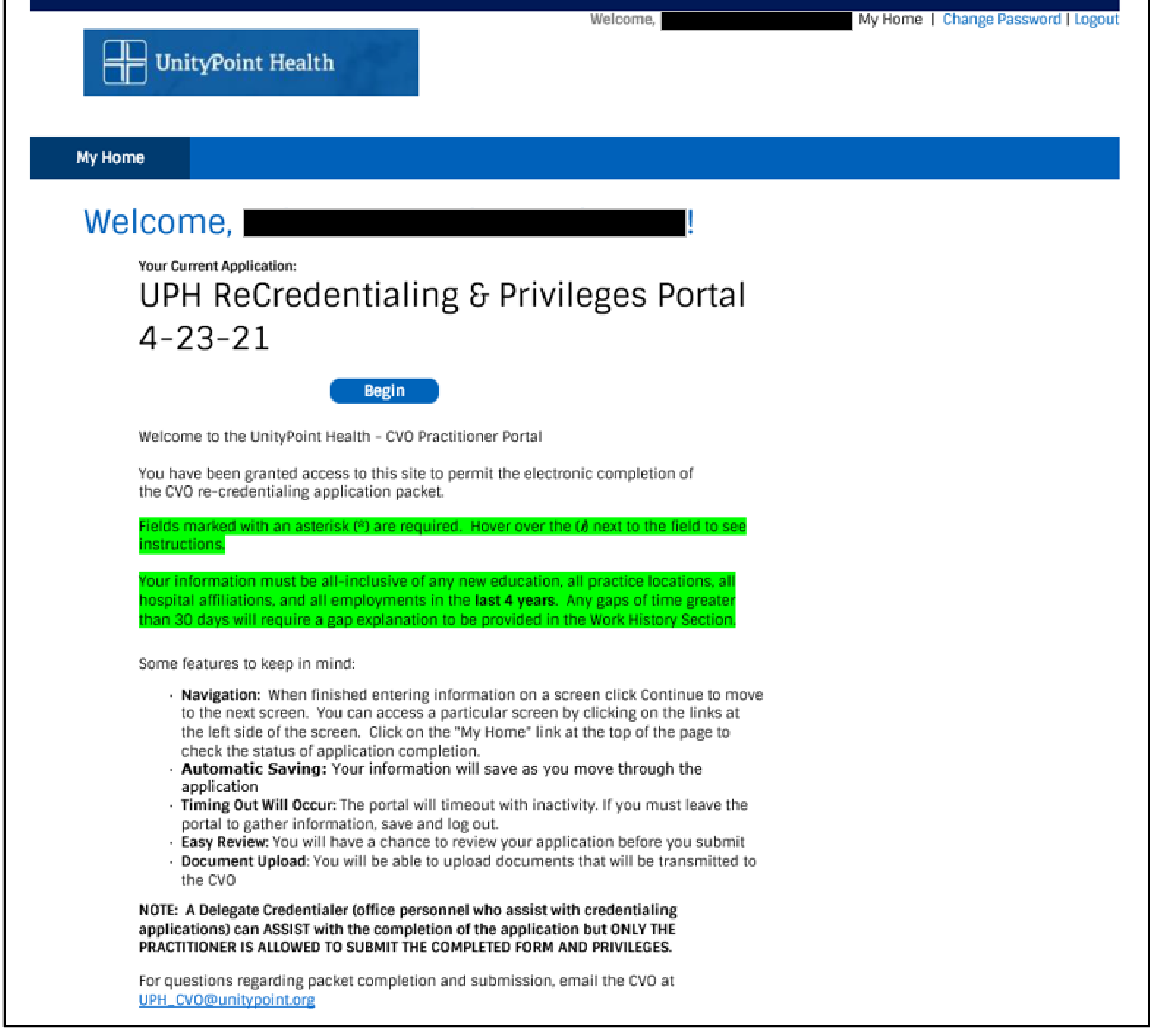


Please be aware the application will timeout and could cause portal issues if left open for an extended length of time without activity.

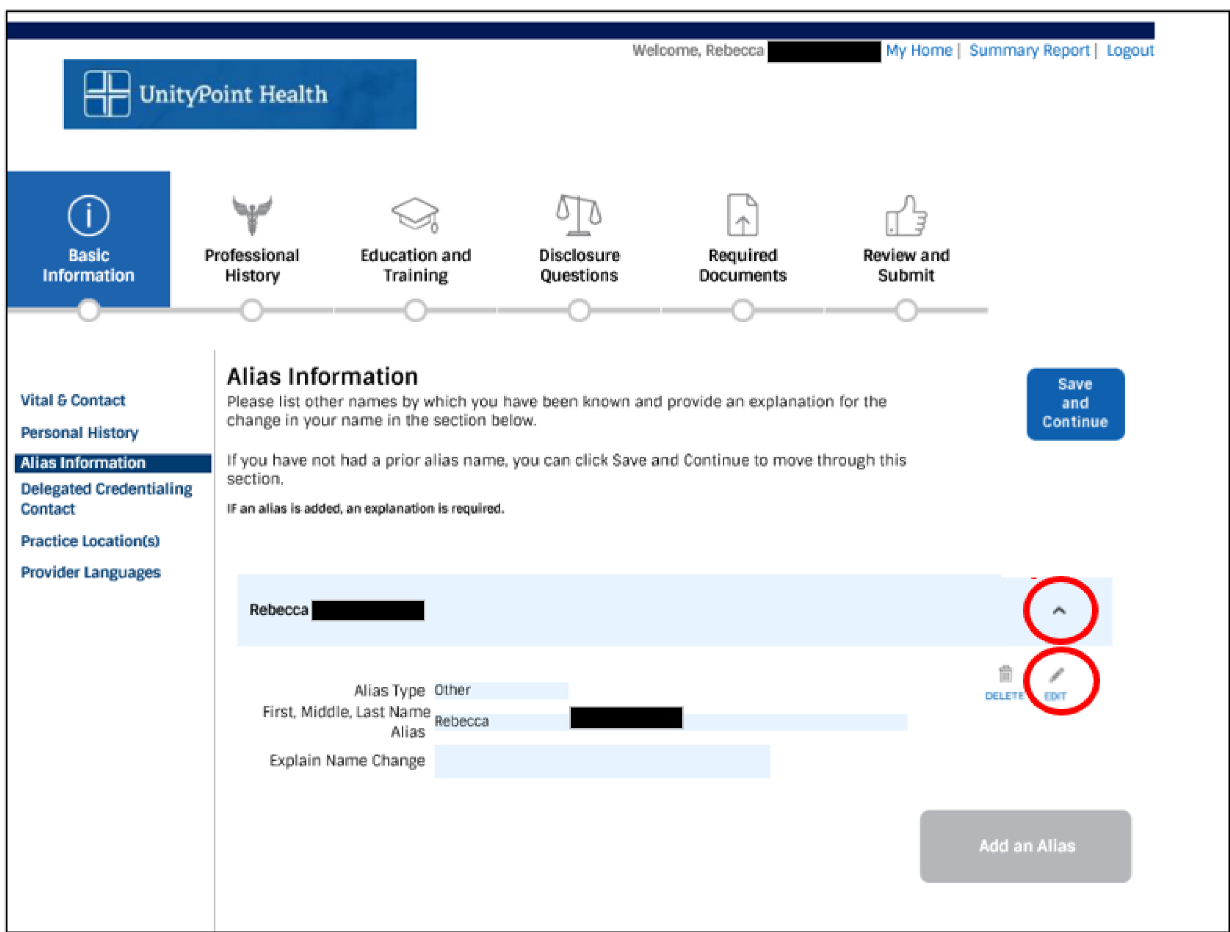
Your session has timed out. Please close the Practitioner Portal browser window.

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.

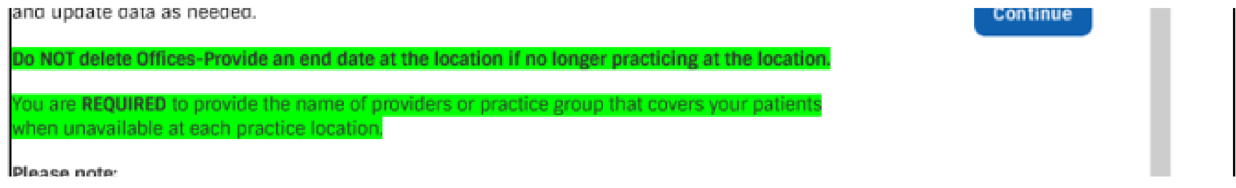
Once logged into the portal the main screen outlines all the required information that will be needed for application completion. The portal will walk the applicant through all the sections, providing instructions along the way.



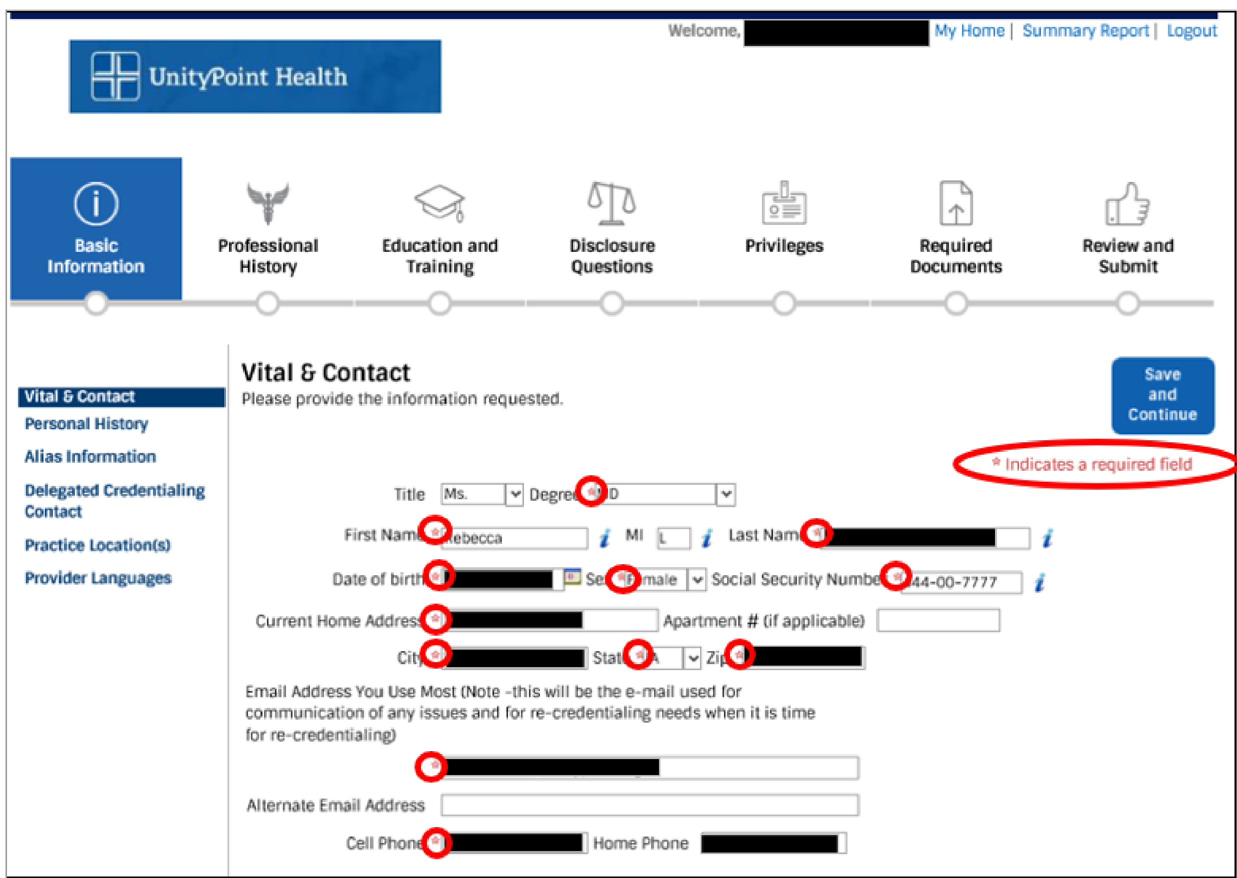
Information will be populated in the portal ***if*** we have the information in our credentialing software system already from prior information supplied by the applicant. This information needs to be reviewed by the applicant for accuracy by clicking on the down arrow next to each entry and "Edit" to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

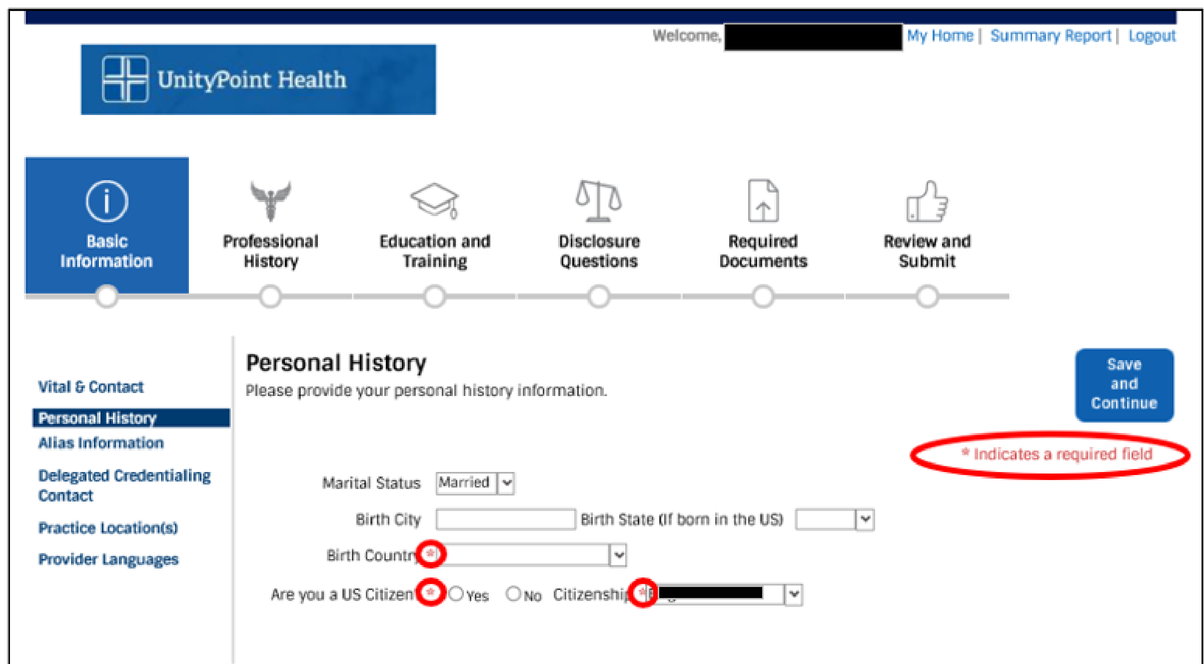


Fields with Red Asterisk* are required fields. If they are not filled in the portal will place a Red Flag next to the section header where a field need addressed.

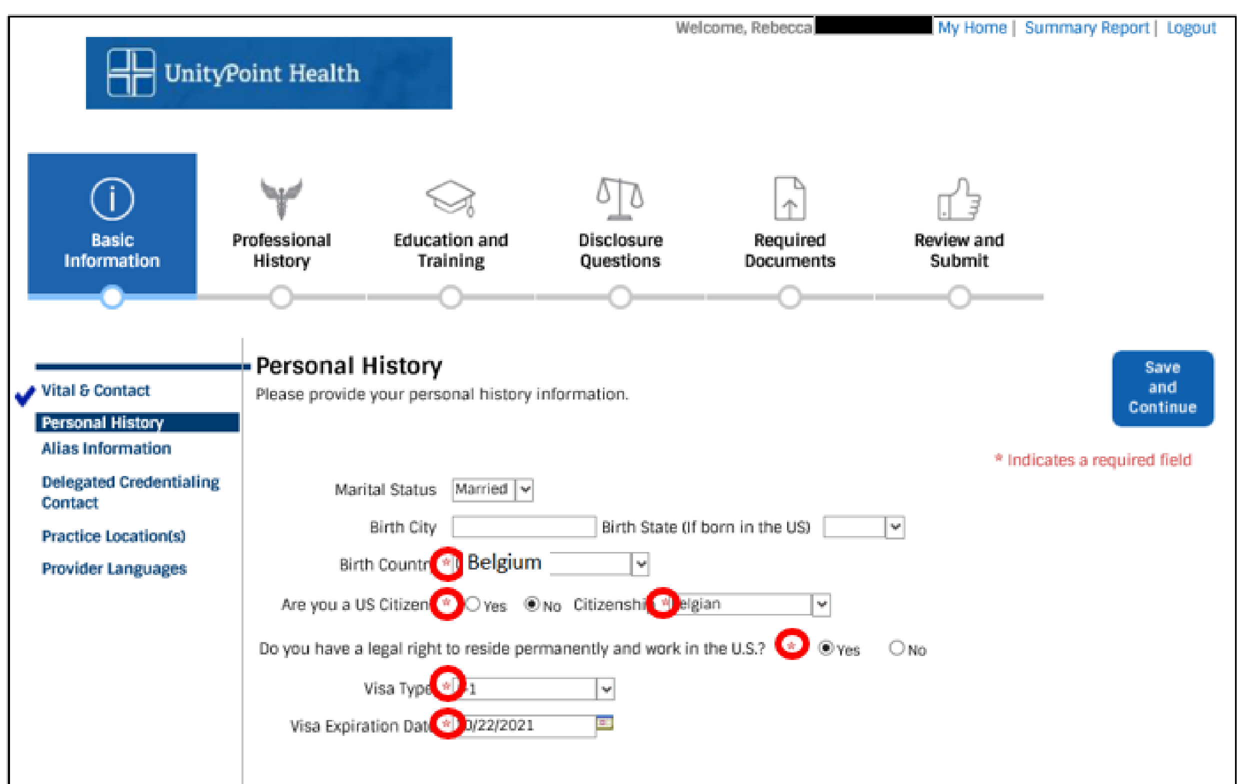


Example of when answering a question may open up another required field:

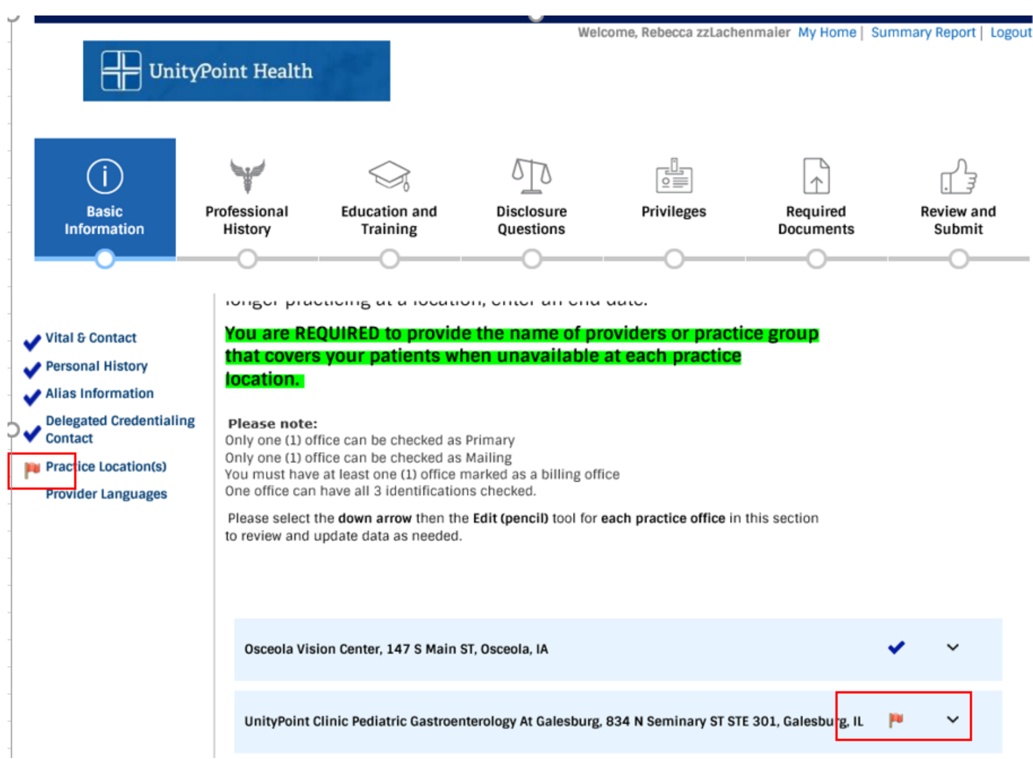
U.S. Citizen = No Visa information required



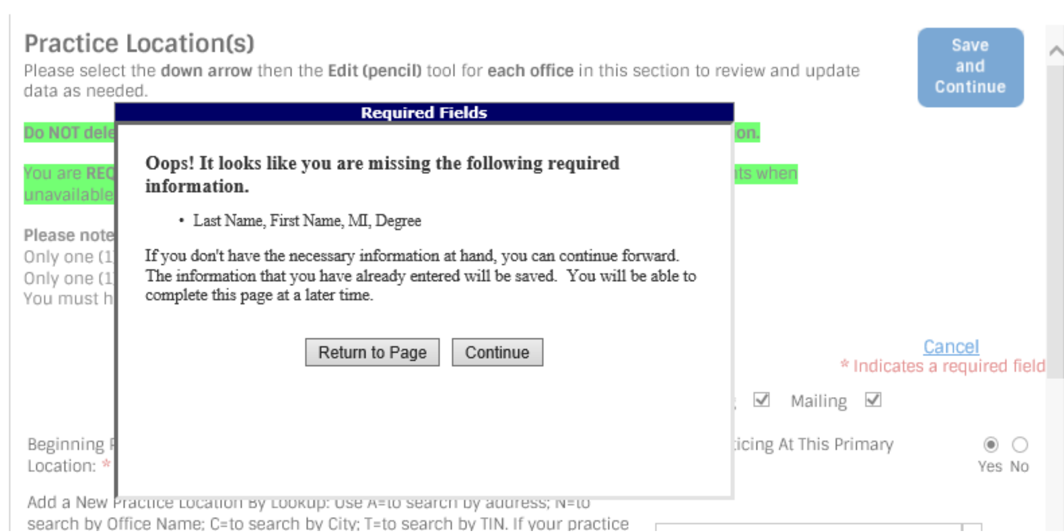
Not a U.S. Citizen = Visa information required



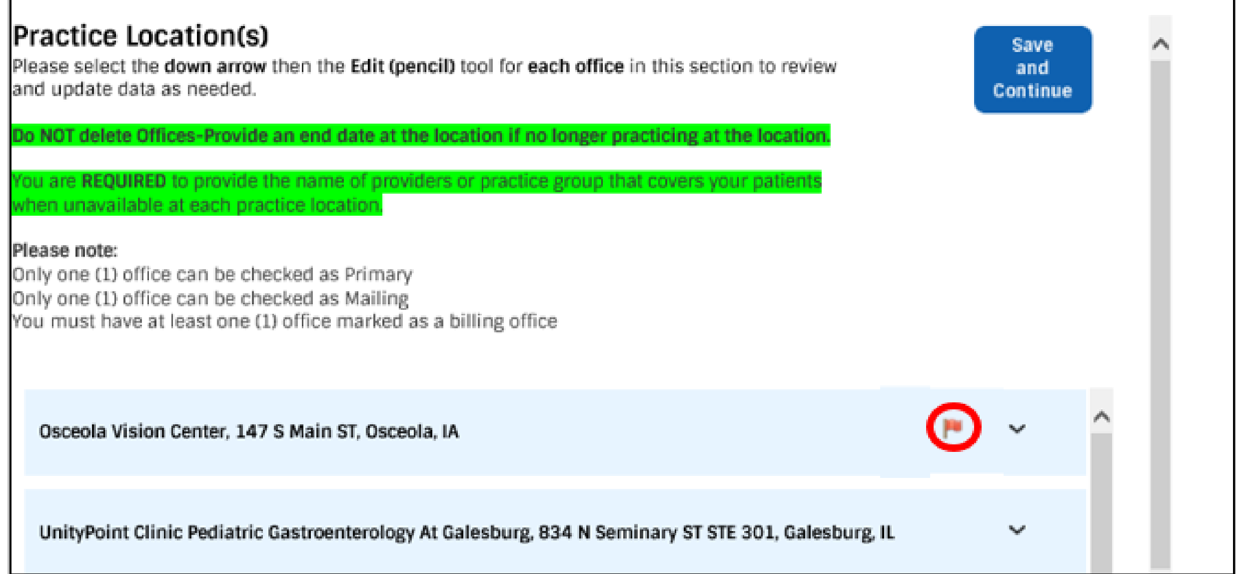
Screen sample of a Red Flag that must be addressed or the portal will not let you submit.


