

# 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](mailto:UPH_CVO@unitypoint.org)

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

<https://www.unitypoint.org/cvo>

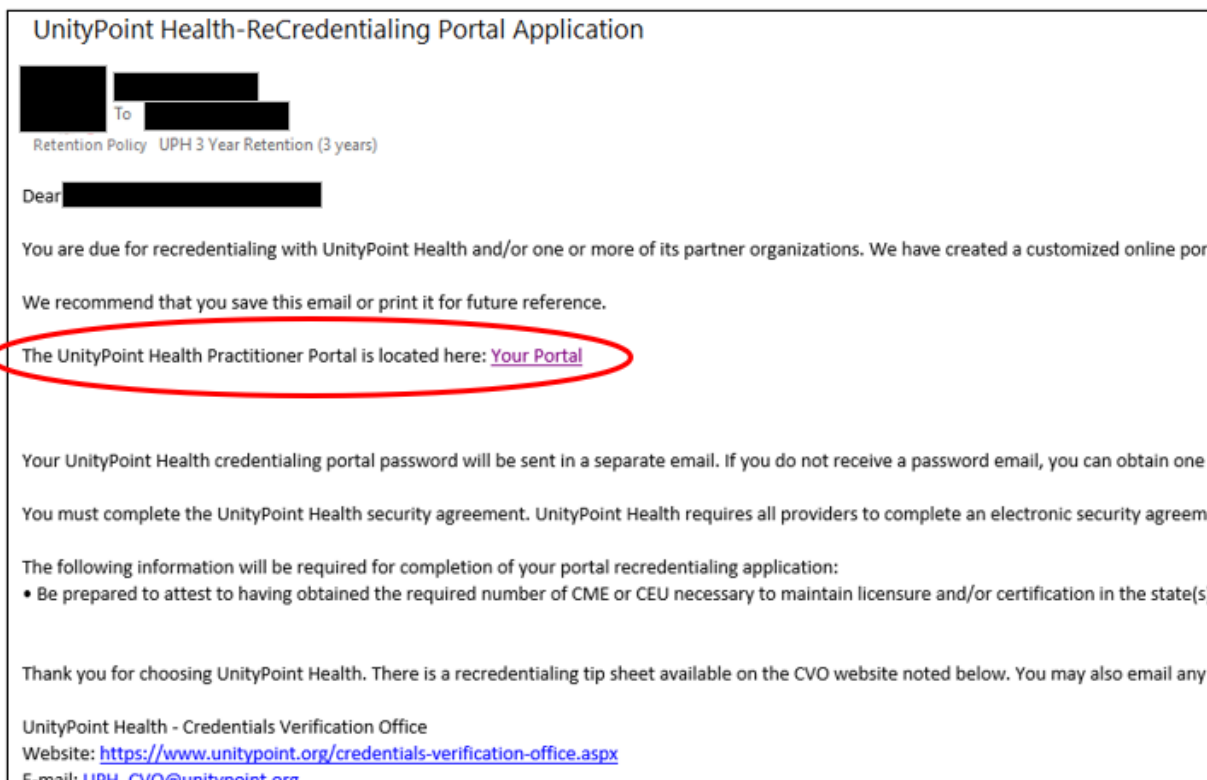
## Contents

Invitation E-mail .....	2
Credentialing Information to have on hand .....	3
Applicant Portal - Basic Info & Troubleshooting.....	4
Basic Information Section .....	15
Professional History Section .....	26
Education and Training Section .....	44
Disclosure Question Section .....	49
Privileges Section (N/A for PHO only enrollment) .....	56
Required Documents Section .....	59
Review and Submission Section.....	61
Next Steps .....	66

## Invitation E-mail

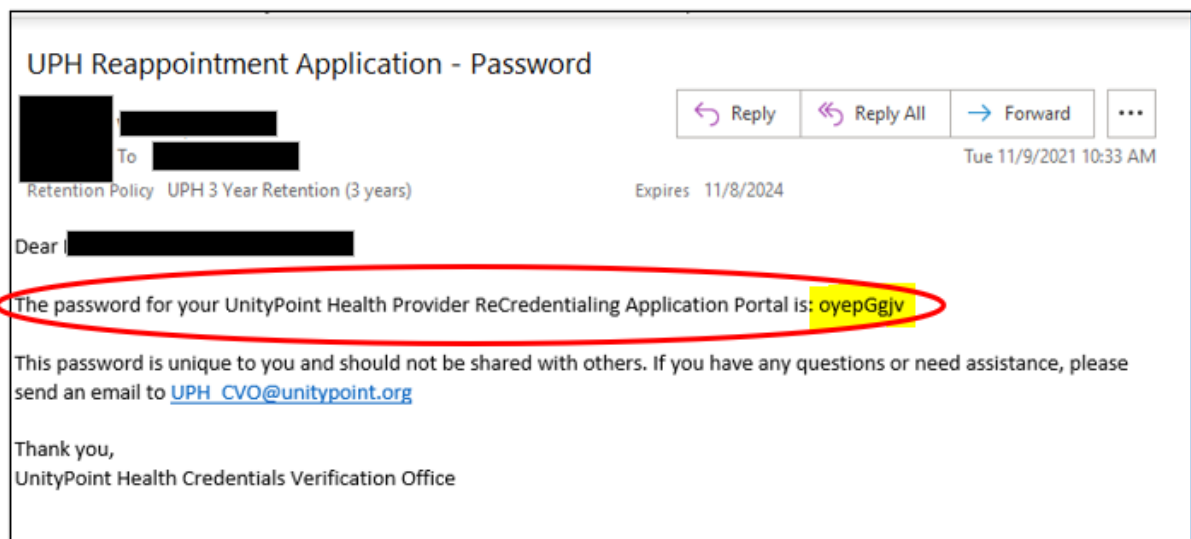
You, and if applicable the Delegate Credentialing Contact, will receive two (2) email notices from the CVO requesting that you complete your recredentialing. The e-mails and logins for the Practitioner and Delegate Credentialing Contacts are NOT interchangeable.