Welcome, Rebecca zzLachenmaier My Home | Summary Report | Logout
UnityPoint Health
Basic Information
Professional History
Education and Training
Disclosure Questions
Privileges
Required Documents
Review and Submit
Vital & Contact
Personal History
Alias Information
Delegated Credentialing Contact
Practice Location(s)
Provider Languages
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.
Osceola Vision Center, 147 S Main ST, Osceola, IA
UnityPoint Clinic Pediatric Gastroenterology At Galesburg, 834 N Seminary ST STE 301, Galesburg, IL

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.

the CVO

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.

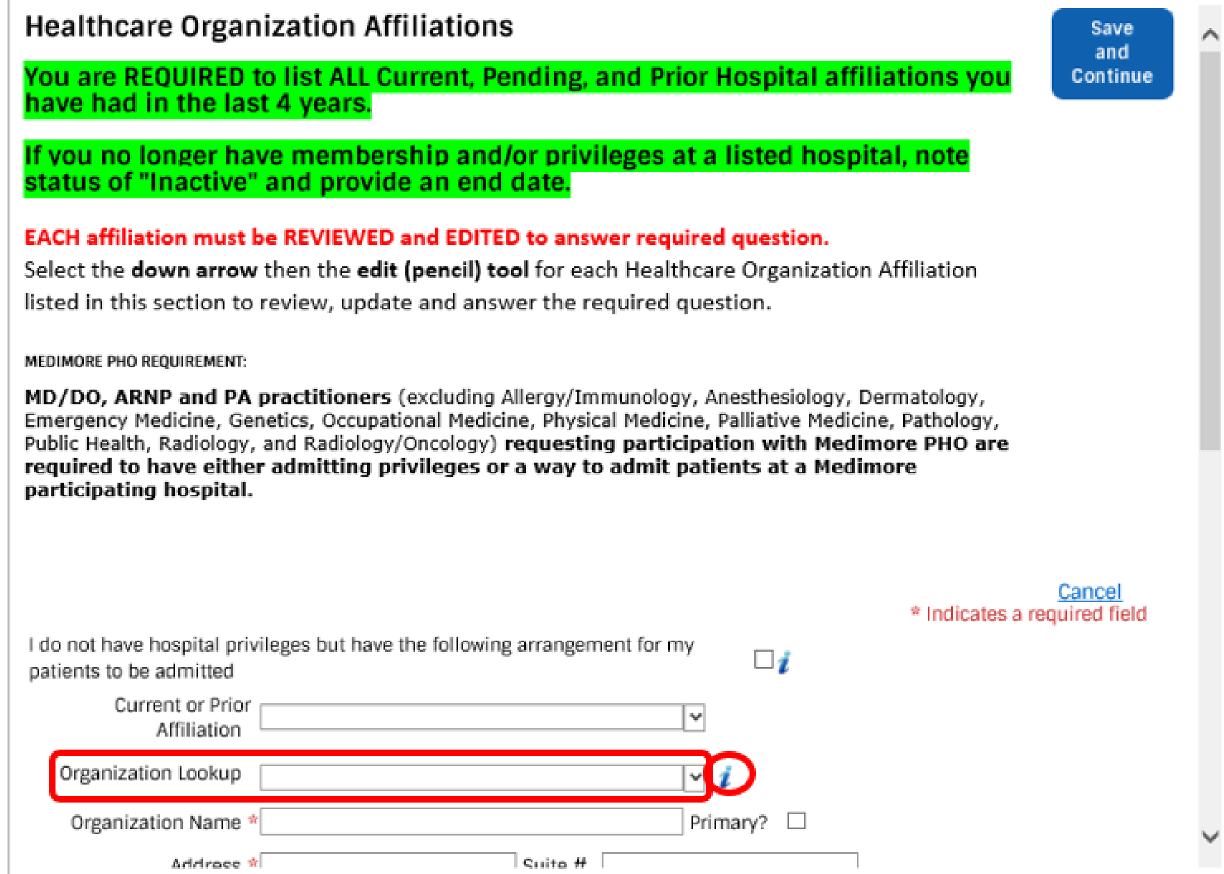
PRACTITIONER IS ALLOWED TO SUBMIT THE COMPLETED FORM AND PRIVILEGES. The Delegate will receive a separate portal invitation to complete their work.

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:

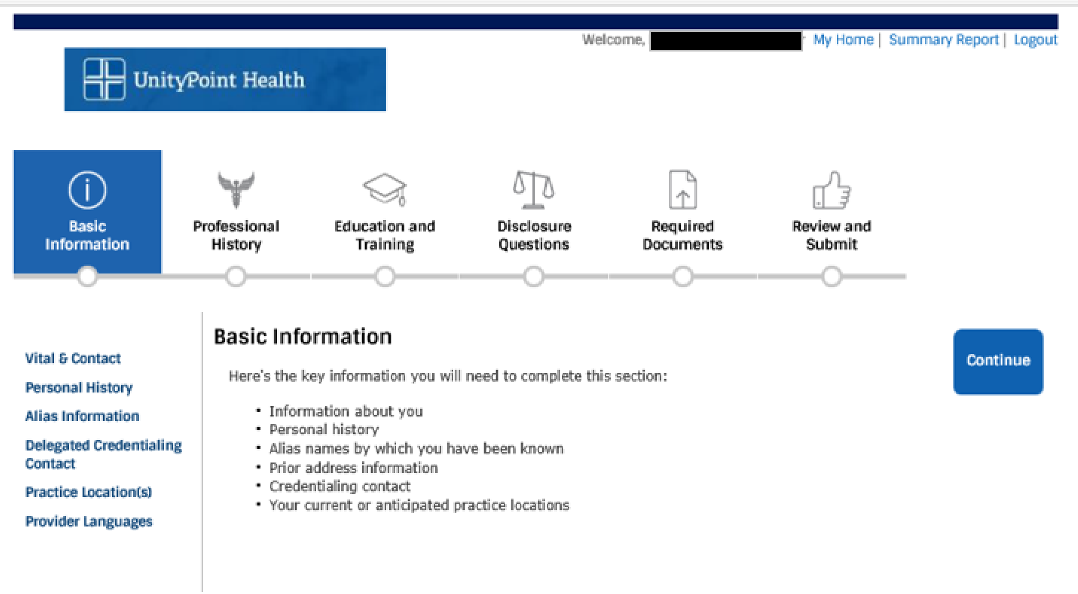
You can use the search feature in our Lookup lines, in the example below it shows how to look up a Hospital or Ambulatory Surgery center. Click on the italics symbol for additional search tips.

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



Basic Information Section

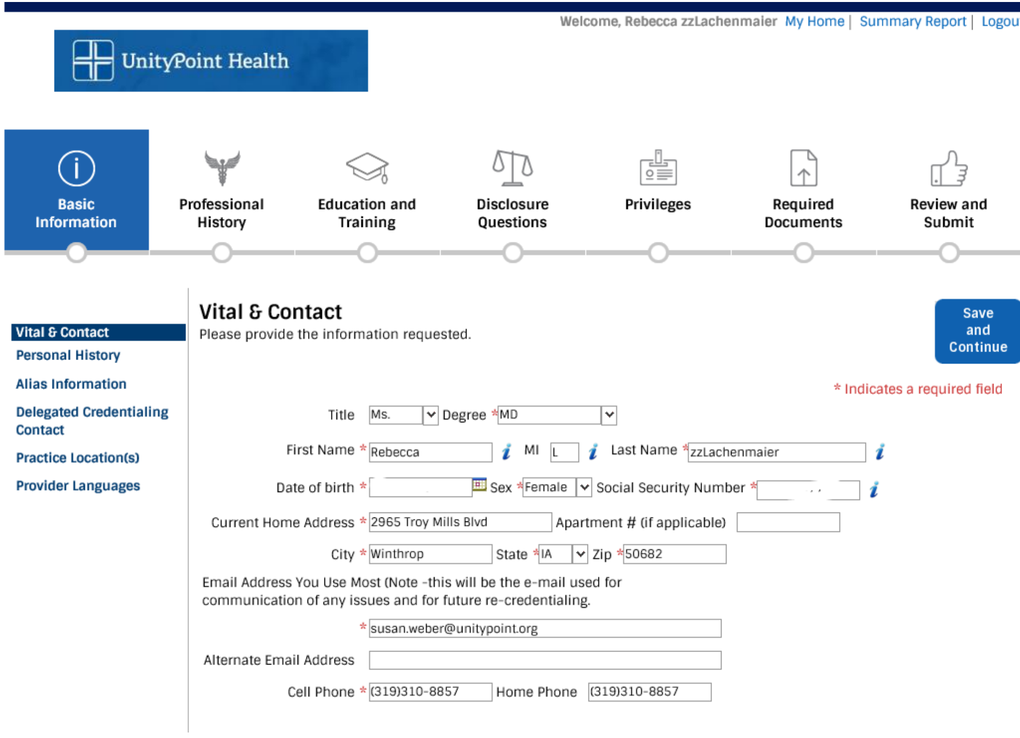
Remember, information will be populated in the portal if we have the information in our credentialing software system already from prior information supplied by the applicant. This information needs to be reviewed by the applicant for accuracy by clicking on the down arrow next to each entry and "Edit"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



Vital & Contact –

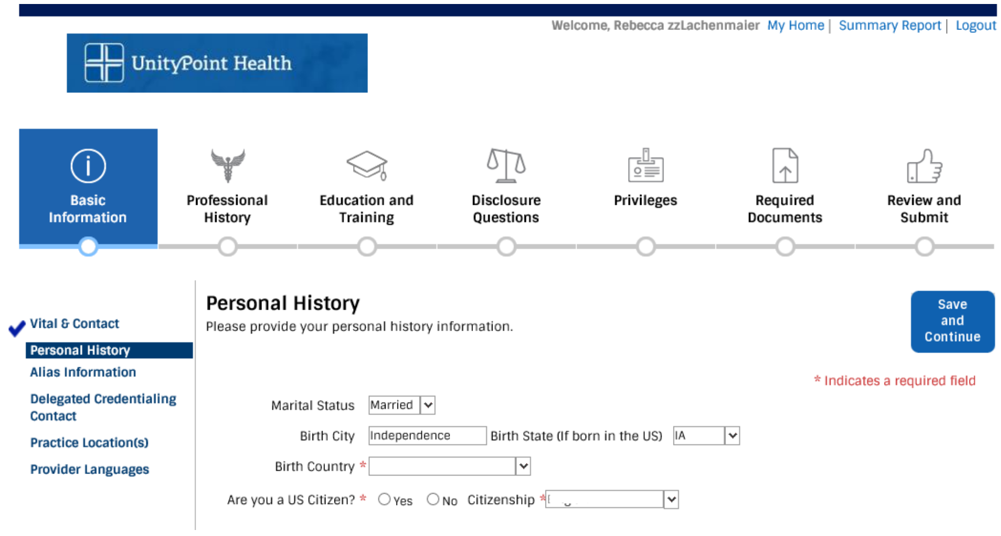
The Primary e-mail and alternate e-mail listed must be for the Applicant, we cannot accept a Delegate Cred Contact in the primary or alternate e-mail fields. Use the Delegated Credentialing Contact section further into the application to list the person who will assist you in completing your credentialing.

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 –

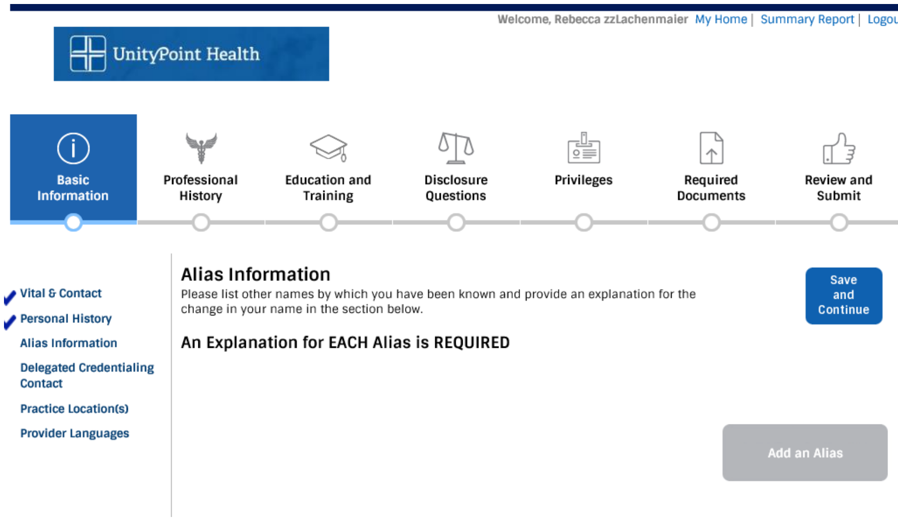
Birth Country and Citizenship must be provided



Alias Information –

Please provide any former or alternate names.

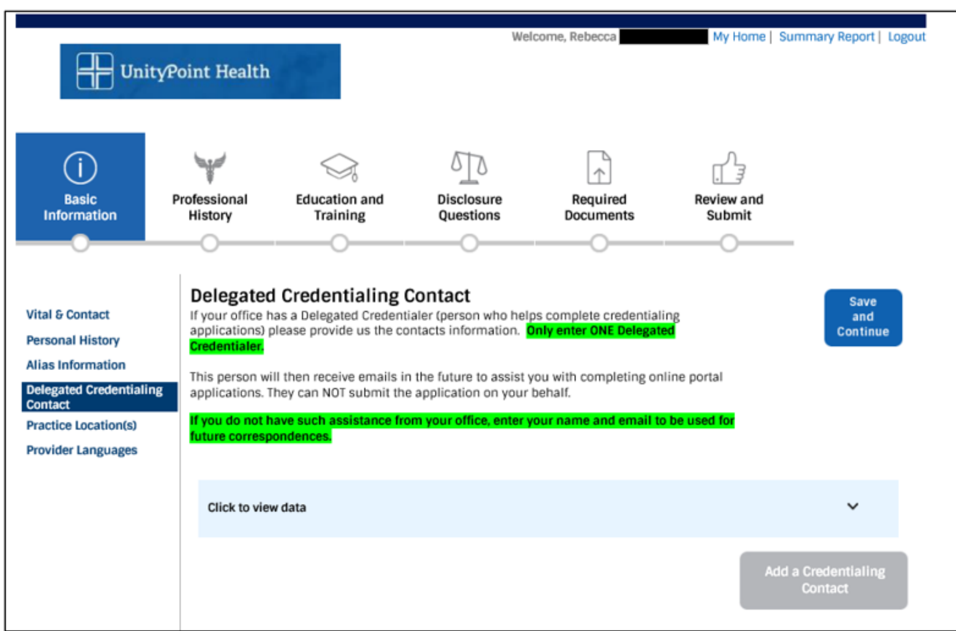
If you have married and had a name change since your last recredentialing cycle we must have appropriate documentation of your name change. The Credentialing Coordinator processing your application will contact you for a marriage certificate, etc. or may ask you to submit a service now request to get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



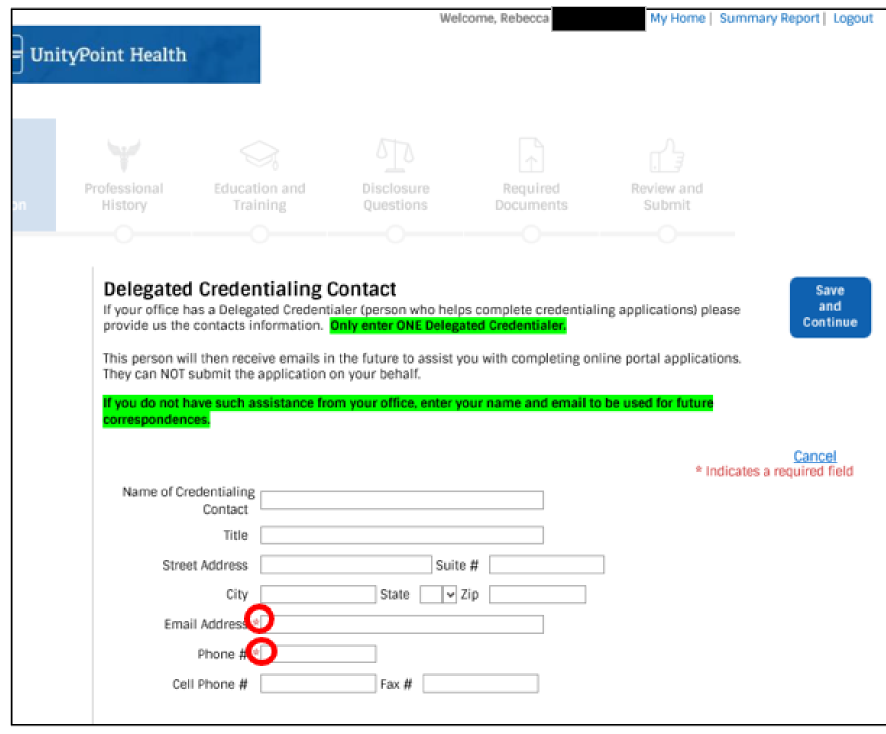
Delegated Credentialing Contact –

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.



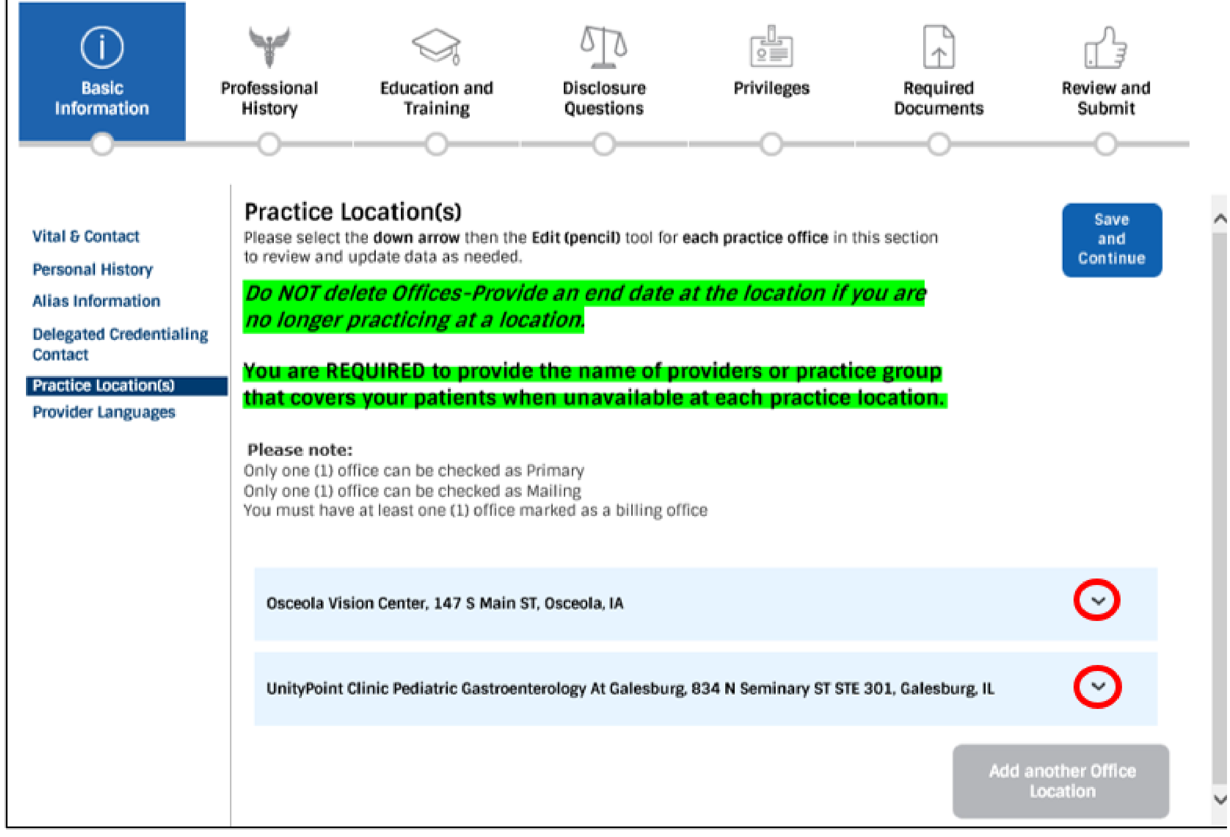
Sample of screen to identify REQUIRED fields identified by Asterisks.



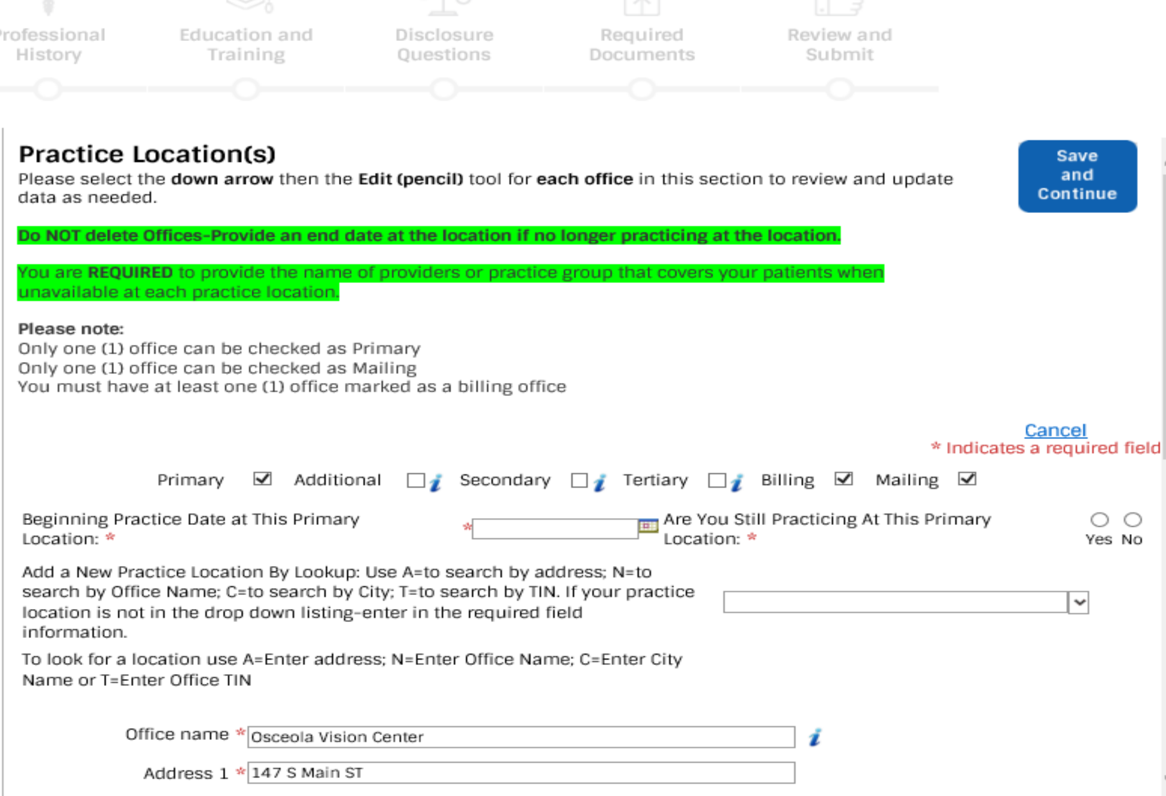
Practice Locations -

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.

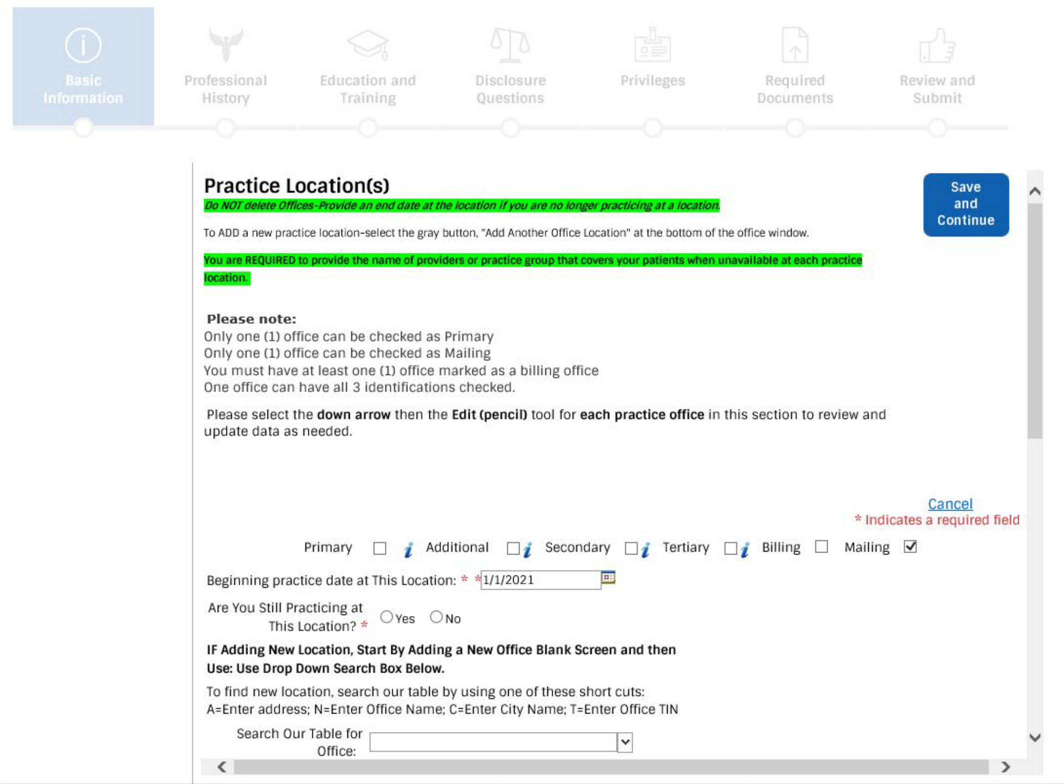


You must identify if you are currently working at the location. If you say No – you are REQUIRED to provide an end date for the location.



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.

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

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

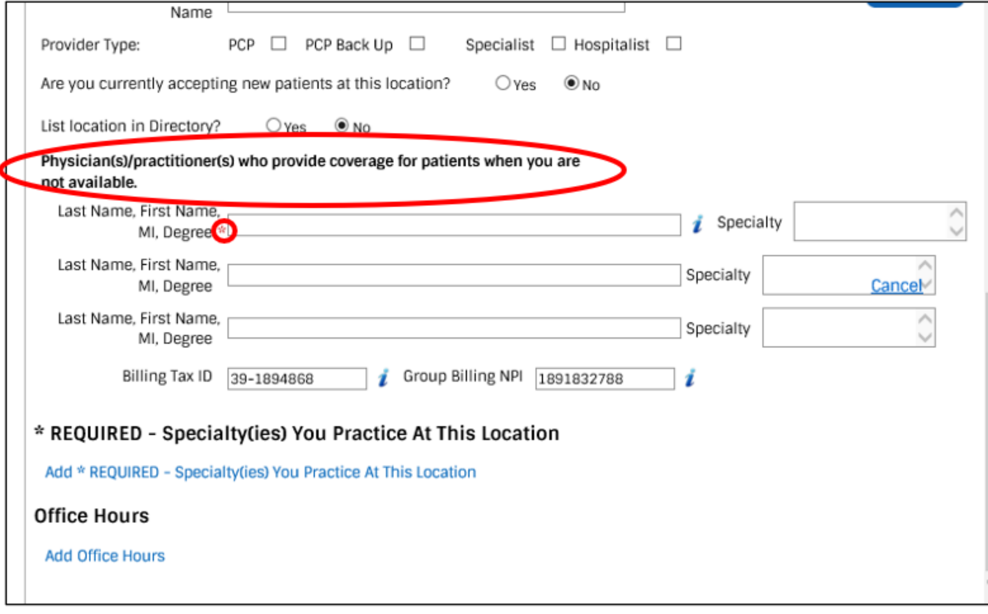
Billing = Private Family Medicine Practice, LLC Billing Office

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.


Name

Provider Type: PCP ☐ PCP Back Up ☐ Specialist ☐ Hospitalist ☐

Are you currently accepting new patients at this location? ○ Yes ◉ No

List location in Directory? ○ Yes ◉ No

Physician(s)/practitioner(s) who provide coverage for patients when you are not available.

Last Name, First Name, MI, Degree * | Specialty

Last Name, First Name, MI, Degree | Specialty | Cancel

Last Name, First Name, MI, Degree | Specialty

Billing Tax ID 39-1894868 | Group Billing NPI 1891832788

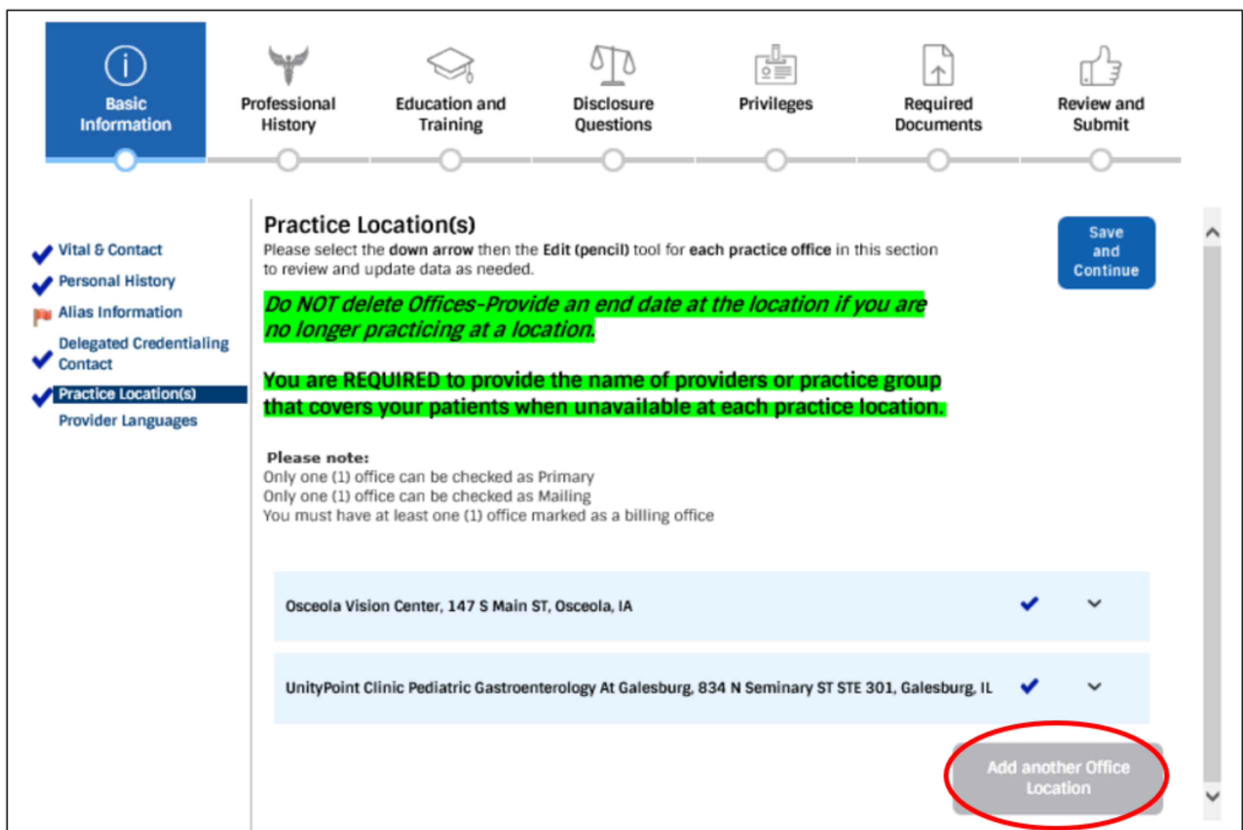
*** REQUIRED - Specialty(ies) You Practice At This Location**

Add * REQUIRED - Specialty(ies) You Practice At This Location

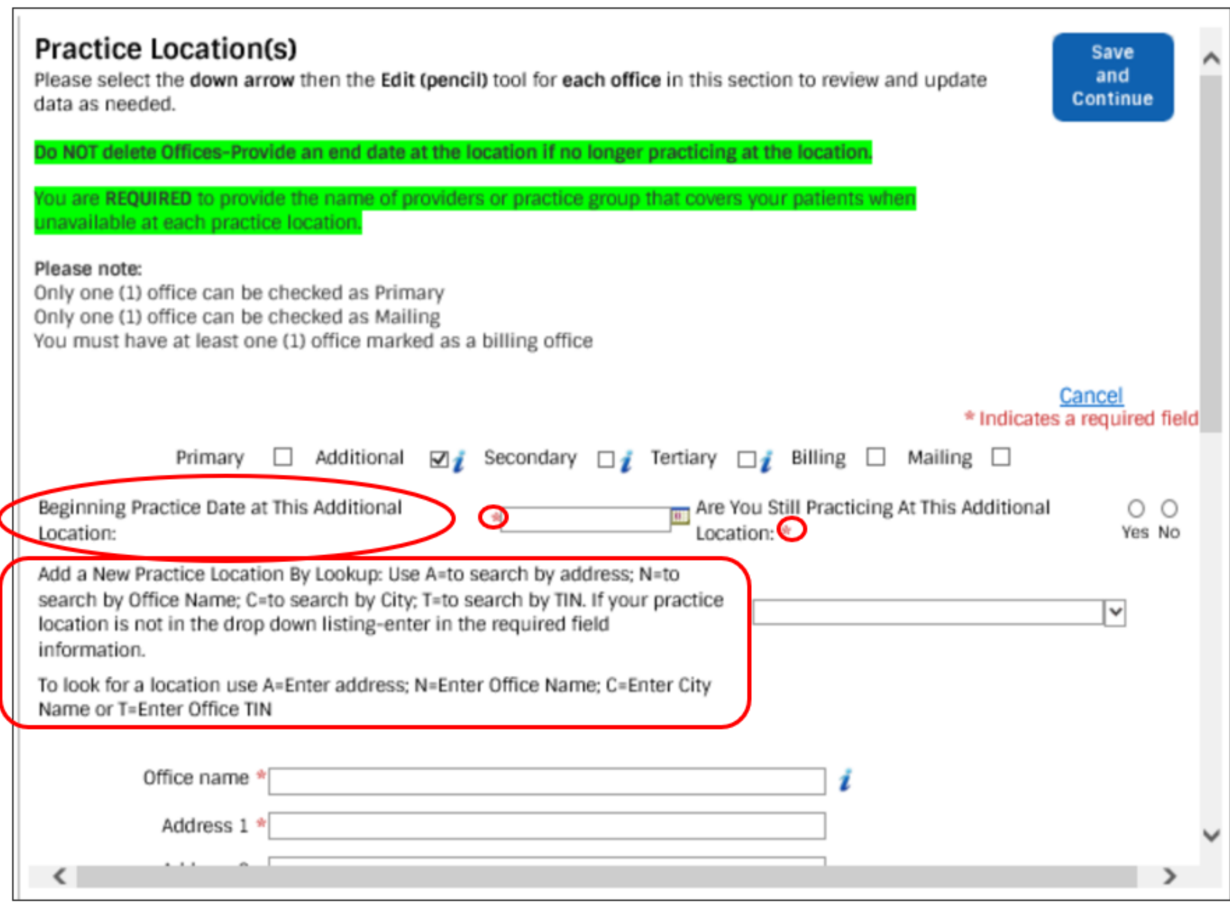
Office Hours

Add Office Hours

You may need to inform us of new practice locations. You will click the gray "Add Another Office Location" button.

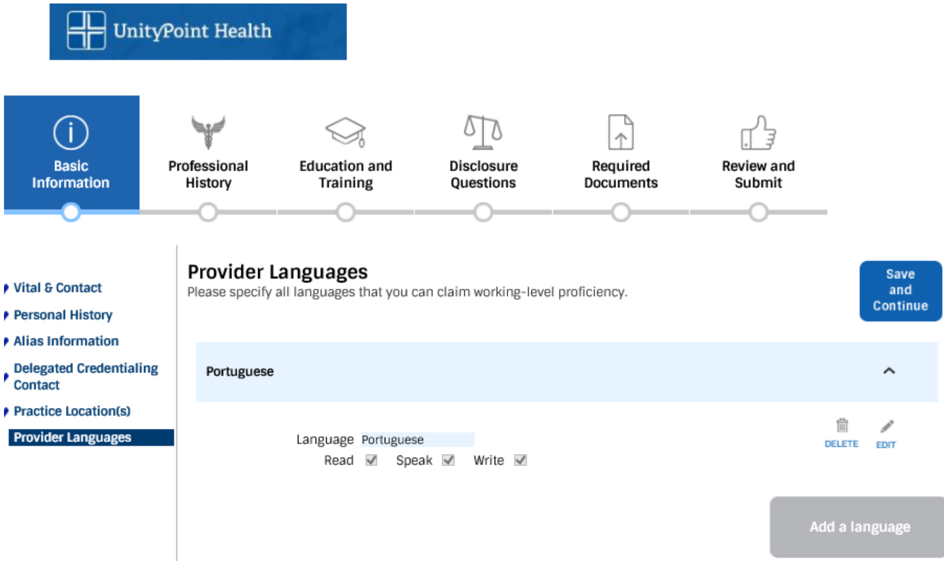


You will need to identify the type of office – Primary, Additional, Secondary, etc. Click on the *i* symbol for additional tips throughout the system.

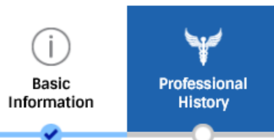

Practice Location(s)
Please select the down arrow then the Edit (pencil) tool for each office in this section to review and update data as needed.
Save and Continue
Do NOT delete Offices-Provide an end date at the location if no longer practicing at the location.
You are REQUIRED to provide the name 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
Cancel
* Indicates a required field
Primary
Additional
Secondary
Tertiary
Billing
Mailing
Beginning Practice Date at This Additional Location:
Are You Still Practicing At This Additional Location:
Yes
No
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 *

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.



Professional History Section



Professional History

Education and Training

Disclosure Questions

Required Documents

Review and Submit

- Licensure, Registrations and Certification Information
- Healthcare Organization Affiliations
- Employment History
- Current and Past Insurance Carriers

Professional History

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

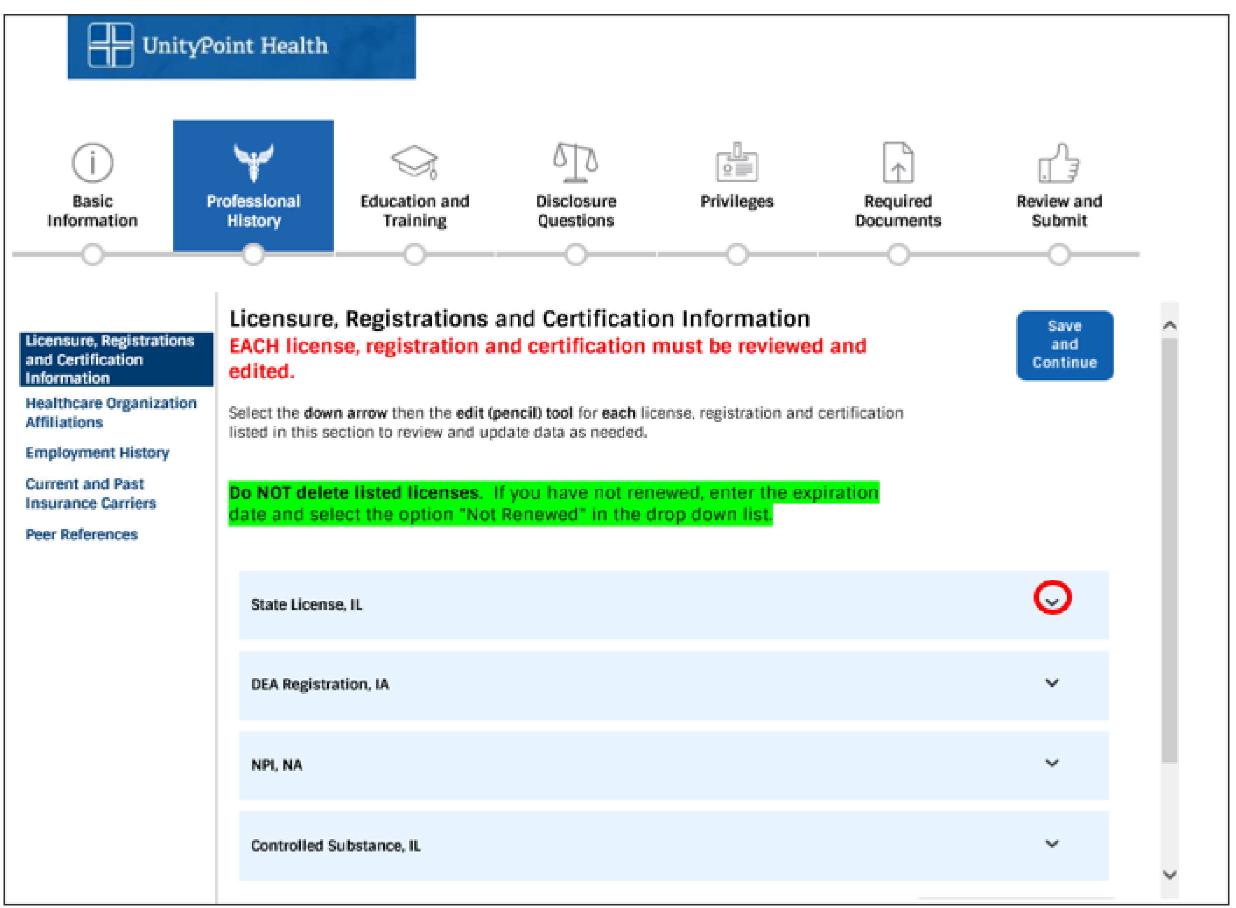
Select the **down arrow** then the **edit (pencil) tool** for **each** license, registration and certification listed in this section to review and update data as needed.

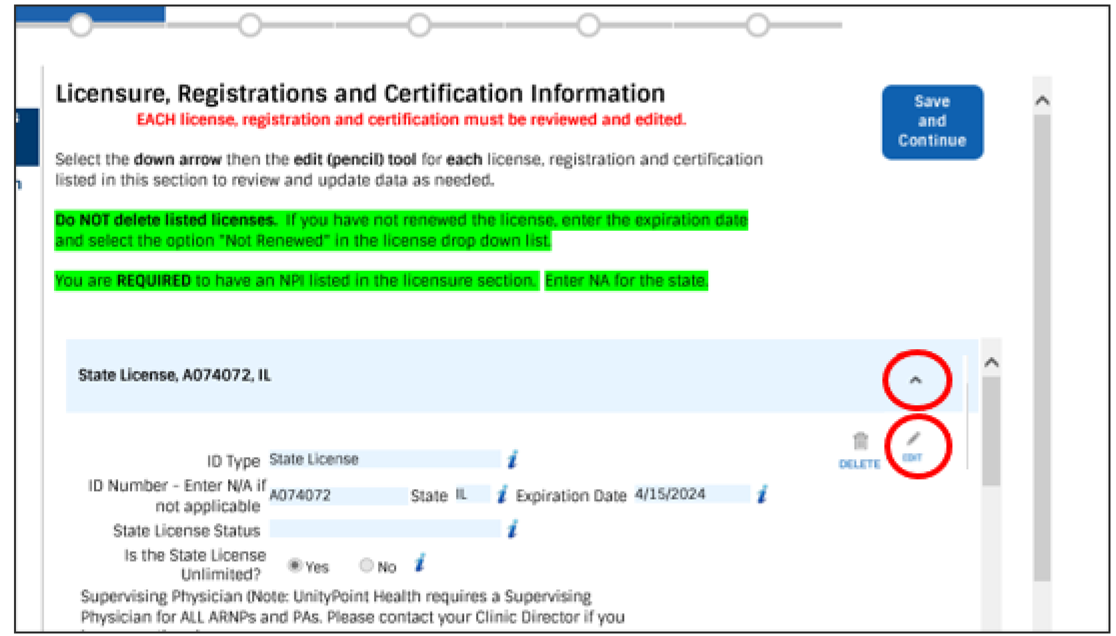
To ADD licenses, DEA or CSA, click on the gray button "Add License/NPI/Life Certifications" and then use the ID Number Type drop down list to select the type of additional license you are adding.