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](mailto: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](mailto:UPH_CVO@unitypoint.org)



Sign In

 **UnityPoint Health**

**Welcome to the UnityPoint Health Practitioner Portal!**

**Browser Requirements:**

**PC - Windows 7, Windows 8 and Windows 10, IE 11, Chrome**

**MAC - OS-X, Chrome, Safari**

**Tablets - Android/iOS, HTML5 compatible browser (Mozzila Firefox is not supported)**

Email Address:

Password:

[forgot your password?](#)

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.



Sign In

 **UnityPoint Health**

Welcome to the UnityPoint Health Practitioner Portal!

**Browser Requirements:**

PC - Windows 7, Windows 8 and Windows 10, IE 11, Chrome

MAC - OS-X, Chrome, Safari

Tablets - Android/iOS, HTML5 compatible browser (Moxzilla Firefox is not supported)

\*To allow us to locate your records, please enter your Last and First name.

Last Name:

First Name:

[Submit](#)

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.



Sign In

 **UnityPoint Health**

Welcome to the UnityPoint Health Practitioner Portal!

**Browser Requirements:**

PC - Windows 7, Windows 8 and Windows 10, IE 11, Chrome

MAC - OS-X, Chrome, Safari

Tablets - Android/iOS, HTML5 compatible browser (Moxzilla Firefox is not supported)

\*An email has been sent to the email address associated with your account containing a new temporary password.

Email Address:

Password:

[Submit](#)

[Forgot your password?](#)

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.

---


## UnityPoint - Portal Password Reset



MSONetPasswordReset@MSOW.com

To [REDACTED]

Retention Policy UPH 3 Year Retention (3 years)

 If there are problems with how this message is displayed, click here to view it in a web browser.

**WARNING!** This email originated from outside of the organi

Dear [REDACTED]

Your new password is 2pX6Kw7v



**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.

The screenshot shows the UnityPoint Health CVO Practitioner Portal home page. At the top, there is a navigation bar with the UnityPoint Health logo on the left and links for 'Welcome', 'My Home', 'Change Password', and 'Logout' on the right. Below the navigation bar is a 'My Home' section. The main content area features a 'Welcome, [redacted]!' message, followed by 'Your Current Application: UPH ReCredentialing & Privileges Portal 4-23-21'. A 'Begin' button is prominently displayed. Below this, a welcome message states: 'Welcome to the UnityPoint Health - CVO Practitioner Portal. You have been granted access to this site to permit the electronic completion of the CVO re-credentialing application packet.' Two green highlighted boxes provide important instructions: 'Fields marked with an asterisk (\*) are required. Hover over the (i) next to the field to see instructions.' and 'Your information must be all-inclusive of any new education, all practice locations, all hospital affiliations, and all employments in the last 4 years. Any gaps of time greater than 30 days will require a gap explanation to be provided in the Work History Section.' A list of features to keep in mind includes: Navigation, Automatic Saving, Timing Out Will Occur, Easy Review, and Document Upload. A note specifies that only Delegate Credentialers can assist with the application. Contact information for the CVO is provided at the bottom.

Welcome, [redacted] | My Home | Change Password | Logout

**My Home**

Welcome, [redacted]!

Your Current Application:  
**UPH ReCredentialing & Privileges Portal**  
4-23-21

**Begin**

Welcome to the UnityPoint Health - CVO Practitioner Portal

You have been granted access to this site to permit the electronic completion of the CVO re-credentialing application packet.

Fields marked with an asterisk (\*) are required. Hover over the (i) next to the field to see instructions.

Your information must be all-inclusive of any new education, all practice locations, all hospital affiliations, and all employments in the last 4 years. Any gaps of time greater than 30 days will require a gap explanation to be provided in the Work History Section.

Some features to keep in mind:

- **Navigation:** When finished entering information on a screen click Continue to move to the next screen. You can access a particular screen by clicking on the links at the left side of the screen. Click on the "My Home" link at the top of the page to check the status of application completion.
- **Automatic Saving:** Your information will save as you move through the application
- **Timing Out Will Occur:** The portal will timeout with inactivity. If you must leave the portal to gather information, save and log out.
- **Easy Review:** You will have a chance to review your application before you submit
- **Document Upload:** You will be able to upload documents that will be transmitted to 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.**

For questions regarding packet completion and submission, email the CVO at [UPH\\_CVO@unitypoint.org](mailto:UPH_CVO@unitypoint.org)

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.

UnityPoint Health

Welcome, Rebecca [redacted] My Home | Summary Report | Logout

Basic Information Professional History Education and Training Disclosure Questions Required Documents Review and Submit

**Alias Information**

Please list other names by which you have been known and provide an explanation for the change in your name in the section below.

If you have not had a prior alias name, you can click Save and Continue to move through this section.

If an alias is added, an explanation is required.

Save and Continue

Vital & Contact  
Personal History  
**Alias Information**  
Delegated Credentialing Contact  
Practice Location(s)  
Provider Languages

Rebecca [redacted]

Alias Type Other

First, Middle, Last Name Rebecca [redacted]

Alias [redacted]

Explain Name Change [redacted]

DELETED EDIT

Add an Alias

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:

Continue



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.