Licensure, Registrations and Certifications Section

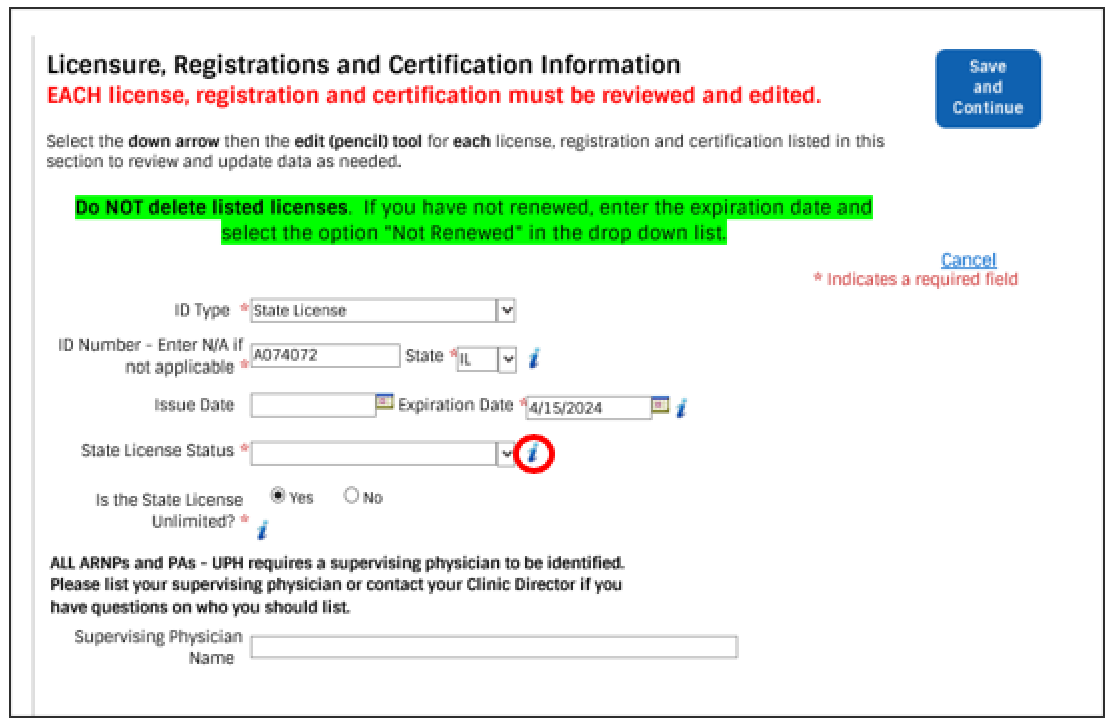
All current, pending, and prior licenses, registrations, and certifications held within the last 4 years must be provided. If we have information in our system already it will populate, and you will need to review those lines for accuracy.

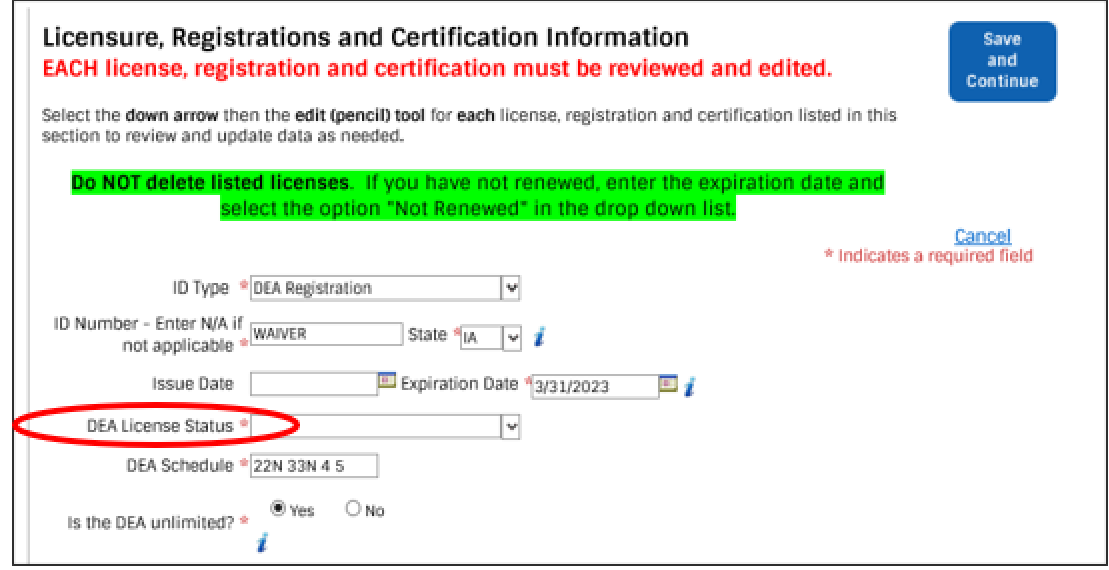
- You will use the ID Type drop down to add licenses, registrations, and certifications
- Advanced Practice Practitioners (ARNP, PA-C) must identify a supervising provider for their licensure unless a waiver has been approved. For additional information on waivers, contact the CVO, UPH_CVO@unitypoint.org
- 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


UnityPoint Health
Basic Information
Professional History
Education and Training
Disclosure Questions
Privileges
Required Documents
Review and Submit
Licensure, Registrations and Certification Information
Healthcare Organization Affiliations
Employment History
Current and Past Insurance Carriers
Peer References
Licensure, Registrations and Certification Information
EACH license, registration and certification must be reviewed and edited.
Save and Continue
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.
State License, IL
DEA Registration, IA
NPI, NA
Controlled Substance, IL

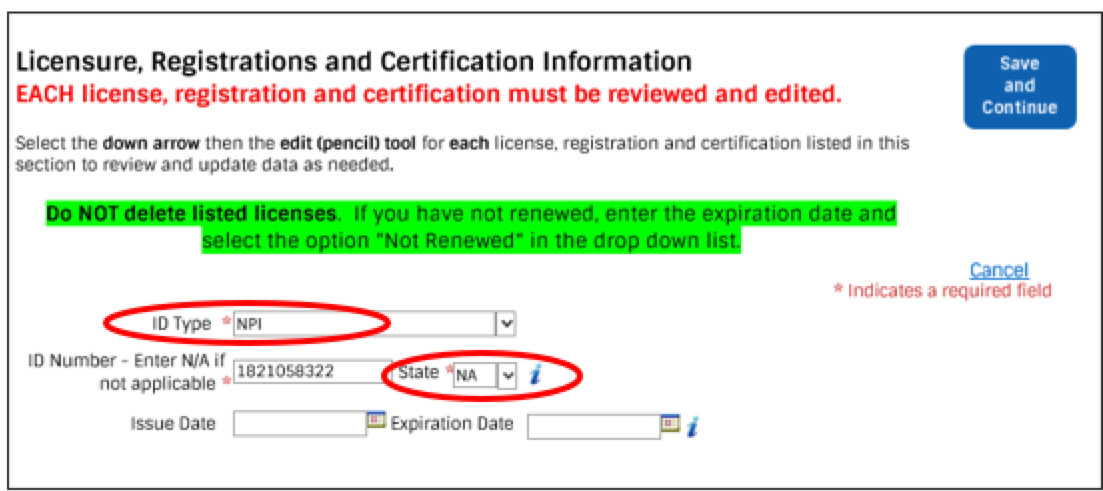

Licensure, Registrations and Certification Information
EACH license, registration and certification must be reviewed and edited.
Save and Continue
Select the down arrow then the edit (pencil) tool for each license, registration and certification listed in this section to review and update data as needed.
Do NOT delete listed licenses. If you have not renewed the license, enter the expiration date and select the option "Not Renewed" in the license drop down list.
You are REQUIRED to have an NPI listed in the licensure section. Enter NA for the state.
State License, A074072, IL
DELETE
EDIT
ID Type State License
ID Number - Enter N/A if not applicable A074072
State IL
Expiration Date 4/15/2024
State License Status
Is the State License Unlimited? Yes No
Supervising Physician (Note: UnityPoint Health requires a Supervising Physician for ALL ARNPs and PAs. Please contact your Clinic Director if you

New to the portal is a required field identifying the status of the licensures.

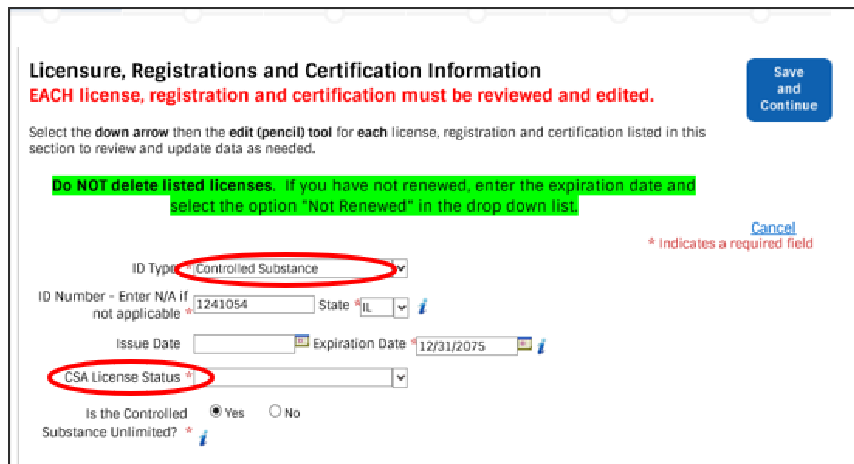




For NPI – Enter NA into the State Field

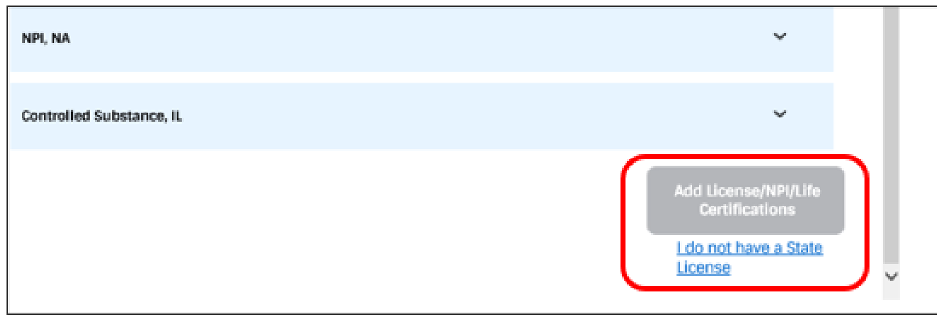


If you add a new CSA or DEA, you will be required to enter in the prescribing schedule.

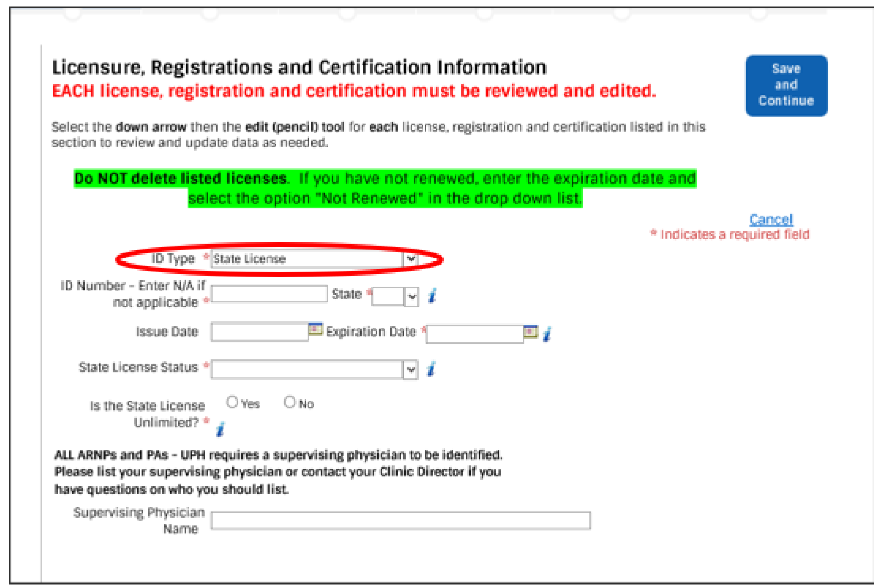


If you need to add more licensures, CSA, DEA, life certifications, etc. you will click on the gray button labelled, “Add License/NPI/Life Certifications.”

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.

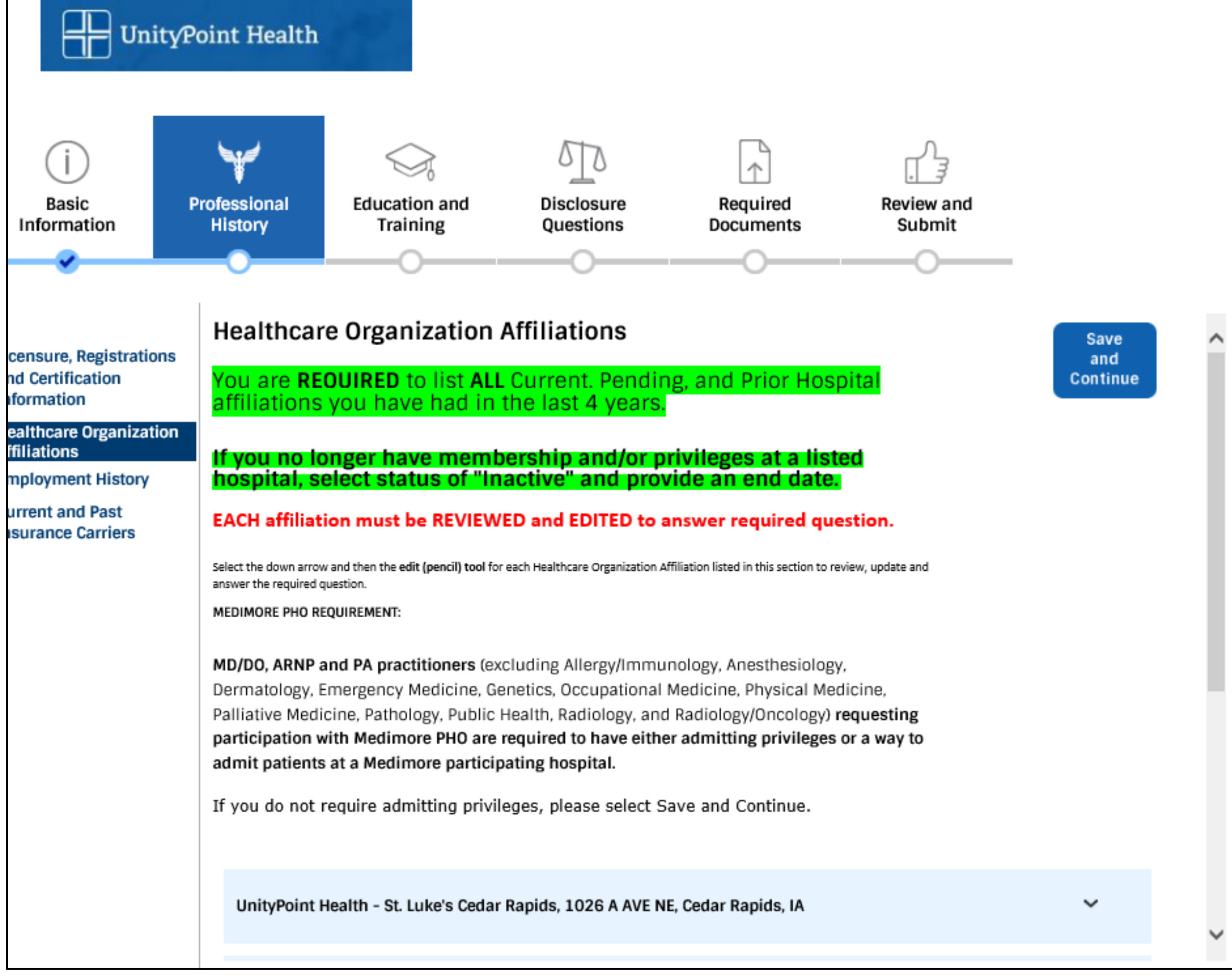


Healthcare Organization Affiliations -

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

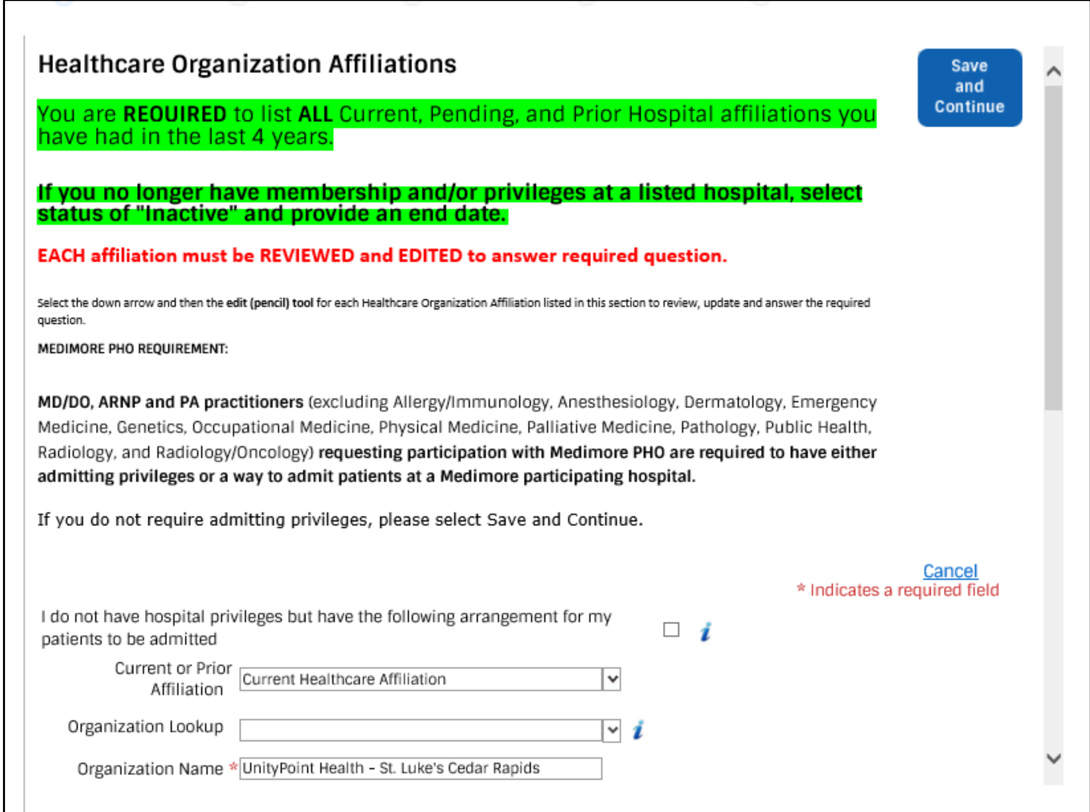
Do NOT delete facilities that you no longer hold membership/privileges. We must have your end date at the location. For affiliations that are no longer active, please review the Disclosure Questions and complete associated Disclosure Forms if applicable.

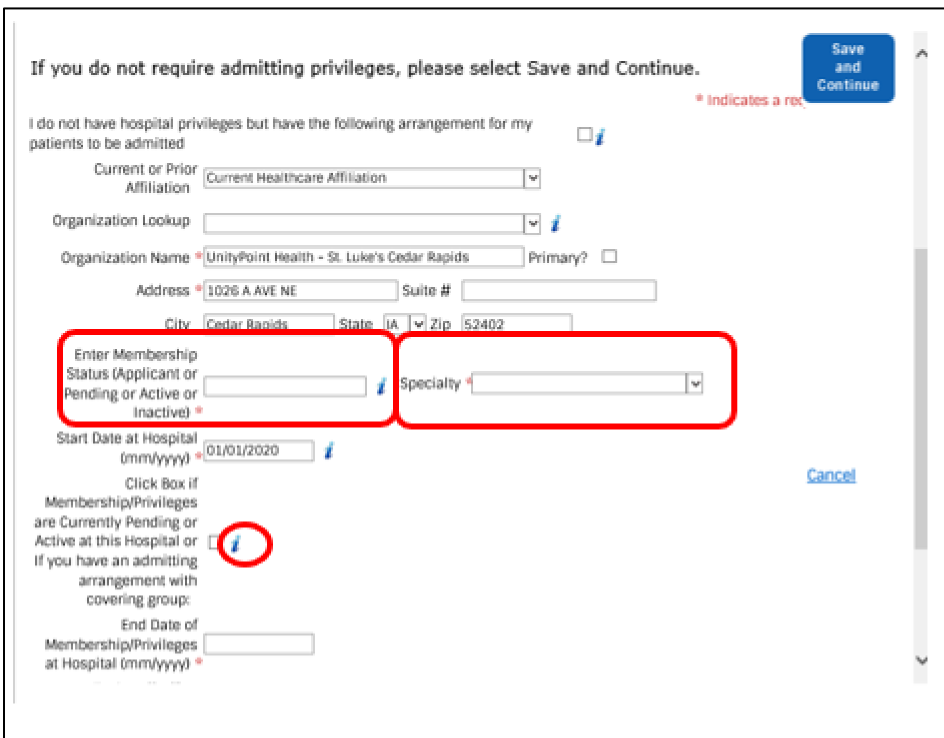
We need to know the status of your membership/privileges at each facility.



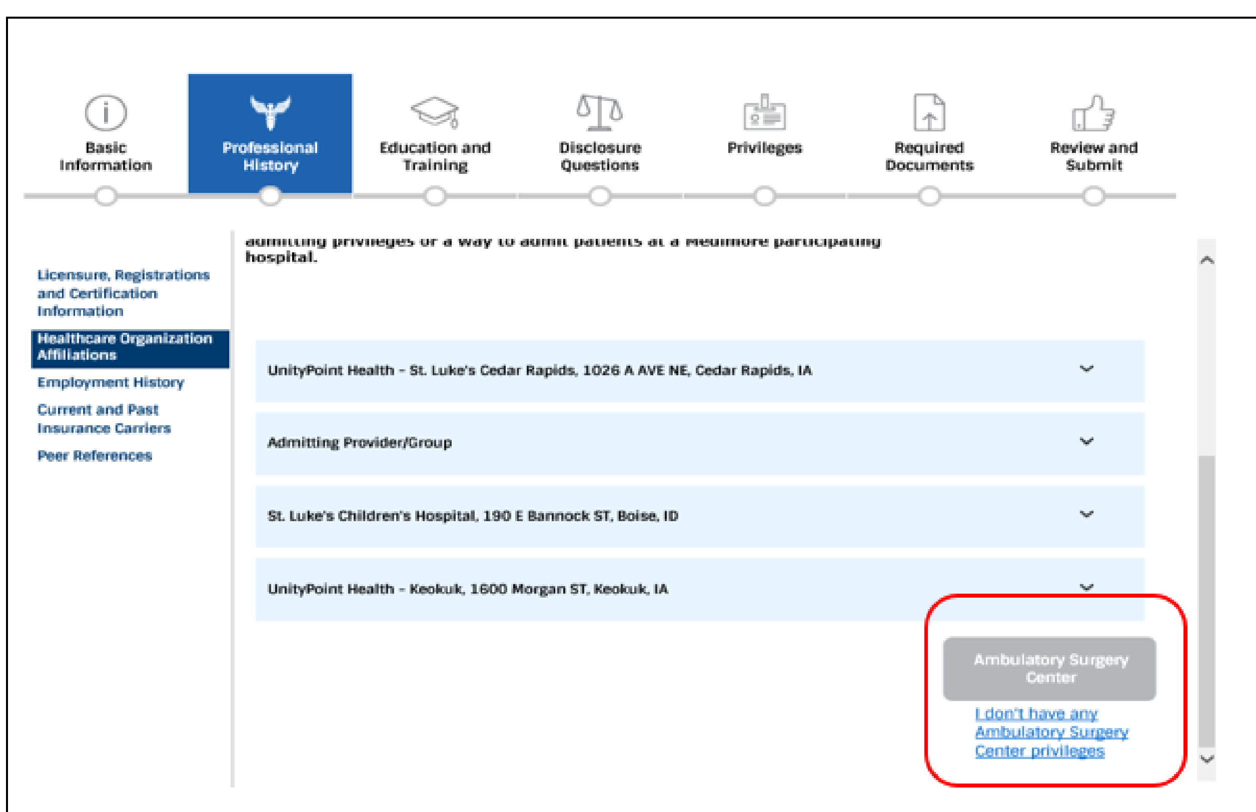
Screen shots of information needed for each affiliation.

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.





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.

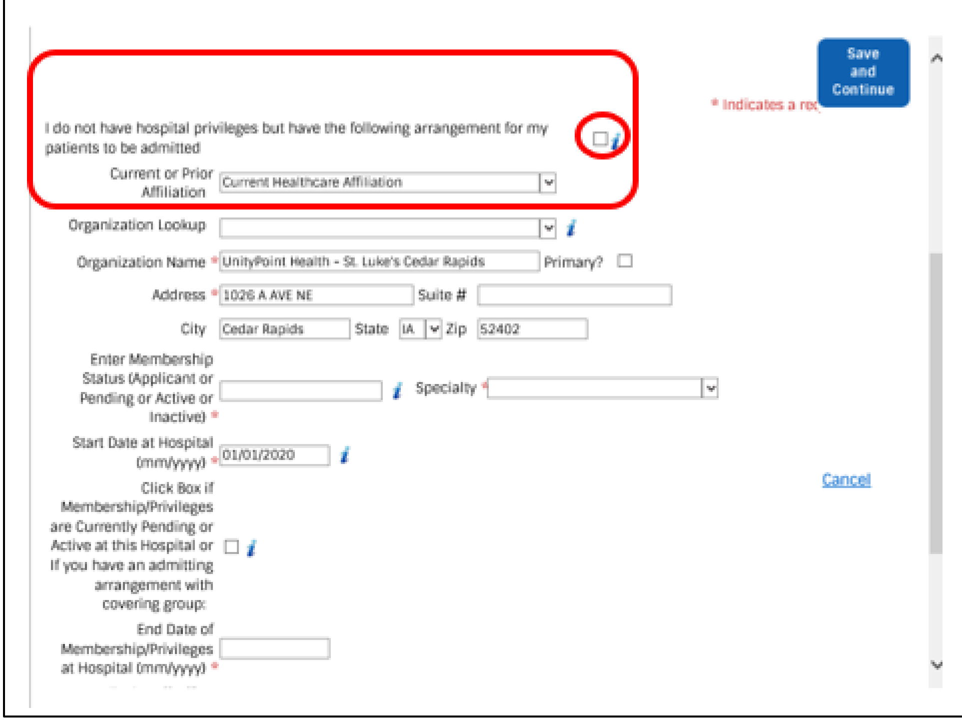


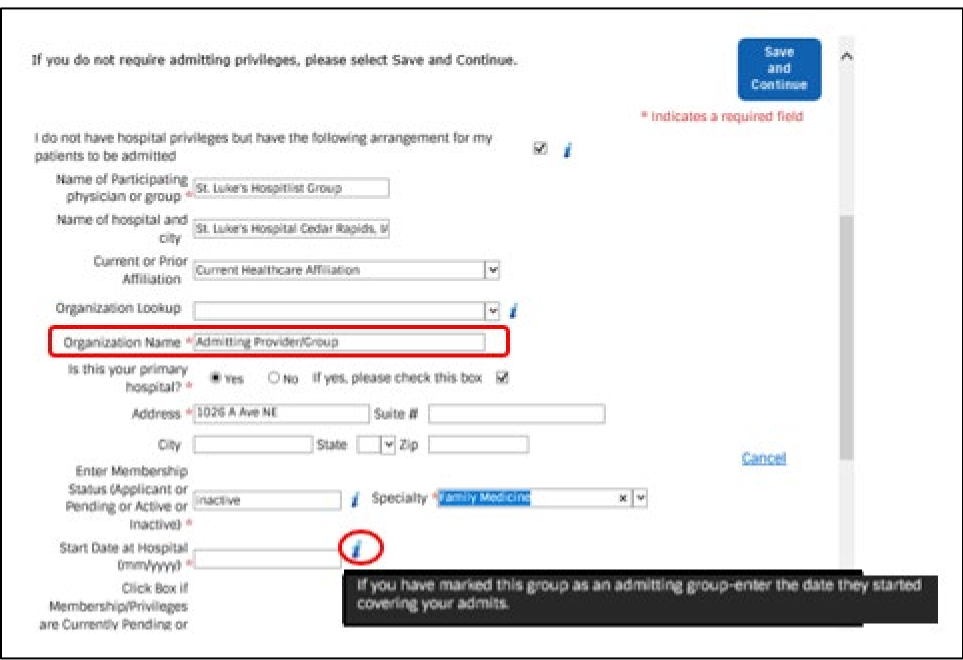
You will need to identify your current status at each facility.

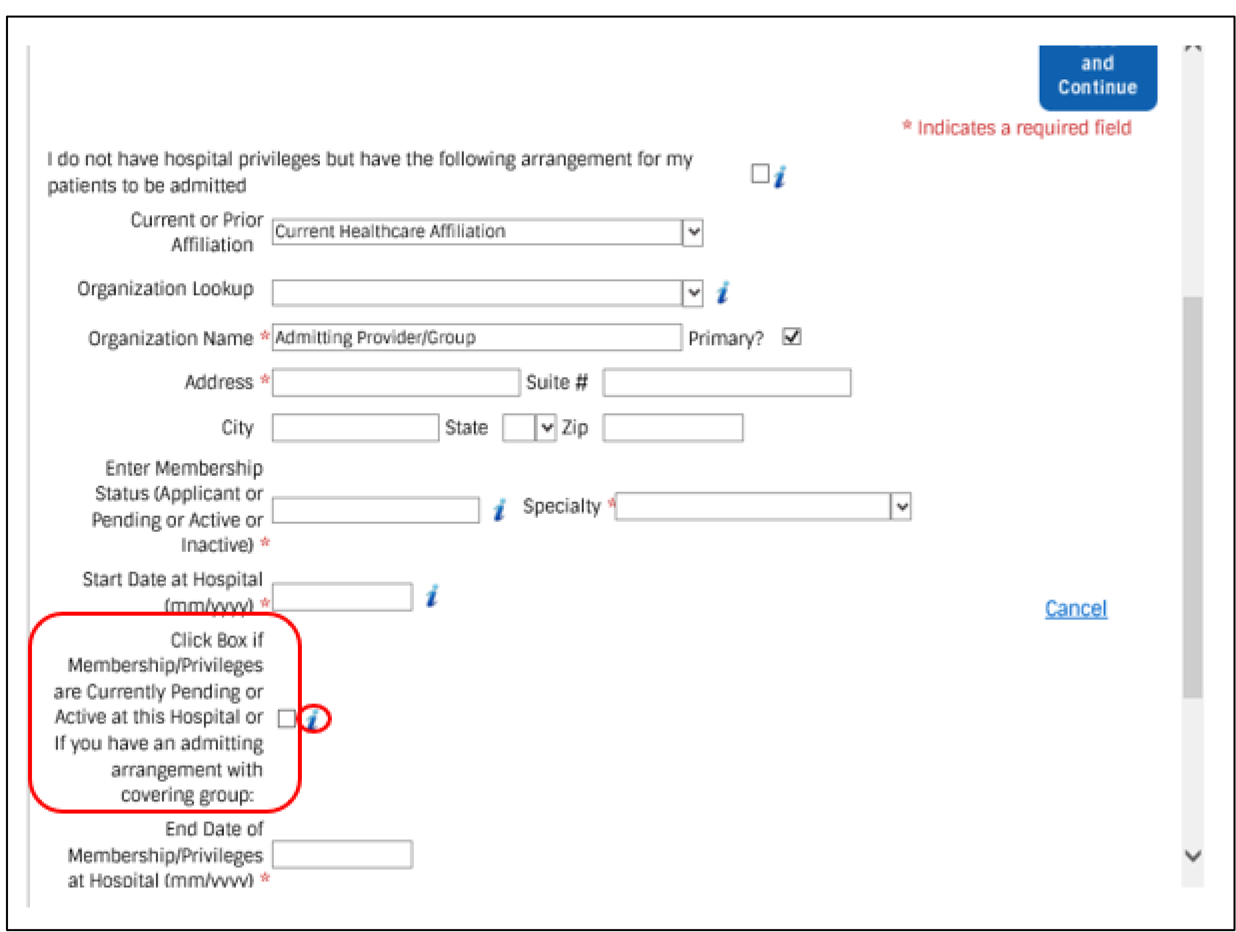
If you do NOT have hospital privileges, you must have an admitting arrangement and you will need to identify who the admitting provider or group you will be using. This is a requirement for the UnityPoint Health PHO, Medimore, participation. You will enter the start date that the admitting arrangement 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.
Save and Continue
* Indicates a required field
I do not have hospital privileges but have the following arrangement for my patients to be admitted
Name of Participating physician or group *
St. Luke's Hospitlist Group
Name of hospital and city
St. Luke's Hospital Cedar Rapids, I
Current or Prior Affiliation
Current Healthcare Affiliation
Organization Lookup
Organization Name *
Admitting Provider/Group
Is this your primary hospital? *
Yes
No
If yes, please check this box
Address *
1026 A Ave NE
Suite #
City
State
Zip
Cancel
Enter Membership Status (Applicant or Pending or Active or Inactive) *
Inactive
Specialty *
Family Medicine
Start Date at Hospital (mm/yyyy) *
Click Box if Membership/Privileges are Currently Pending or
If you have marked this group as an admitting group-enter the date they started covering your admits.


and Continue
* Indicates a required field
I do not have hospital privileges but have the following arrangement for my patients to be admitted
Current or Prior Affiliation
Current Healthcare Affiliation
Organization Lookup
Organization Name *
Admitting Provider/Group
Primary?
Address *
Suite #
City
State
Zip
Enter Membership Status (Applicant or Pending or Active or Inactive) *
Specialty *
Start Date at Hospital (mm/yyyy) *
Cancel
Click Box if Membership/Privileges are Currently Pending or Active at this Hospital or If you have an admitting arrangement with covering group:
End Date of Membership/Privileges at Hospital (mm/yyyy) *

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

Save and Continue

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.**

Cancel

* Indicates a required field

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 * Primary?

Address * Suite #

Employment History

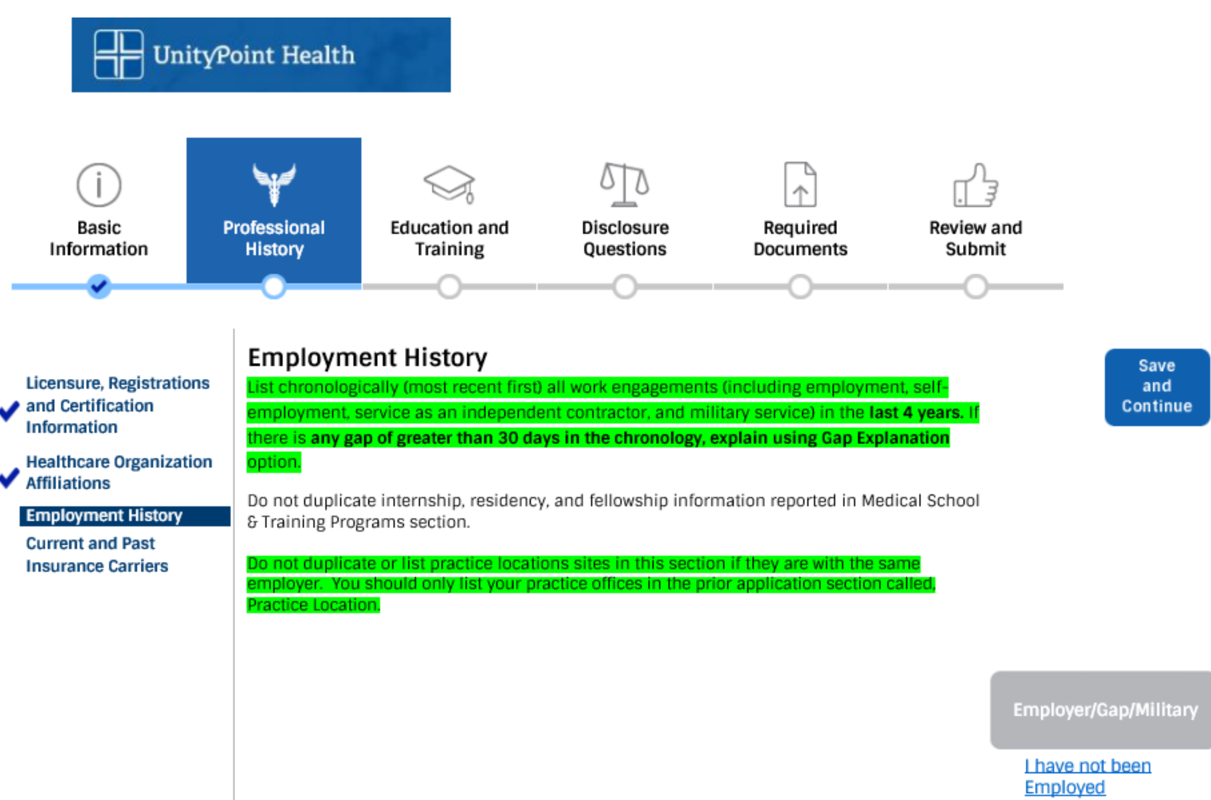
You are REQUIRED to list all employment engagements for the last 4 years.

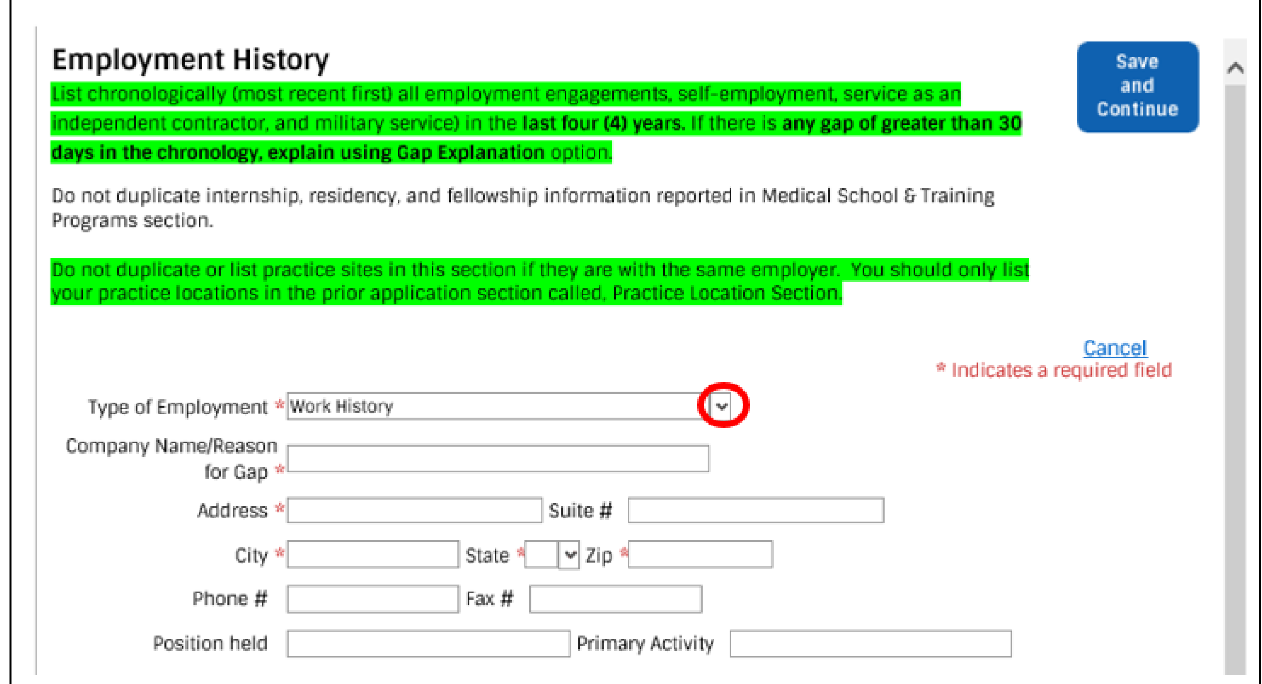
All work engagements must be entered, including explanation of any gaps in your employment greater than 30 or 60 days as requested in your portal.

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.

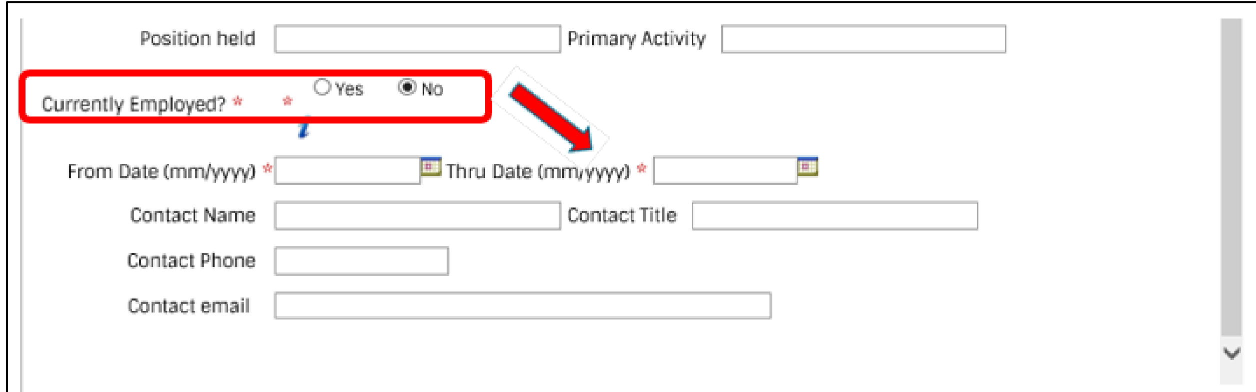
NOTE – Practice locations that are under the same employer do not get listed here. Only enter your primary location with that employer in this section, and any additional locations you practice at or billing/mailing locations under your employer should be listed under the Practice Locations section of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


UnityPoint Health
Basic Information
Professional History
Education and Training
Disclosure Questions
Required Documents
Review and Submit
Licensure, Registrations and Certification Information
Healthcare Organization Affiliations
Employment History
Current and Past Insurance Carriers
Employment History
List chronologically (most recent first) all work 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.
Save and Continue
Employer/Gap/Military
I have not been Employed


Employment History
List chronologically (most recent first) all employment engagements, self-employment, service as an independent contractor, and military service) in the last four (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 sites in this section if they are with the same employer. You should only list your practice locations in the prior application section called, Practice Location Section.
Save and Continue
Cancel
* Indicates a required field
Type of Employment * Work History
Company Name/Reason for Gap *
Address *
Suite #
City *
State *
Zip *
Phone #
Fax #
Position held
Primary Activity

In order for the "Thru Date" to populate you must check "No" for "Currently Employed?", even for Gap Explanations



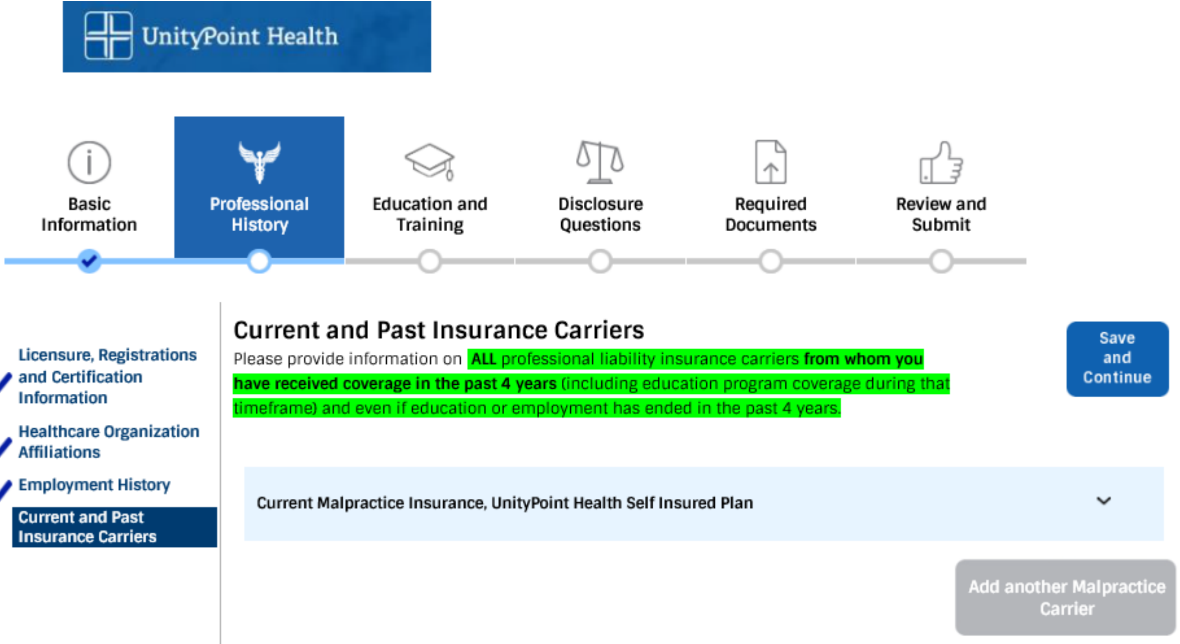
Current and Past Insurance Carriers –

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.

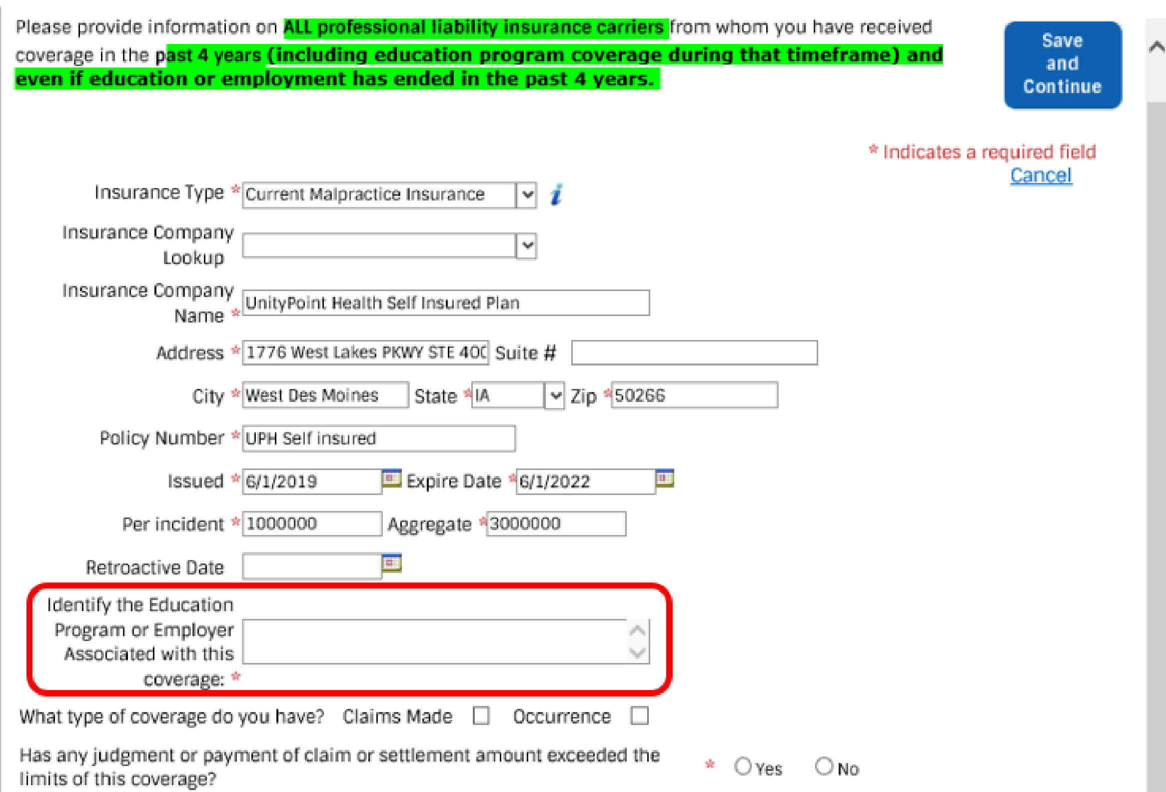
UnityPoint Health (UPH) applicants – Please collaborate closely with your delegate credentialing contact to validate the entity providing current malpractice coverage for you.