The screenshot shows the UnityPoint Health portal interface. At the top, there is a navigation bar with the UnityPoint Health logo and a user profile section. Below this is a horizontal menu with icons for 'Basic Information', 'Professional History', 'Education and Training', 'Disclosure Questions', 'Privileges', 'Required Documents', and 'Review and Submit'. The 'Basic Information' section is active, and the 'Vital & Contact' sub-section is selected. The form contains several fields, many of which are marked with a red asterisk to indicate they are required. A red oval highlights a legend that states '\* Indicates a required field'. The 'Save and Continue' button is also visible.

**Vital & Contact** Please provide the information requested. Save and Continue

\* Indicates a required field

Title Ms. Degree D

First Name Rebecca MI Last Name

Date of birth Sex male Social Security Number 44-00-7777

Current Home Address Apartment # (if applicable)

City State Zip

Email Address You Use Most (Note -this will be the e-mail used for communication of any issues and for re-credentiating needs when it is time for re-credentiating)

Alternate Email Address

Cell Phone Home Phone

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

U.S. Citizen = No Visa information required

Welcome, [REDACTED] [My Home](#) | [Summary Report](#) | [Logout](#)

**UnityPoint Health**

Basic Information | Professional History | Education and Training | Disclosure Questions | Required Documents | Review and Submit

**Vital & Contact**

- Personal History**
- Alias Information
- Delegated Credentialing Contact
- Practice Location(s)
- Provider Languages

**Personal History**  
Please provide your personal history information.

Save and Continue

\* Indicates a required field

Marital Status: Married

Birth City: [REDACTED] Birth State (If born in the US): [REDACTED]

Birth Country: [REDACTED]

Are you a US Citizen?  Yes  No Citizenship: [REDACTED]

Not a U.S. Citizen = Visa information required

Welcome, Rebecca [REDACTED] [My Home](#) | [Summary Report](#) | [Logout](#)

**UnityPoint Health**

Basic Information | Professional History | Education and Training | Disclosure Questions | Required Documents | Review and Submit

**Vital & Contact**

- Personal History**
- Alias Information
- Delegated Credentialing Contact
- Practice Location(s)
- Provider Languages

**Personal History**  
Please provide your personal history information.

Save and Continue

\* Indicates a required field

Marital Status: Married

Birth City: [REDACTED] Birth State (If born in the US): [REDACTED]

Birth Country: Belgium

Are you a US Citizen?  Yes  No Citizenship: Belgian

Do you have a legal right to reside permanently and work in the U.S.?  Yes  No

Visa Type: [REDACTED]

Visa Expiration Date: [REDACTED]

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



- 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

no longer practicing at a location, enter an end date.

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

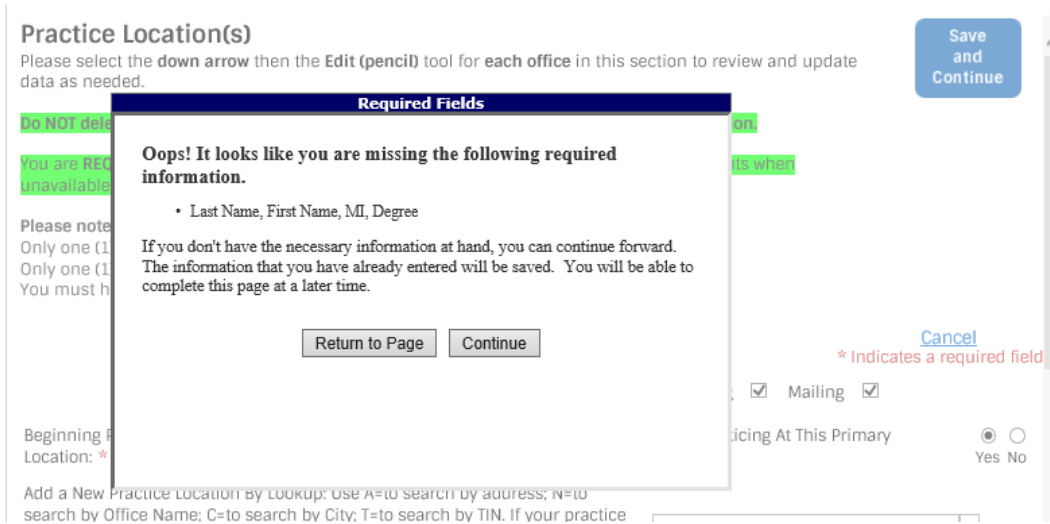
**Please note:**  
Only one (1) office can be checked as Primary  
Only one (1) office can be checked as Mailing  
You must have at least one (1) office marked as a billing office  
One office can have all 3 identifications checked.

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

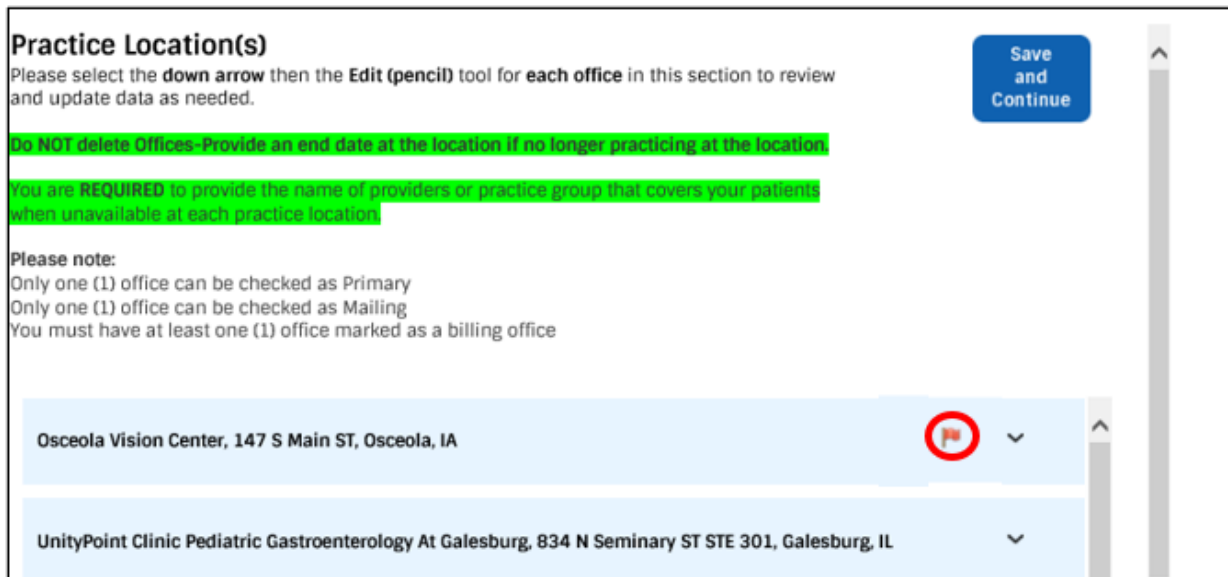
Osceola Vision Center, 147 S Main ST, Osceola, IA	✓	▼
UnityPoint Clinic Pediatric Gastroenterology At Galesburg, 834 N Seminary ST STE 301, Galesburg, IL	✗	▼




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.

### 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  *i*

Current or Prior Affiliation

**Organization Lookup**  *i*

Organization Name \*  Primary?

Address \*  Suite #

[Cancel](#)  
\* Indicates a required field

## 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.

The screenshot displays the UnityPoint Health portal interface. At the top, a dark blue header contains the UnityPoint Health logo on the left and the text "Welcome, [redacted] My Home | Summary Report | Logout" on the right. Below the header is a navigation bar with six icons: a blue circle with an 'i' for "Basic Information", a stethoscope for "Professional History", a graduation cap for "Education and Training", a scale of justice for "Disclosure Questions", a document with an arrow for "Required Documents", and a thumbs up for "Review and Submit". The "Basic Information" icon is highlighted with a white circle. Below the navigation bar, a vertical sidebar on the left lists menu items: "Vital & Contact", "Personal History", "Alias Information", "Delegated Credentialing Contact", "Practice Location(s)", and "Provider Languages". The main content area is titled "Basic Information" and contains the text "Here's the key information you will need to complete this section:" followed by a bulleted list: "Information about you", "Personal history", "Alias names by which you have been known", "Prior address information", "Credentialing contact", and "Your current or anticipated practice locations". A blue "Continue" button is positioned to the right of the list.

## 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.

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

Please provide the information requested. [Save and Continue](#)

\* Indicates a required field

Title  Degree

First Name  MI  Last Name

Date of birth  Sex  Social Security Number

Current Home Address \*  Apartment # (if applicable)

City \*  State \*  Zip \*

Email Address You Use Most (Note -this will be the e-mail used for communication of any issues and for future re-credentialing.)

Alternate Email Address

Cell Phone \*  Home Phone

## Personal History –

Birth Country and Citizenship must be provided

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

### Personal History

Please provide your personal history information. [Save and Continue](#)

\* Indicates a required field

Marital Status

Birth City  Birth State (if born in the US)

Birth Country \*

Are you a US Citizen? \*  Yes  No Citizenship \*



## 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.

Welcome, Rebecca zzLachenmaler [My Home](#) | [Summary Report](#) | [Logout](#)

UnityPoint Health

- Basic Information**
- Professional History
- Education and Training
- Disclosure Questions
- Privileges
- Required Documents
- Review and Submit

### Alias Information

Please list other names by which you have been known and provide an explanation for the change in your name in the section below.

**An Explanation for EACH Alias is REQUIRED**

Save and Continue

Add an Alias

- Vital & Contact
- Personal History
- Alias Information
- Delegated Credentialing Contact
- Practice Location(s)
- Provider Languages

## 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.

The screenshot shows the UnityPoint Health portal interface. At the top, there is a navigation bar with the user's name 'Welcome, Rebecca' and links for 'My Home', 'Summary Report', and 'Logout'. Below this is a main navigation menu with icons for 'Basic Information', 'Professional History', 'Education and Training', 'Disclosure Questions', 'Required Documents', and 'Review and Submit'. The 'Delegated Credentialing Contact' section is active, showing a 'Save and Continue' button. The section title is 'Delegated Credentialing Contact'. Below the title, there is a paragraph explaining the role of a Delegated Credentialer and a note: 'Only enter ONE Delegated Credentialer'. A second paragraph states: 'This person will then receive emails in the future to assist you with completing online portal applications. They can NOT submit the application on your behalf.' A third paragraph, highlighted in green, says: 'If you do not have such assistance from your office, enter your name and email to be used for future correspondences'. Below this text is a light blue box with the text 'Click to view data' and a dropdown arrow. At the bottom right of the section is a button labeled 'Add a Credentialing Contact'.

Sample of screen to identify REQUIRED fields identified by Asterisks.

This screenshot shows the 'Delegated Credentialing Contact' form in the UnityPoint Health portal. The form includes a 'Save and Continue' button and a 'Cancel' link. A red asterisk indicates a required field. The form fields are: 'Name of Credentialing Contact' (required), 'Title', 'Street Address' (with a 'Suite #' field), 'City', 'State' (dropdown), 'Zip', 'Email Address' (required), 'Phone #' (required), 'Cell Phone #', and 'Fax #'. A red asterisk is placed to the right of the 'Email Address' and 'Phone #' fields. A red circle highlights the asterisk next to the 'Phone #' field. A red asterisk is also placed to the right of the 'Name of Credentialing Contact' field.