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.


Please provide information on ALL professional liability insurance carriers from whom you have received coverage in the past 4 years (including education program coverage during that timeframe) and even if education or employment has ended in the past 4 years.

Save and Continue

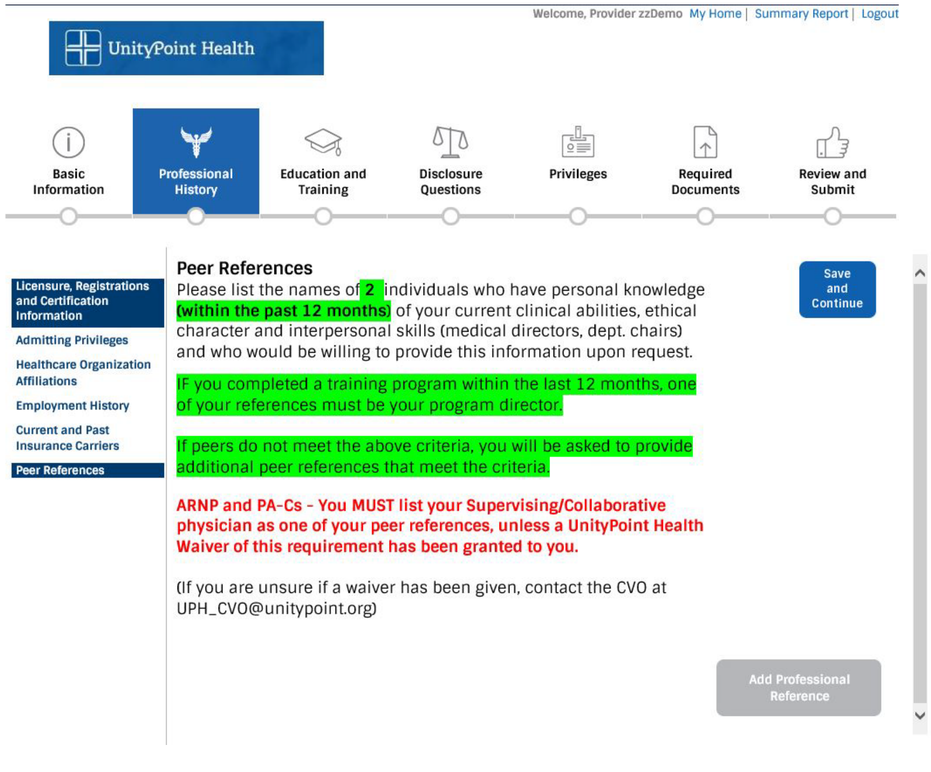
* Indicates a required field
Cancel

Insurance Type * Current Malpractice Insurance
Insurance Company Lookup
Insurance Company Name * UnityPoint Health Self Insured Plan
Address * 1776 West Lakes PKWY STE 400 Suite #
City * West Des Moines State * IA Zip * 50266
Policy Number * UPH Self insured
Issued * 6/1/2019 Expire Date * 6/1/2022
Per incident * 1000000 Aggregate * 3000000
Retroactive Date
Identify the Education Program or Employer Associated with this coverage: *
What type of coverage do you have? Claims Made Occurrence
Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage? * Yes No

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.



* Indicates a required field

Reference Type: Professional Reference

ARNP/PA Applicants only - One of your references must be your Supervising/Collaborating Physician

Department Chair ☐ Peer ☐ Training Director ☐ Supervising/Collaborating Physician ☐

Full Name * Degree *

Specialty * Years Known *

Specialty

Email Address *

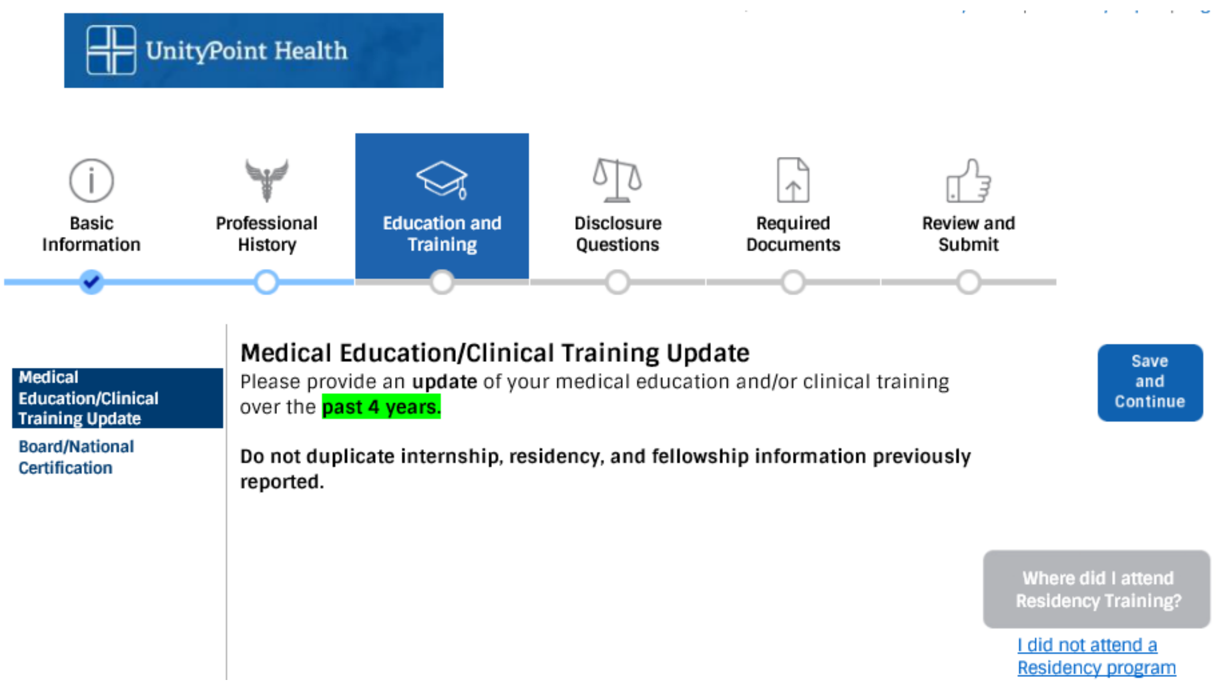
Phone # *

Cancel

Education and Training Section

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

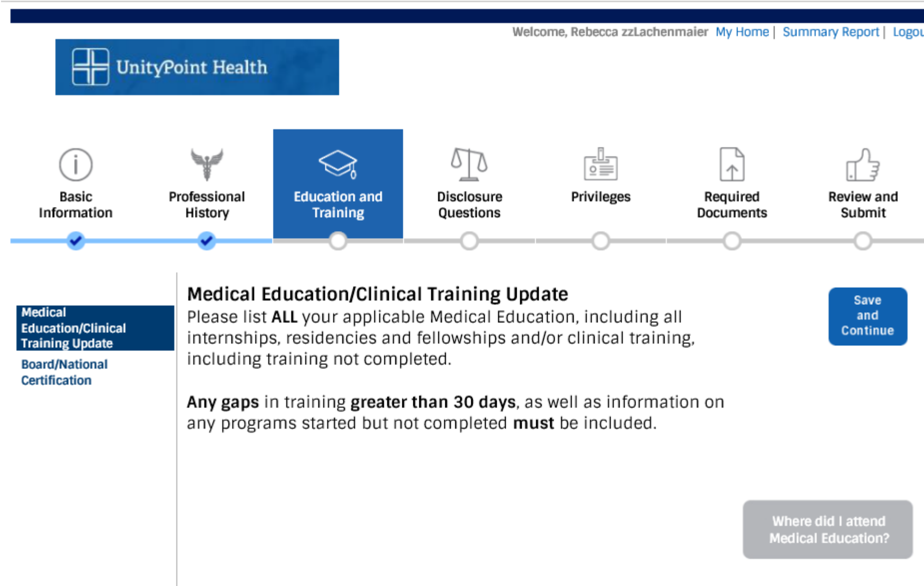
If you have completed the Education and Training within the last 4 years and the information has already been reported to us, you do not need to duplicate the information.

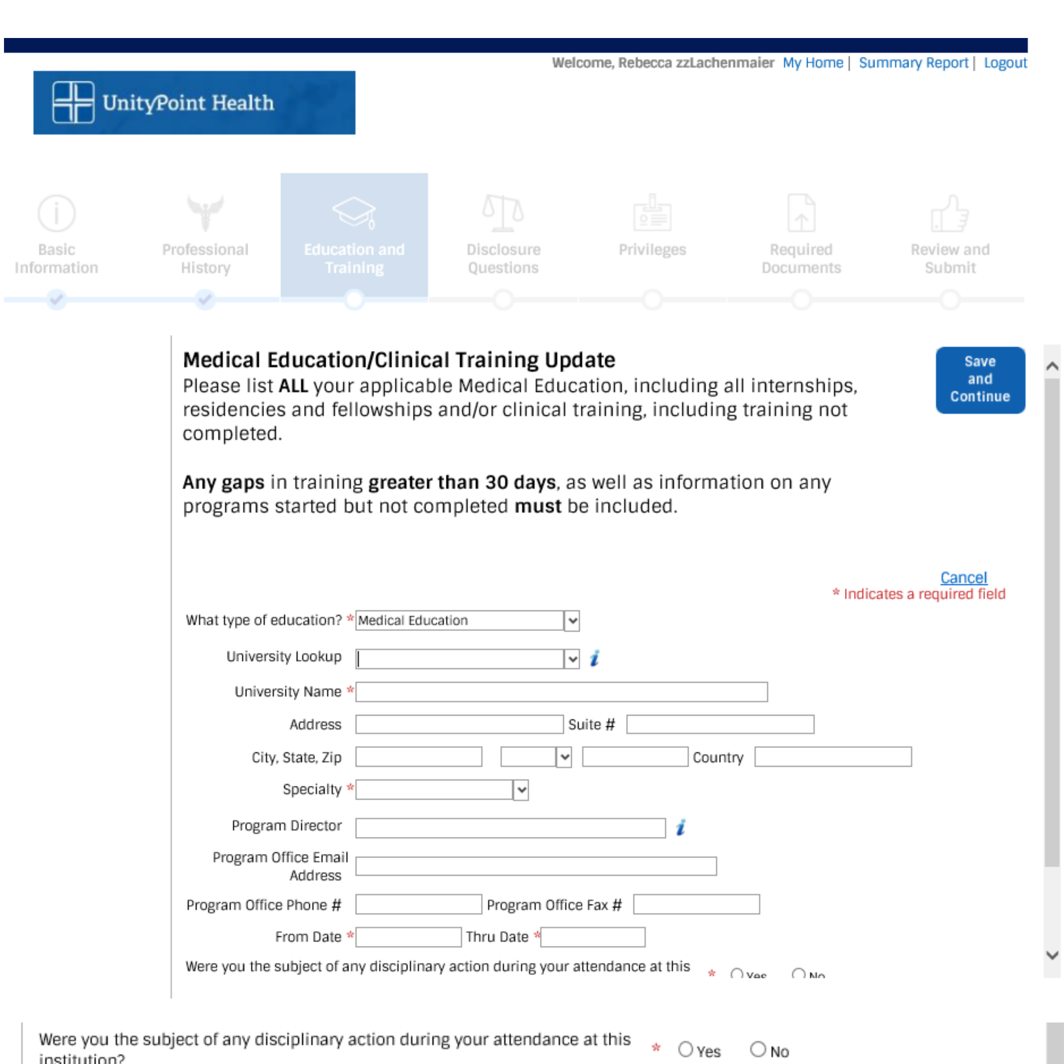


UnityPoint Health

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.





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

Did you successfully complete this program? * ○ Yes ○ No

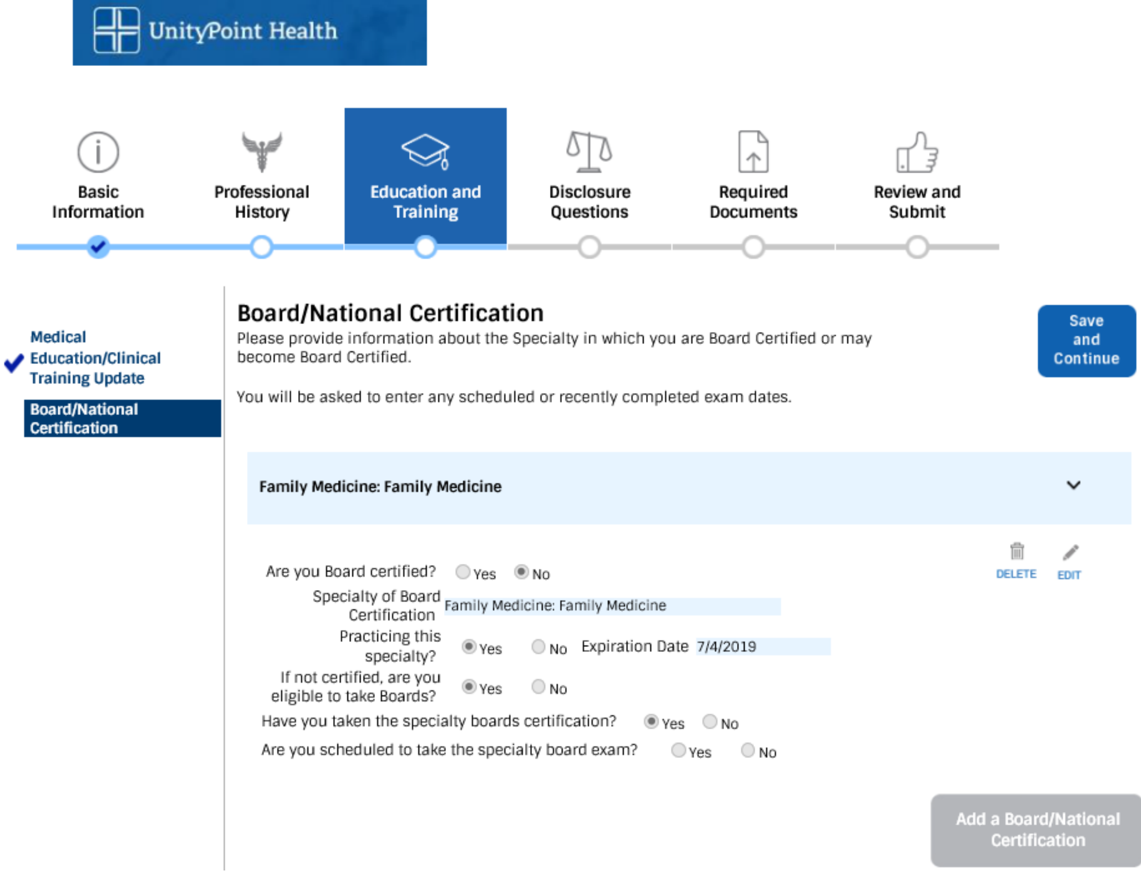
Board Certifications/National Certifications Section

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

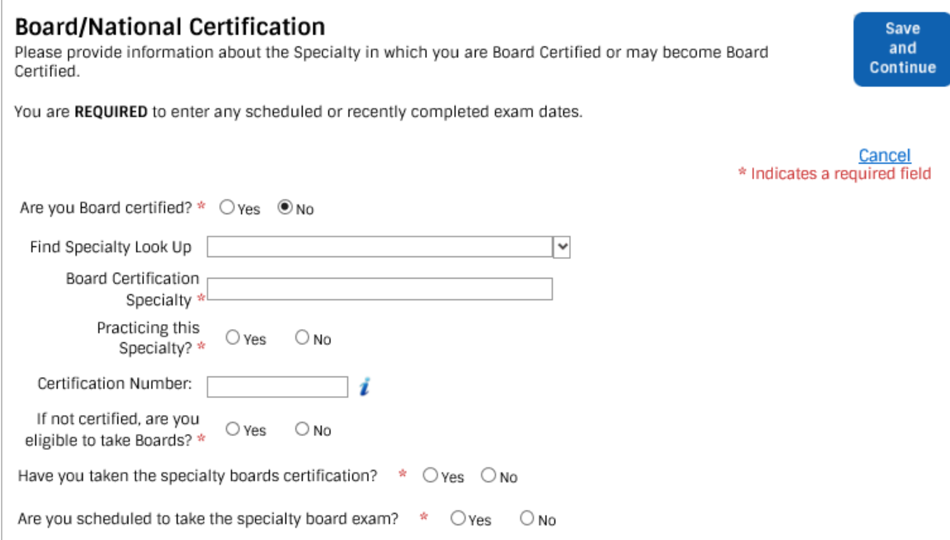
Board/National Certification is a threshold requirement for application processing. Board eligibility information must be completed if you are not currently Board certified.

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 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.

Save and Continue

Cancel
* Indicates a required field

Are you Board certified? * Yes No

Find Specialty Look Up

Board Certification Specialty *

Practicing this Specialty? * Yes No

Certification Number:

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

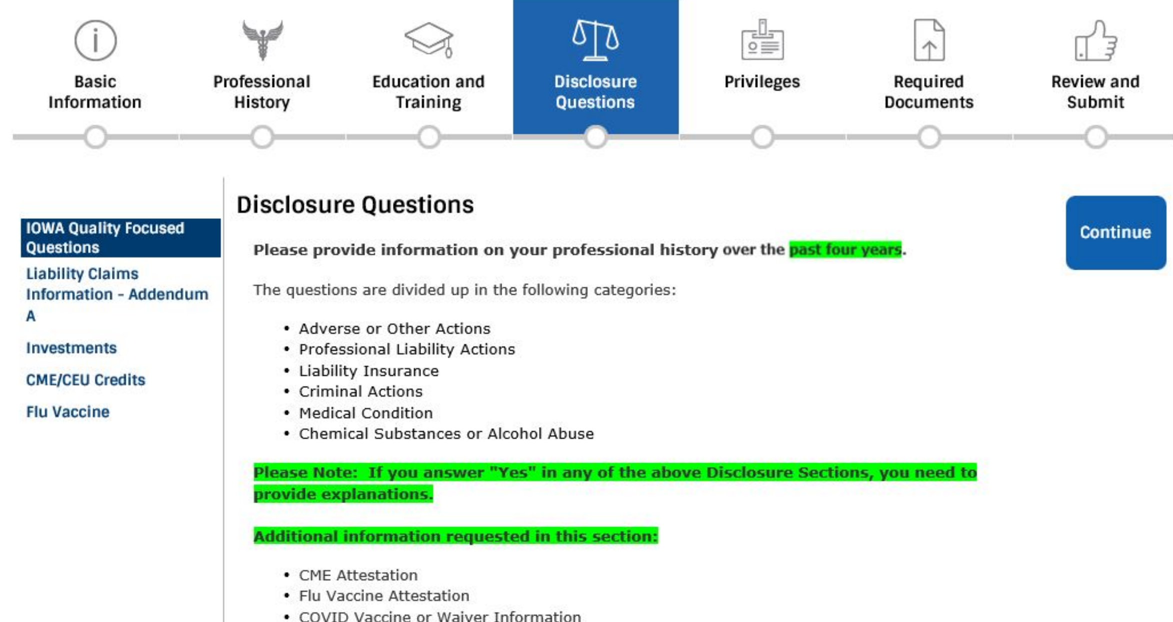
Disclosure Question Section

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.

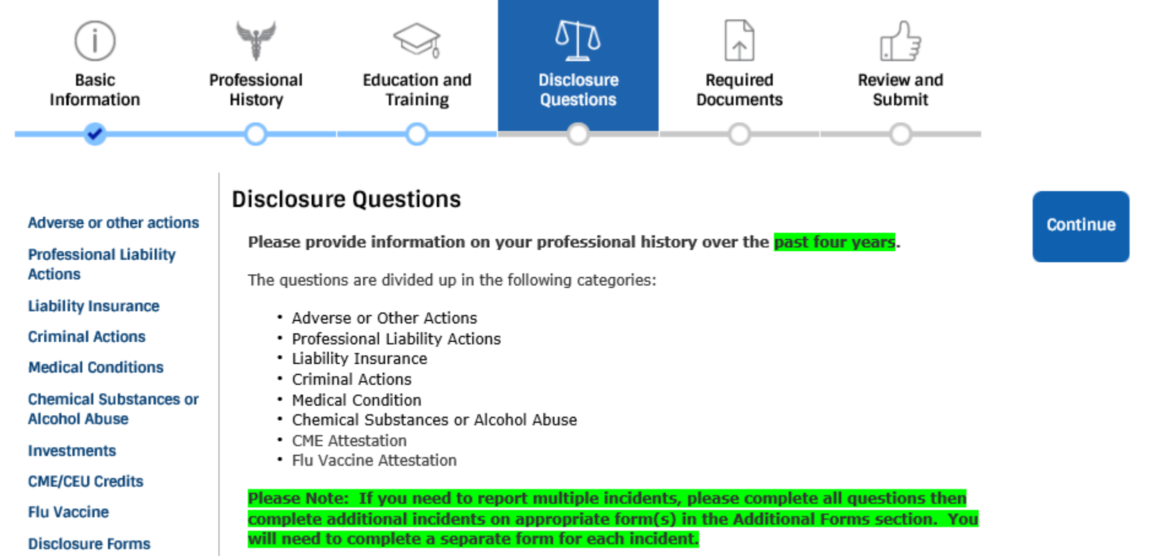
Any questions answered "**YES**" will need the associated supplemental information field or form completed. If the form is not completed, the CVO will return the application for completion, causing delays in processing.

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

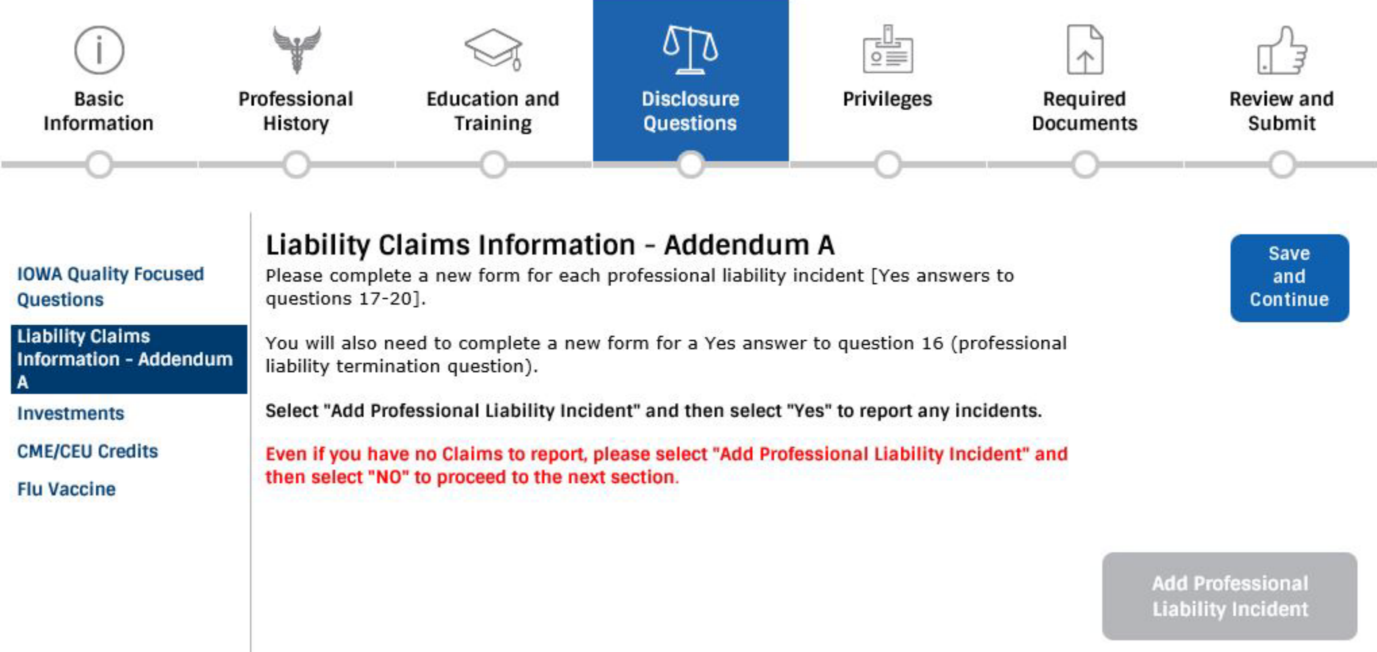
21. Has/have any adverse action(s) or malpractice report(s) about you been made to the National Practitioner Data Bank, or any other databank?
    - If you have any reports made to the NPDB or any other databanks

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?