## 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.

**Practice Location(s)**

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

**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.**

**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

Osceola Vision Center, 147 S Main ST, Osceola, IA	
UnityPoint Clinic Pediatric Gastroenterology At Galesburg, 834 N Seminary ST STE 301, Galesburg, IL	

[Add another Office Location](#)

[Save and Continue](#)

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.

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 Primary Location: \*  Are You Still Practicing At This Primary 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

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 \*

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

**Practice Location(s)**

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

To ADD a new practice location-select the gray button, "Add Another Office Location" at the bottom of the office window.

*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.

Primary  Additional  Secondary  Tertiary  Billing  Mailing

\* Indicates a required field

Beginning practice date at This Location: \*

Are You Still Practicing at This Location? \*  Yes  No

**IF Adding New Location, Start By Adding a New Office Blank Screen and then Use: Use Drop Down Search Box Below.**

To find new location, search our table by using one of these short cuts:  
 A=Enter address; N=Enter Office Name; C=Enter City Name; T=Enter Office TIN

Search Our Table for Office:

[Cancel](#)

[Save and Continue](#)

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

Primary  Additional  Secondary  Tertiary  Billing  Mailing

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.

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  Group Billing NPI

**\* 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.

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


**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.**

**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

Osceola Vision Center, 147 S Main ST, Osceola, IA	✓	▼
UnityPoint Clinic Pediatric Gastroenterology At Galesburg, 834 N Seminary ST STE 301, Galesburg, IL	✓	▼

Add another Office Location

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

Primary  Additional   Secondary   Tertiary  Billing  Mailing

## 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.

- Basic Information
- Professional History
- Education and Training
- Disclosure Questions
- Required Documents
- Review and Submit

- Vital & Contact
- Personal History
- Alias Information
- Delegated Credentialing Contact
- Practice Location(s)
- Provider Languages**

### Provider Languages

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

Portuguese

Language Portuguese

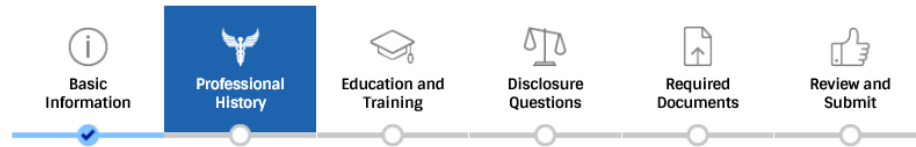
Read  Speak  Write

DELETE EDIT

Add a language

Save and Continue

# Professional History Section



- 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.**

Continue



## 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](mailto: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**

**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.**

Save and Continue

- Healthcare Organization Affiliations
- Employment History
- Current and Past Insurance Carriers
- Peer References

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.**

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.**

Save and Continue

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: [dropdown]

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.

### 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.**

[Cancel](#)  
\* Indicates a required field

ID Type \*

ID Number - Enter N/A if not applicable \*  State \*

Issue Date  Expiration Date \*

State License Status \*

Is the State License Unlimited? \*  Yes  No

**ALL ARNPs and PAs - UPH requires a supervising physician to be identified. Please list your supervising physician or contact your Clinic Director if you have questions on who you should list.**

Supervising Physician Name

### 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.**

[Cancel](#)  
\* Indicates a required field

ID Type \*

ID Number - Enter N/A if not applicable \*  State \*

Issue Date  Expiration Date \*

DEA License Status \*

DEA Schedule \*

Is the DEA unlimited? \*  Yes  No

For NPI – Enter NA into the State Field

**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**

**ID Type** \* NPI  
**ID Number - Enter N/A if not applicable** \* 1821058322 **State** \* NA  
**Issue Date** **Expiration Date**

[Cancel](#)  
\* Indicates a required field

**Save and Continue**

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

**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**

**ID Type** \* Controlled Substance  
**ID Number - Enter N/A if not applicable** \* 1241054 **State** \* IL  
**Issue Date** **Expiration Date** \* 12/31/2075  
**CSA License Status** \*  
**Is the Controlled Substance Unlimited?** \*  Yes  No

[Cancel](#)  
\* Indicates a required field

**Save and Continue**

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"

NPI, NA  
Controlled Substance, IL

**Add License/NPI/Life Certifications**  
[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.



**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.**


[Cancel](#)  
\* Indicates a required field

ID Type \*  

ID Number - Enter N/A if not applicable \*  State   

Issue Date   Expiration Date   

State License Status \*   

Is the State License Unlimited? \*  Yes  No 

**ALL ARNPs and PAs - UPH requires a supervising physician to be identified. Please list your supervising physician or contact your Clinic Director if you have questions on who you should list.**

Supervising Physician Name

## 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.

**UnityPoint Health**

Basic Information | **Professional History** | Education and Training | Disclosure Questions | Required Documents | Review and Submit

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

### 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, 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.

Save and Continue

UnityPoint Health - St. Luke's Cedar Rapids, 1026 A AVE NE, Cedar Rapids, IA



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.

### 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, 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.

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 \*

[Cancel](#)  
\* Indicates a required field

[Save and Continue](#)

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  [i](#) \* Indicates a red

Current or Prior Affiliation

Organization Lookup

Organization Name  Primary?

Address  Suite #

City  State  Zip

Enter Membership Status (Applicant or Pending or Active or Inactive) \*  [i](#) Specialty

Start Date at Hospital (mm/yyyy)  [i](#)

Click Box if Membership/Privileges are Currently Pending or Active at this Hospital or If you have an admitting arrangement with covering group:  [i](#)

End Date of Membership/Privileges at Hospital (mm/yyyy) \*

[Save and Continue](#) [Cancel](#)

To add in new facilities, you will select 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.

Basic Information | **Professional History** | Education and Training | Disclosure Questions | Privileges | Required Documents | Review and Submit

admitting privileges or a way to admit patients at a nonparticipating hospital.

Licensure, Registrations and Certification Information

**Healthcare Organization Affiliations**

Employment History

Current and Past Insurance Carriers

Peer References

UnityPoint Health - St. Luke's Cedar Rapids, 1026 A AVE NE, Cedar Rapids, IA	▼
Admitting Provider/Group	▼
St. Luke's Children's Hospital, 190 E Bannock ST, Boise, ID	▼
UnityPoint Health - Keokuk, 1600 Morgan ST, Keokuk, IA	▼

Ambulatory Surgery Center

[I don't have any Ambulatory Surgery Center privileges](#)

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](mailto:uph_medimorecred@unitypoint.org)

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

\* Indicates a required field

Save and Continue

Current or Prior Affiliation

Organization Lookup

Organization Name  Primary?

Address  Suite #

City  State  Zip

Enter Membership Status (Applicant or Pending or Active or Inactive) \*  Specialty

Start Date at Hospital (mm/yyyy) \*

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) \*

Cancel

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  [i](#)

Name of Participating physician or group

Name of hospital and city

Current or Prior Affiliation

Organization Lookup

Organization Name

is this your primary hospital?  Yes  No If yes, please check this box

Address  Suite #

City  State  Zip

Enter Membership Status (Applicant or Pending or Active or Inactive)  [i](#) Specialty

Start Date at Hospital (mm/yyyy)  [i](#)

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.

[Cancel](#)

[Save and Continue](#)

*\* Indicates a required field*

I do not have hospital privileges but have the following arrangement for my patients to be admitted  [i](#)

Current or Prior Affiliation

Organization Lookup

Organization Name  Primary?

Address  Suite #

City  State  Zip

Enter Membership Status (Applicant or Pending or Active or Inactive)  [i](#) Specialty

Start Date at Hospital (mm/yyyy)  [i](#)

Click Box if Membership/Privileges are Currently Pending or Active at this Hospital or If you have an admitting arrangement with covering group:  [i](#)

End Date of Membership/Privileges at Hospital (mm/yyyy)

[Cancel](#)

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 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  *i*

Current or Prior Affiliation

**Organization Lookup**  *i*

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 some common examples below:

### Employer with multiple clinic locations

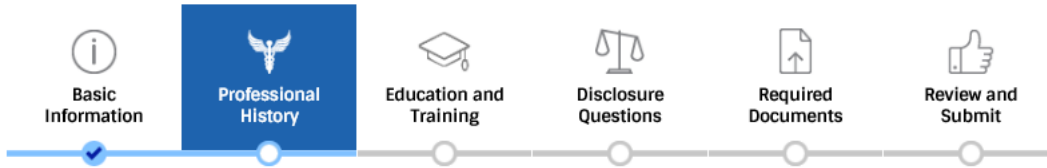
If you are employed by an entity that has multiple clinical locations we only need the primary location listed in your employment history, we do not need all of the various clinic office locations you may see patients at under that employment history.

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.





- ✓ 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.

[Cancel](#)  
\* Indicates a required field

Type of Employment \*  v

Company Name/Reason for Gap \*

Address \*  Suite #

City \*  State \*  Zip \*

Phone #  Fax #

Position held  Primary Activity

Save and Continue

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

The image shows a screenshot of a web form with several input fields. At the top, there are two text boxes labeled "Position held" and "Primary Activity". Below these is a red-bordered box containing the text "Currently Employed? \* \*" followed by two radio buttons: "Yes" and "No". The "No" radio button is selected. A red arrow points from this box down to the "Thru Date (mm/yyyy) \*" field. Below the "Currently Employed?" box are two date input fields: "From Date (mm/yyyy) \*" and "Thru Date (mm/yyyy) \*". Below the date fields are three more text boxes: "Contact Name", "Contact Title", "Contact Phone", and "Contact email". A vertical scrollbar is visible on the right side of the form.



## 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.

The screenshot shows the UnityPoint Health credentialing application interface. At the top, the UnityPoint Health logo is displayed. Below it is a progress bar with six steps: Basic Information, Professional History, Education and Training, Disclosure Questions, Required Documents, and Review and Submit. The 'Professional History' step is currently active. On the left side, there is a navigation menu with five items: Licensure, Registrations and Certification Information; Healthcare Organization Affiliations; Employment History; Current and Past Insurance Carriers (which is highlighted); and a 'Save and Continue' button. The main content area is titled 'Current and Past Insurance Carriers' and contains the instruction: '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.' Below this instruction, there is a dropdown menu showing 'Current Malpractice Insurance, UnityPoint Health Self Insured Plan'. To the right of the dropdown is a 'Save and Continue' button. At the bottom right of the main content area, there is a button labeled 'Add another Malpractice Carrier'.

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 \*  ⓘ

Insurance Company Lookup

Insurance Company Name \*

Address \*  Suite #

City \*  State \*  Zip \*

Policy Number \*

Issued \*  Expire Date \*

Per incident \*  Aggregate \*

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.

Welcome, Provider zzDemo | My Home | Summary Report | Logout

**UnityPoint Health**

Basic Information | **Professional History** | Education and Training | Disclosure Questions | Privileges | Required Documents | Review and Submit

**Peer References**

Please list the names of **2** individuals who have personal knowledge **(within the past 12 months)** of your current clinical abilities, ethical character and interpersonal skills (medical directors, dept. chairs) and who would be willing to provide this information upon request.