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.

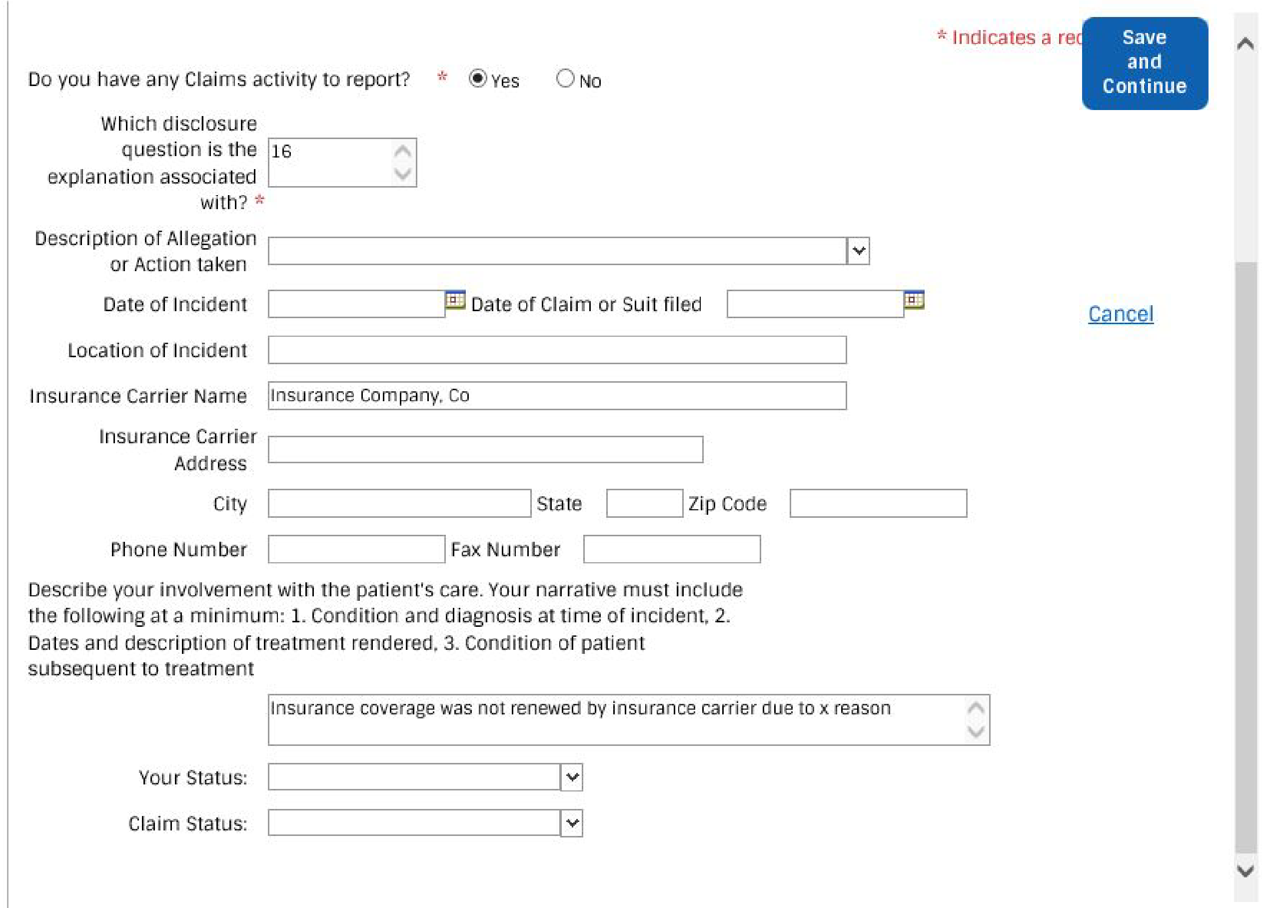
Cancel
* Indicates a required field

Do you have any Claims activity to report? * Yes No

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**


* Indicates a rec

Save and Continue

Do you have any Claims activity to report? * Yes No

Which disclosure question is the explanation associated with? * 16

Description of Allegation or Action taken

Date of Incident

Date of Claim or Suit filed

Cancel

Location of Incident

Insurance Carrier Name: Insurance Company, Co

Insurance Carrier Address

City

State

Zip Code

Phone Number

Fax Number

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

Insurance coverage was not renewed by insurance carrier due to x reason

Your Status:

Claim Status:

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

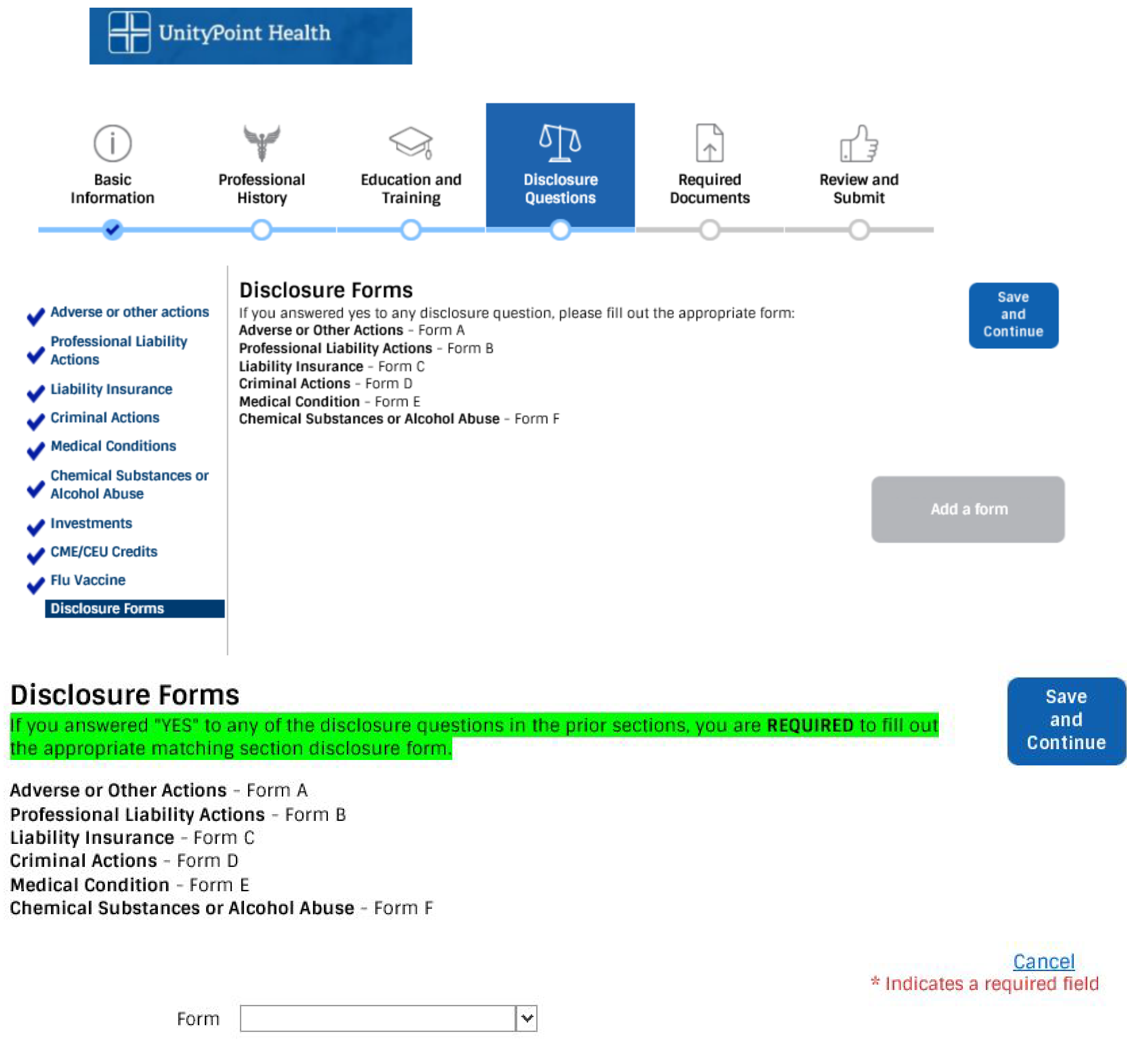
Liability Insurance - Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled, non- renewed or limits reduced?

- 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

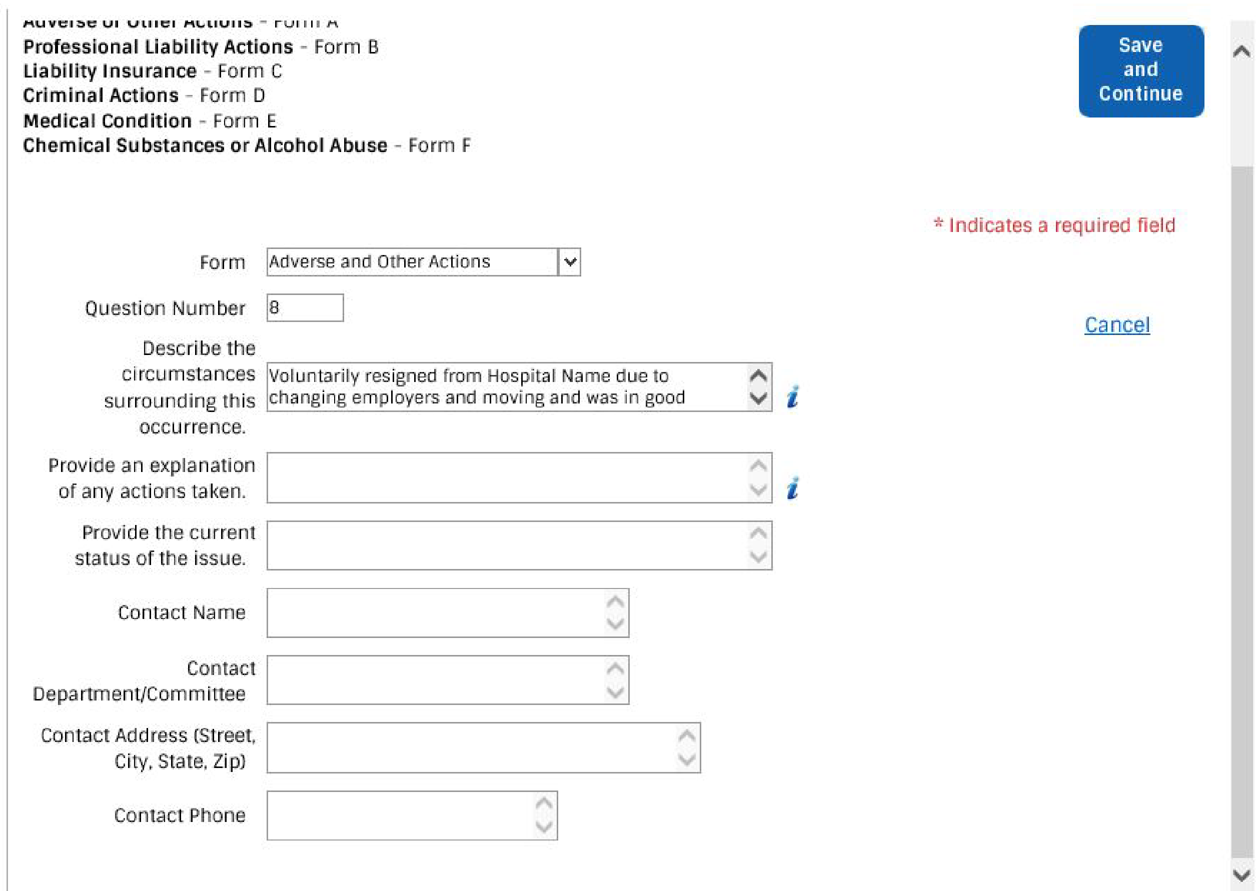
REMEMBER – If any of the Disclosure Section questions were answered "YES," the matching Disclosure Field or Form MUST be added and filled out with additional details.

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



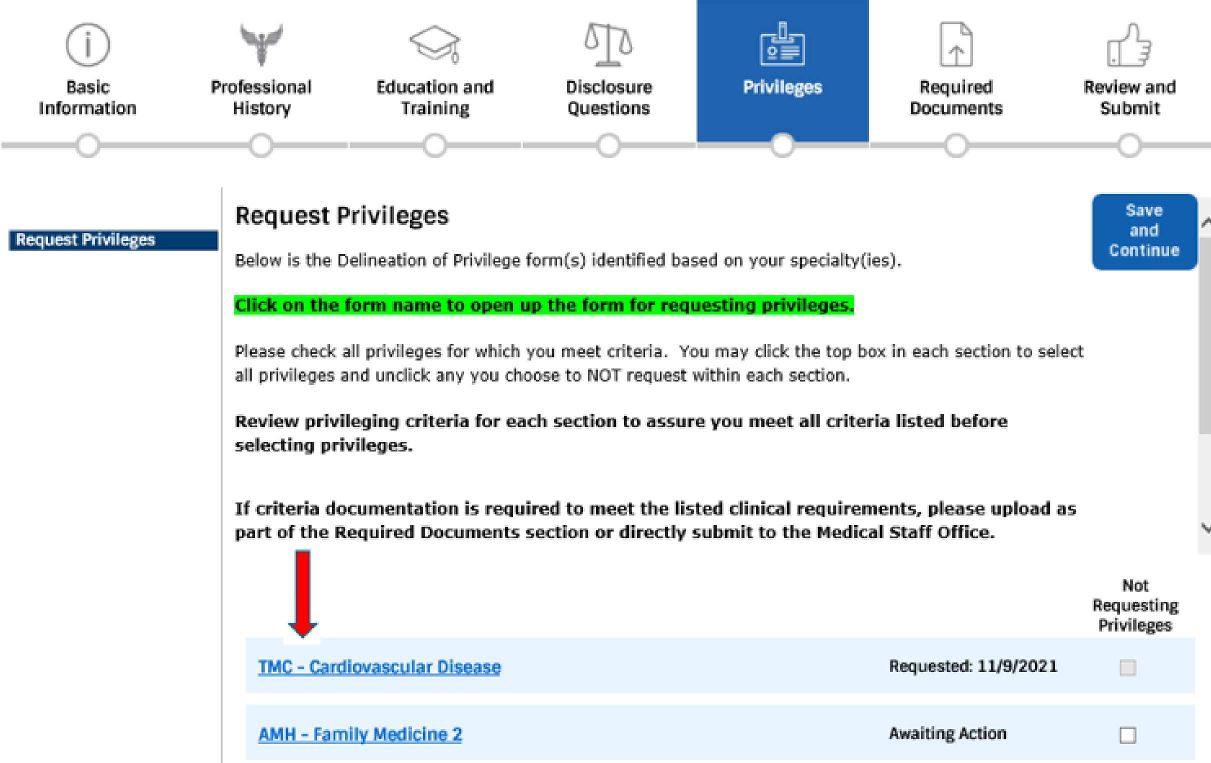
Privileges Section (N/A for PHO only enrollment)

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

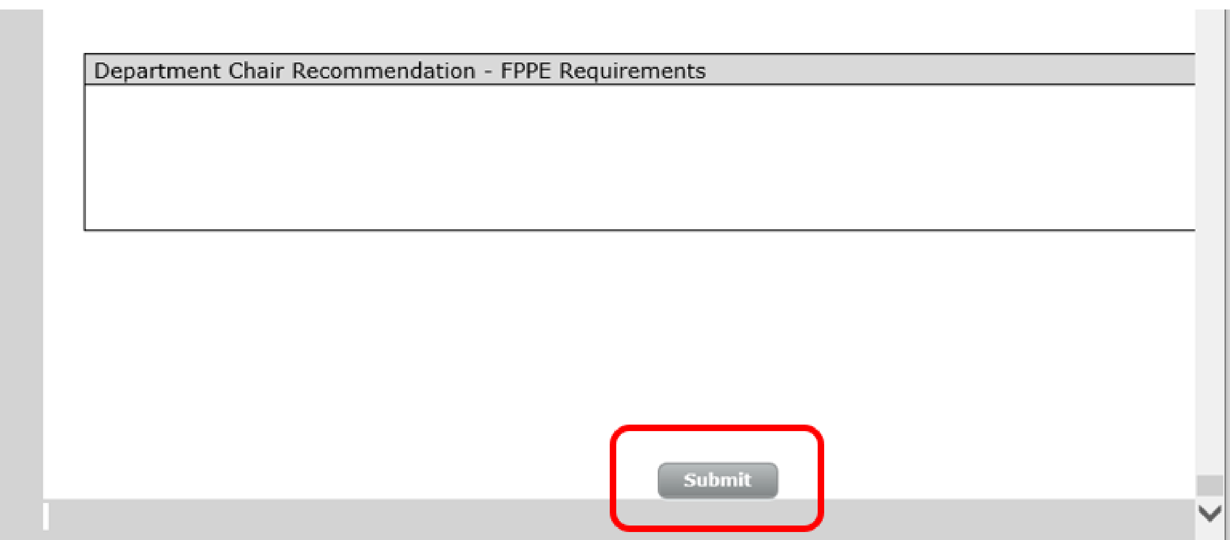
Providers who are needing to be recredentialed at hospitals for membership/privileges, you will see a section called "Privileges" on the top of the portal page.

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

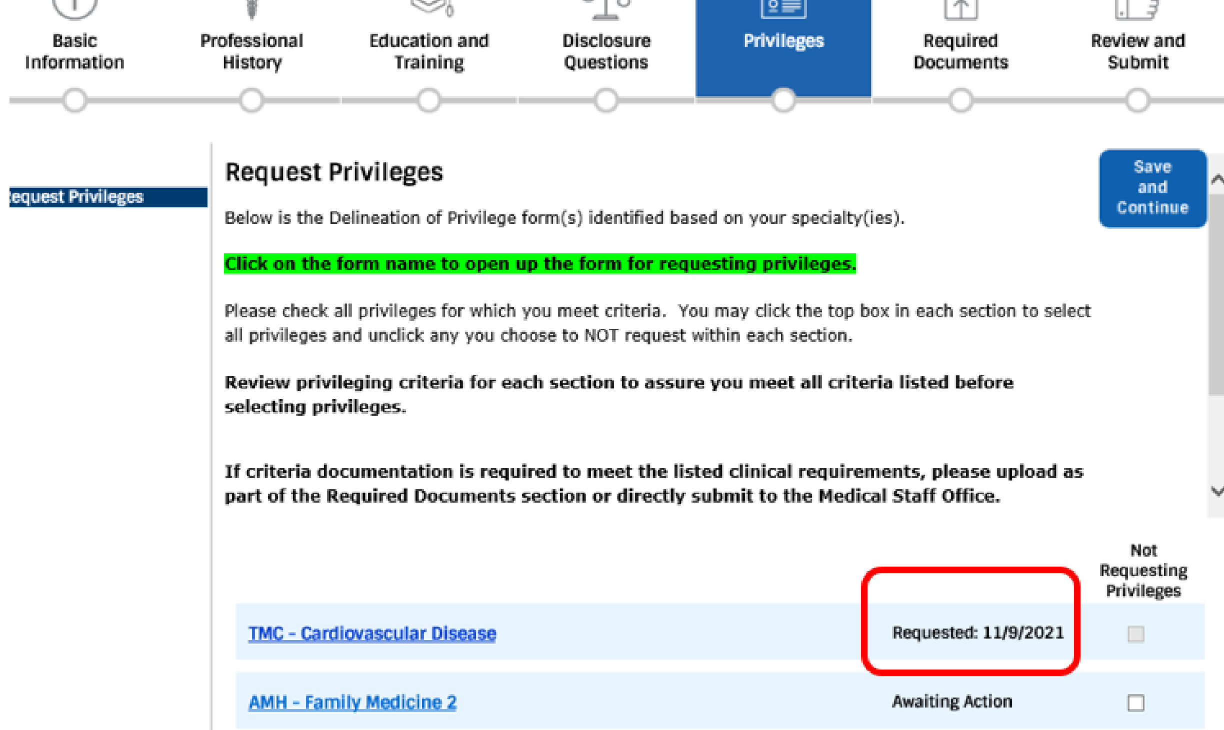
You will need to click on EACH privilege set name to open the form for requesting the privileges.



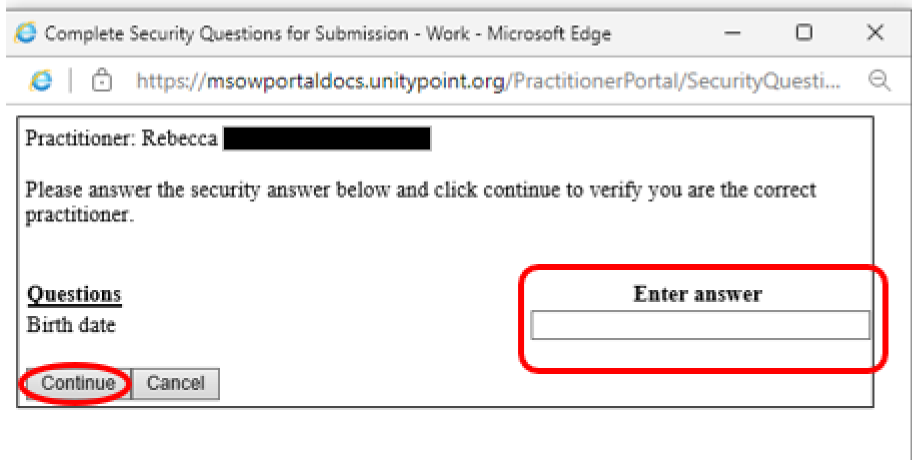
At the end of the privilege request form, you MUST click the "Submit" button.



Once successfully submitted, the main Privilege Section screen changes to show you have requested the privileges with a date noted.