**If you completed a training program within the last 12 months, one of your references must be your program director.**

**If peers do not meet the above criteria, you will be asked to provide additional peer references that meet the criteria.**

**ARNP and PA-Cs - You MUST list your Supervising/Collaborative physician as one of your peer references, unless a UnityPoint Health Waiver of this requirement has been granted to you.**

(If you are unsure if a waiver has been given, contact the CVO at UPH\_CVO@unitypoint.org)

Save and Continue

Add Professional Reference

\* 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.

Progress bar with steps: Basic Information (checked), Professional History, Education and Training (active), Disclosure Questions, Required Documents, Review and Submit.

Medical Education/Clinical Training Update  
Board/National Certification

### Medical Education/Clinical Training Update

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

Do not duplicate internship, residency, and fellowship information previously reported.

Save and Continue

Where did I attend Residency Training?

[I did not attend a Residency program](#)

## 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.

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

**Medical Education/Clinical Training Update**  
Board/National Certification

### 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.

**Save and Continue**

Where did I attend Medical Education?



Basic Information   Professional History   **Education and Training**   Disclosure Questions   Privileges   Required Documents   Review and Submit

### 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.

Save and Continue

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

Cancel

\* Indicates a required field

What type of education? \*

University Lookup

University Name \*

Address  Suite #

City, State, Zip    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  Yes  No

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.

The screenshot shows the UnityPoint Health application interface. At the top left is the UnityPoint Health logo. Below it is a navigation bar with six steps: Basic Information, Professional History, Education and Training (highlighted), Disclosure Questions, Required Documents, and Review and Submit. The main content area is titled "Board/National Certification" and includes a "Save and Continue" button. The left sidebar shows a menu with "Medical Education/Clinical Training Update" and "Board/National Certification" (selected). The main form contains a dropdown menu for "Family Medicine: Family Medicine" with "DELETE" and "EDIT" icons. Below this are several questions with radio button options: "Are you Board certified?" (Yes/No), "Specialty of Board Certification" (Family Medicine: 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), and "Are you scheduled to take the specialty board exam?" (Yes/No). An "Add a Board/National Certification" button is located at the bottom right of the form area.

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.

Save and Continue

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

[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.

The screenshot shows a progress bar at the top with seven steps: Basic Information, Professional History, Education and Training, Disclosure Questions (highlighted in blue), Privileges, Required Documents, and Review and Submit. Below the progress bar, the 'Disclosure Questions' section is active. On the left, a sidebar lists 'IOWA Quality Focused Questions' with sub-items: Liability Claims Information - Addendum A, Investments, CME/CEU Credits, and Flu Vaccine. The main content area has the heading 'Disclosure Questions' and a blue 'Continue' button. The text reads: 'Please provide information on your professional history over the **past four years**.' It lists categories: Adverse or Other Actions, Professional Liability Actions, Liability Insurance, Criminal Actions, Medical Condition, and Chemical Substances or Alcohol Abuse. A note states: 'Please Note: If you answer "Yes" in any of the above Disclosure Sections, you need to provide explanations.' Additional information requested includes CME Attestation, Flu Vaccine Attestation, and COVID Vaccine or Waiver Information.

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

The screenshot shows a progress bar at the top with six steps: Basic Information (checked with a blue checkmark), Professional History, Education and Training, Disclosure Questions (highlighted in blue), Required Documents, and Review and Submit. Below the progress bar, the 'Disclosure Questions' section is active. On the left, a sidebar lists: Adverse or other actions, Professional Liability Actions, Liability Insurance, Criminal Actions, Medical Conditions, Chemical Substances or Alcohol Abuse, Investments, CME/CEU Credits, Flu Vaccine, and Disclosure Forms. The main content area has the heading 'Disclosure Questions' and a blue 'Continue' button. The text reads: 'Please provide information on your professional history over the **past four years**.' It lists categories: Adverse or Other Actions, Professional Liability Actions, Liability Insurance, Criminal Actions, Medical Condition, Chemical Substances or Alcohol Abuse, CME Attestation, and Flu Vaccine Attestation. A note states: '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.'

**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 \*

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.

**IOWA Quality Focused Questions**

- Liability Claims Information - Addendum A
- Investments
- CME/CEU Credits
- Flu Vaccine

### Liability Claims Information - Addendum A

Please complete a new form for each professional liability incident [Yes answers to questions 17-20].

You will also need to complete a new form for a Yes answer to question 16 (professional liability termination question).

Select "Add Professional Liability Incident" and then select "Yes" to report any incidents.

**Even if you have no Claims to report, please select "Add Professional Liability Incident" and then select "NO" to proceed to the next section.**

[Save and Continue](#)

[Add Professional Liability Incident](#)

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 required field

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

Which disclosure question is the explanation associated with? \*

Description of Allegation or Action taken

Date of Incident  Date of Claim or Suit filed

Location of Incident

Insurance Carrier Name

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

Your Status:

Claim Status:

[Save and Continue](#) [Cancel](#)

## 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 subspecialty 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.

**Disclosure Forms**

If you answered yes to any disclosure question, please fill out the appropriate form:  
Adverse or Other Actions - Form A  
Professional Liability Actions - Form B  
Liability Insurance - Form C  
Criminal Actions - Form D  
Medical Condition - Form E  
Chemical Substances or Alcohol Abuse - Form F

Save and Continue

Add a form

### Disclosure Forms

If you answered “YES” to any of the disclosure questions in the prior sections, you are **REQUIRED** to fill out the appropriate matching section disclosure form.