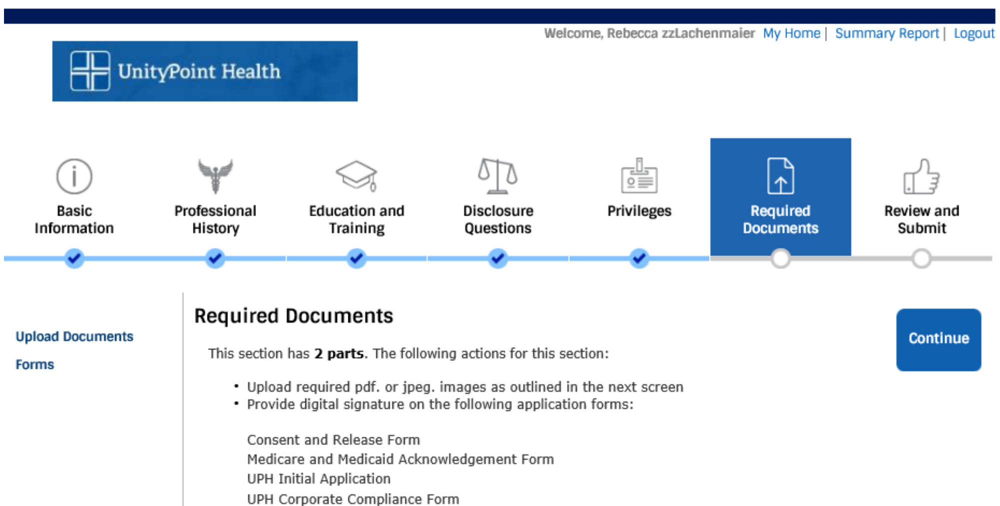
You may be prompted to add your Date of Birth before the portal privileges will fully submit. If you are using two (2) monitors, watch for this message to appear on your second screen.



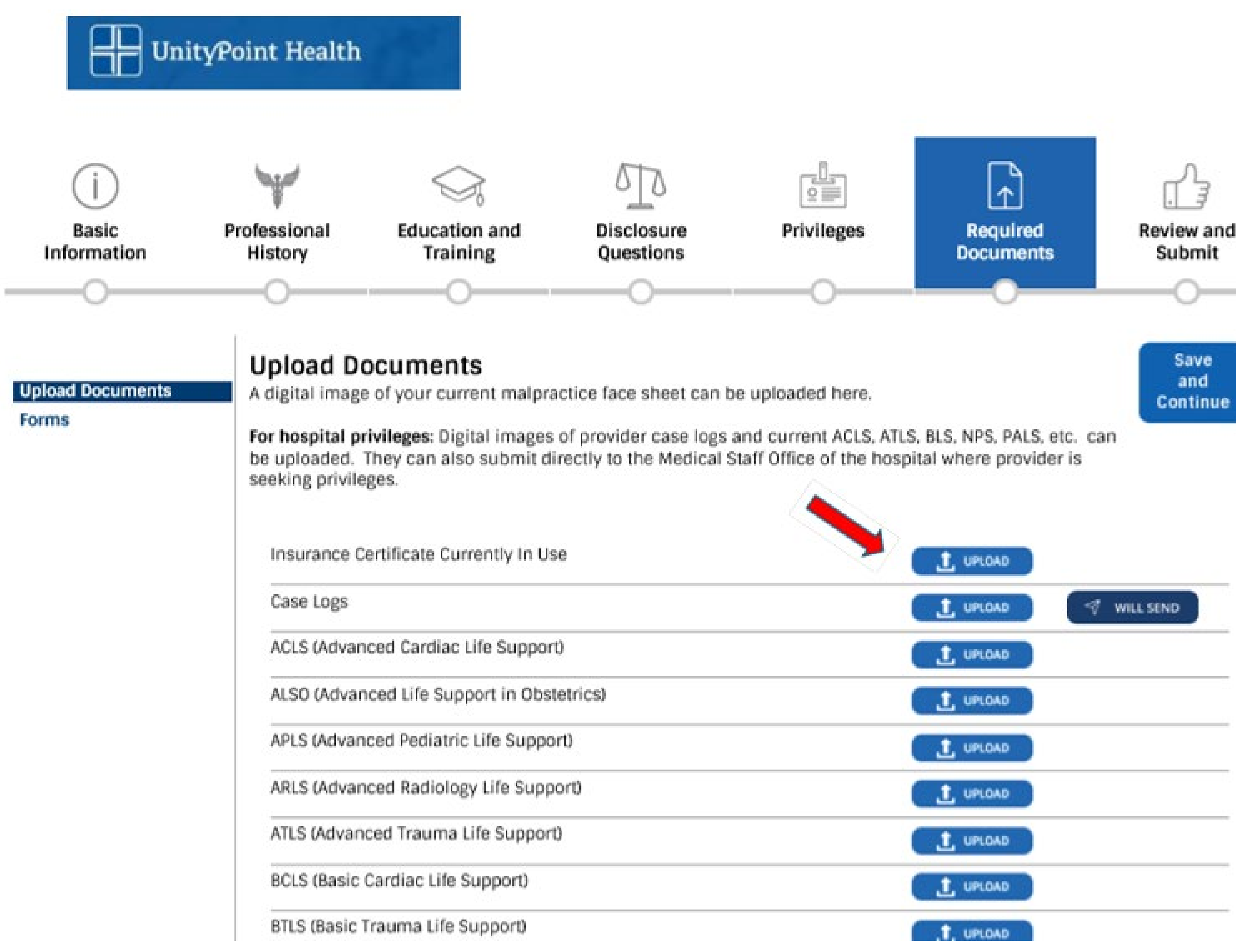
Required Documents Section

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.



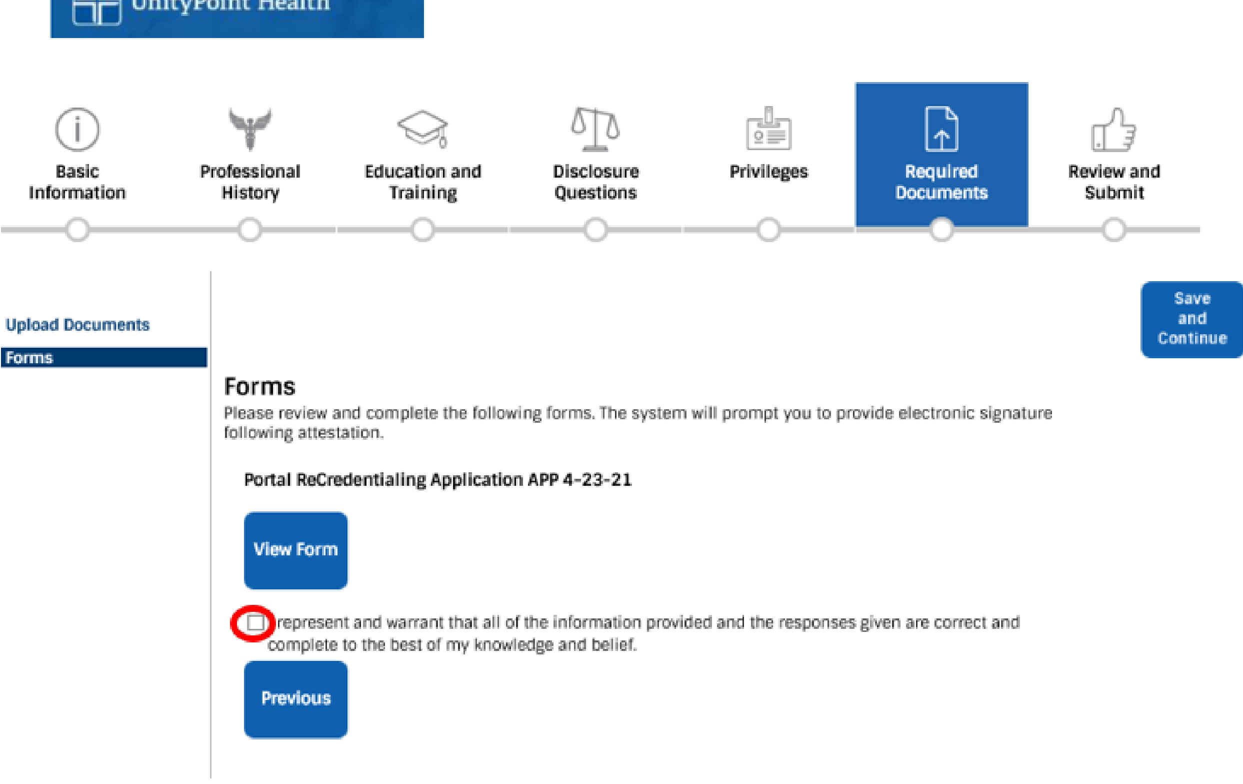
Forms -

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.

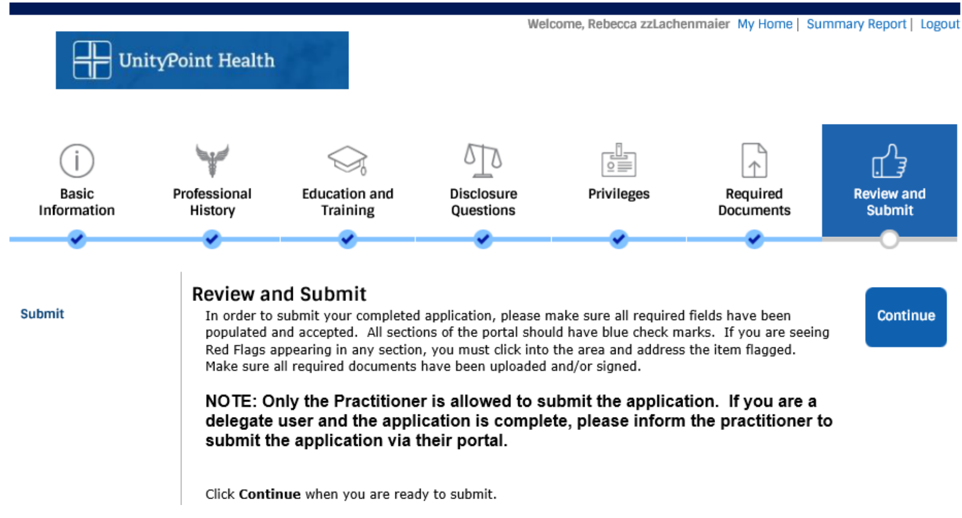
You will need to click the box below View Form for the forms for your electronic signature and date stamp to be placed on the forms.

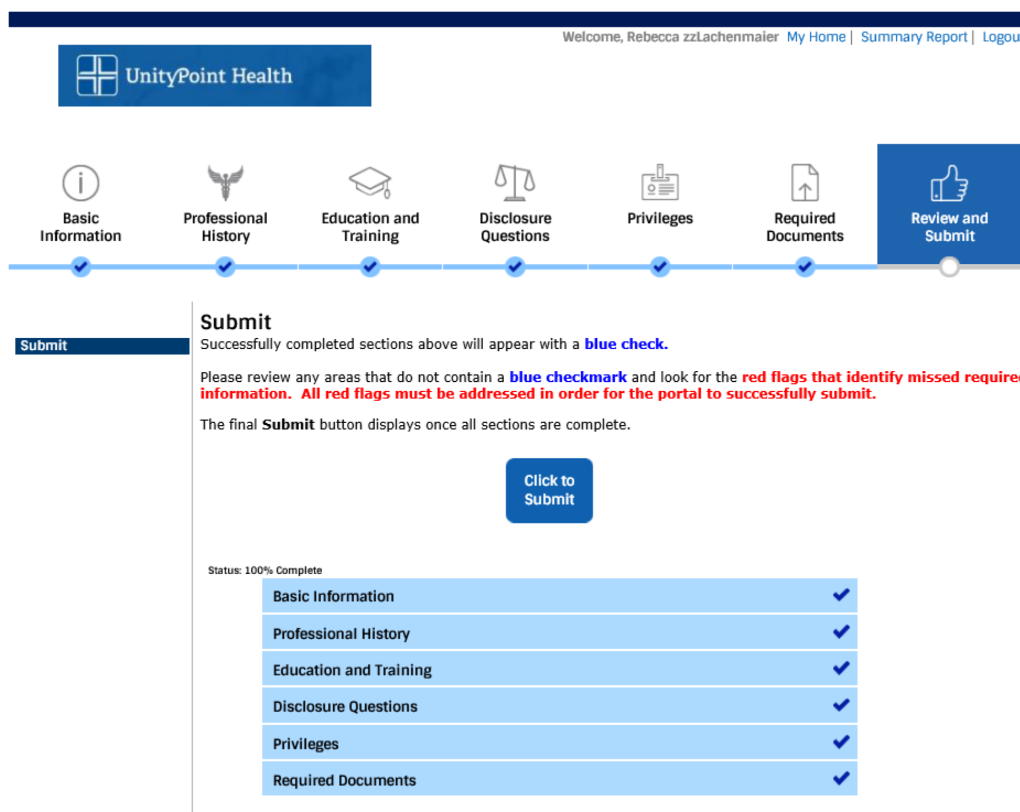


Review and Submission Section

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 it the application to successfully submit.

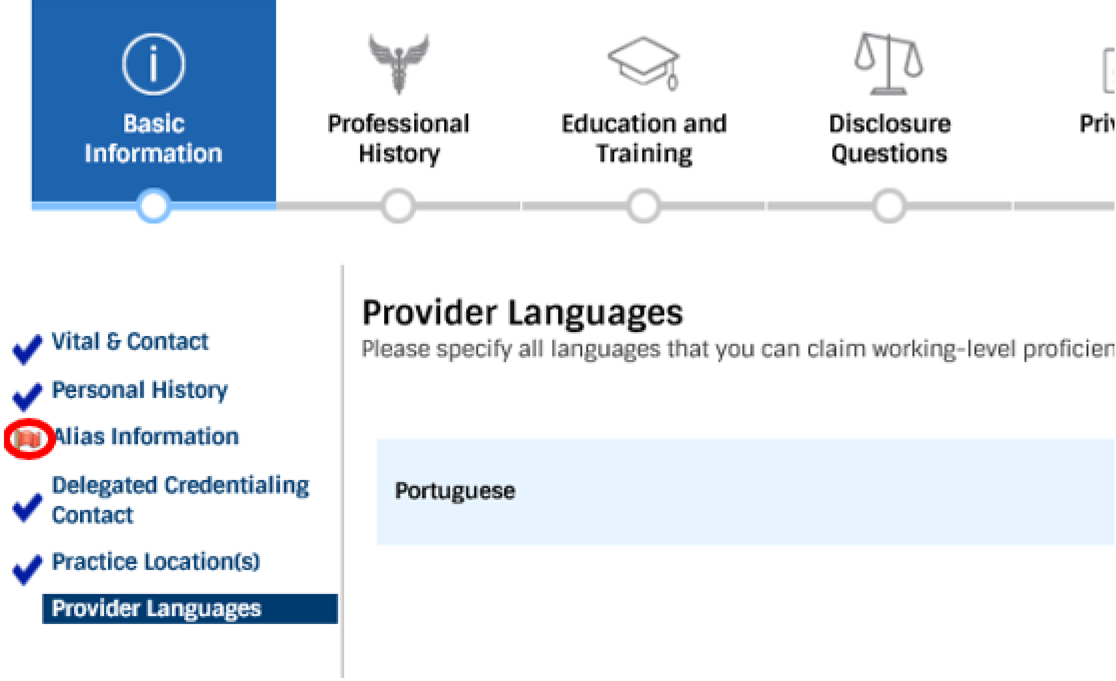




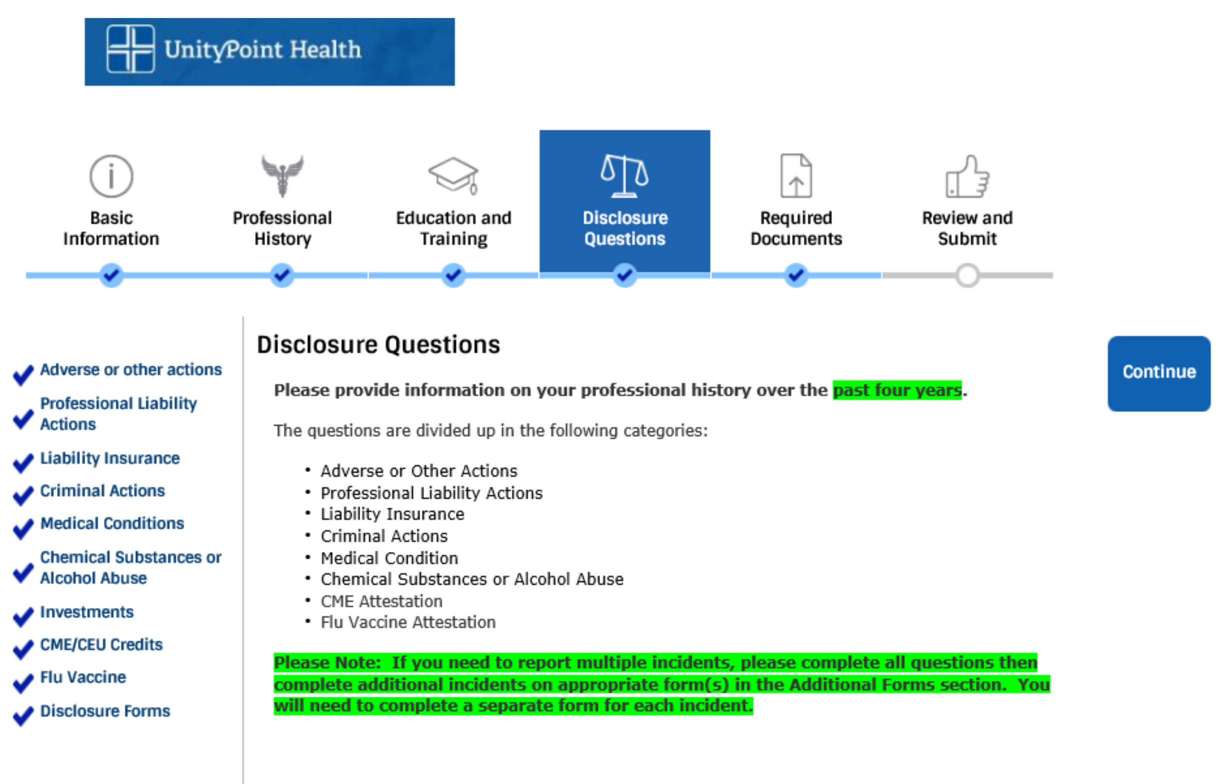
If you see a missing checkmark, return to the section, and look for a Red Flag.

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

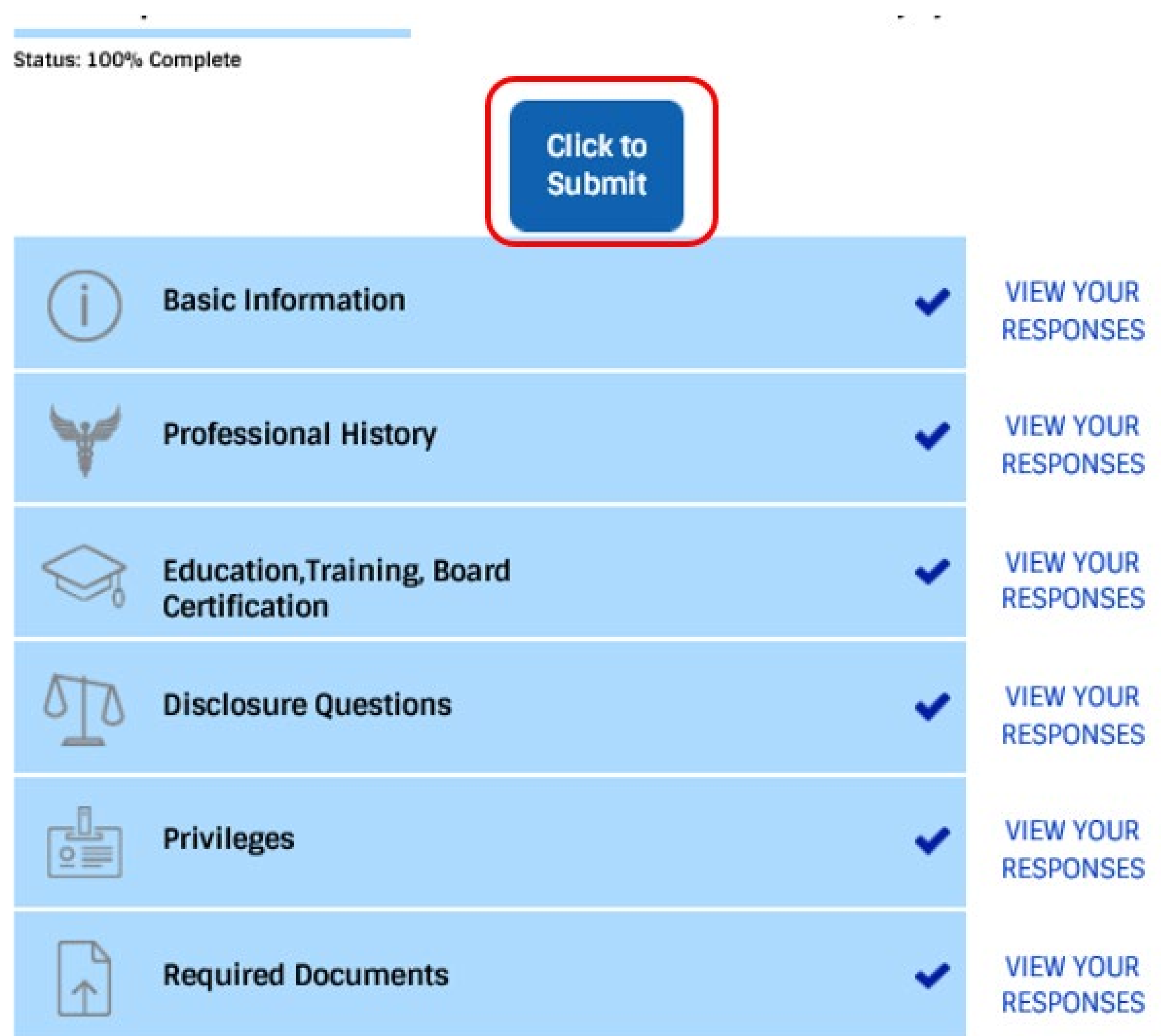
You can click into the section and a Red Flag will identify the item that is need further completion. Look for the red Asterisk fields in the sections.



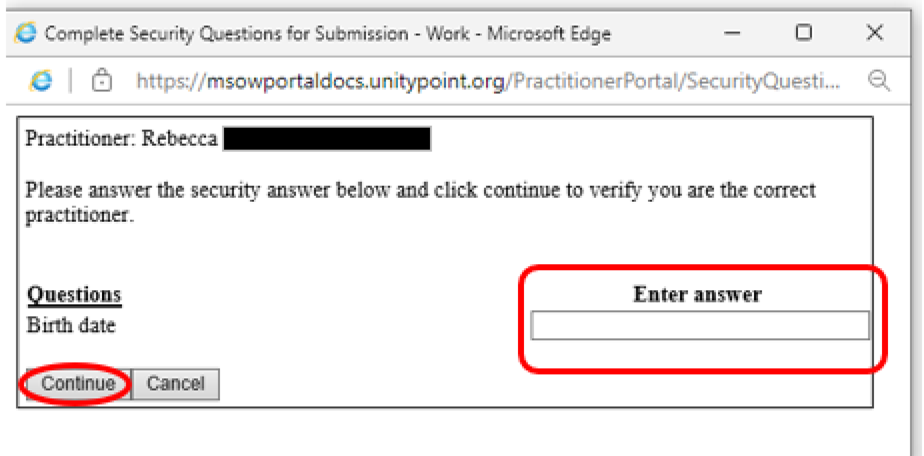
Once all sections are successfully complete the portal is now eligible for submission.



Click the “Submit” Button

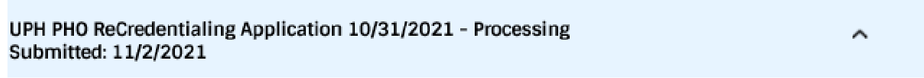


You will be prompted to add your Date of Birth before the portal will fully submit. If you are using two (2) monitors, watch for this message to appear on your second screen.



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)