- Adverse or Other Actions - Form A
- Professional Liability Actions - Form B
- Liability Insurance - Form C
- Criminal Actions - Form D
- Medical Condition - Form E
- Chemical Substances or Alcohol Abuse - Form F

Save and Continue

[Cancel](#)

\* Indicates a required field

Form



Example of the Adverse and Other Actions Form A for **Question #8** when you have resigned privileges due to a change in employment

- Adverse or Other Actions - Form A
- Professional Liability Actions - Form B
- Liability Insurance - Form C
- Criminal Actions - Form D
- Medical Condition - Form E
- Chemical Substances or Alcohol Abuse - Form F

Save and Continue

\* Indicates a required field

Form

Question Number

Describe the circumstances surrounding this occurrence.

Provide an explanation of any actions taken.

Provide the current status of the issue.

Contact Name

Contact Department/Committee

Contact Address (Street, City, State, Zip)

Contact Phone

Cancel

## 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.

**Request Privileges**

Below is the Delineation of Privilege form(s) identified based on your specialty(ies).

**Click on the form name to open up the form for requesting privileges.**

Please check all privileges for which you meet criteria. You may click the top box in each section to select all privileges and unclick any you choose to NOT request within each section.

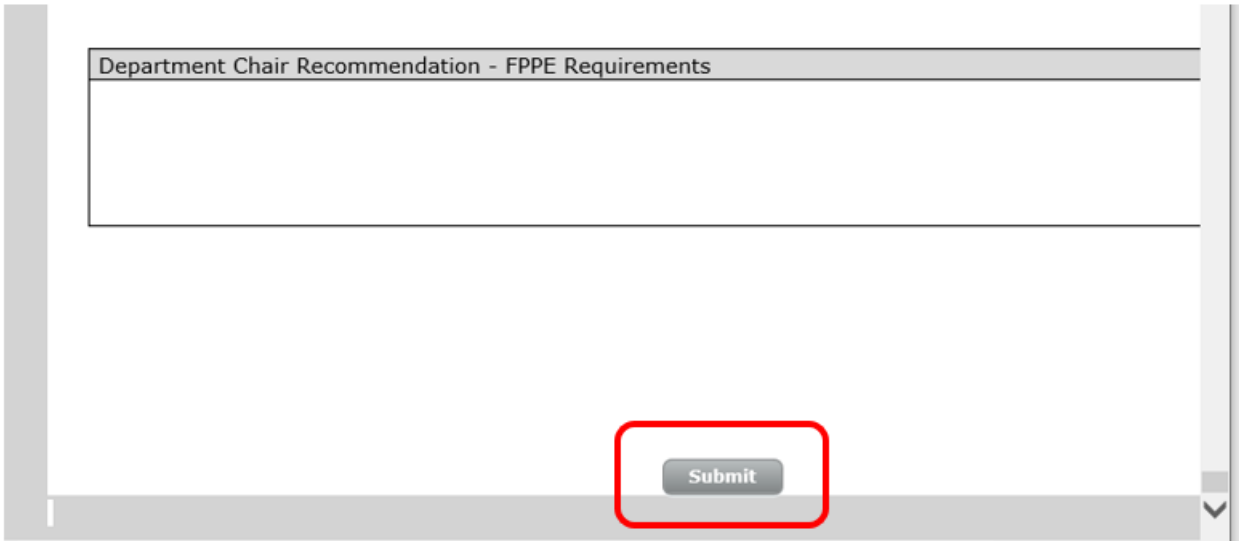
**Review privileging criteria for each section to assure you meet all criteria listed before selecting privileges.**

**If criteria documentation is required to meet the listed clinical requirements, please upload as part of the Required Documents section or directly submit to the Medical Staff Office.**

		Not Requesting Privileges
<a href="#">TMC - Cardiovascular Disease</a>	Requested: 11/9/2021	<input type="checkbox"/>
<a href="#">AMH - Family Medicine 2</a>	Awaiting Action	<input type="checkbox"/>

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.

A screenshot of the "Request Privileges" section in a web application. At the top, there is a progress bar with seven steps: "Basic Information", "Professional History", "Education and Training", "Disclosure Questions", "Privileges" (which is highlighted in blue), "Required Documents", and "Review and Submit". Below the progress bar, the "Request Privileges" section is active. It contains instructions and a table of requested privileges. A red box highlights the "Requested: 11/9/2021" date in the table.

**Request Privileges**

Below is the Delineation of Privilege form(s) identified based on your specialty(ies).  
**Click on the form name to open up the form for requesting privileges.**

Please check all privileges for which you meet criteria. You may click the top box in each section to select all privileges and unclick any you choose to NOT request within each section.

**Review privileging criteria for each section to assure you meet all criteria listed before selecting privileges.**

**If criteria documentation is required to meet the listed clinical requirements, please upload as part of the Required Documents section or directly submit to the Medical Staff Office.**

		Not Requesting Privileges
<a href="#">TMC - Cardiovascular Disease</a>	Requested: 11/9/2021	<input type="checkbox"/>
<a href="#">AMH - Family Medicine 2</a>	Awaiting Action	<input type="checkbox"/>

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.

The screenshot shows a Microsoft Edge browser window titled "Complete Security Questions for Submission - Work - Microsoft Edge". The address bar shows the URL "https://msowportaldocs.unitypoint.org/PractitionerPortal/SecurityQuesti...". The main content area displays the following text:

Practitioner: Rebecca [REDACTED]

Please answer the security answer below and click continue to verify you are the correct practitioner.

**Questions**  
Birth date

Below the question, there is a text input field with the placeholder text "Enter answer".

At the bottom left, there are two buttons: "Continue" and "Cancel".

Red circles highlight the "Continue" button and the "Enter answer" input field.

# 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.

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

**Required Documents**

This section has **2 parts**. The following actions for this section:

- Upload required pdf, or jpeg, images as outlined in the next screen
- Provide digital signature on the following application forms:

Consent and Release Form  
Medicare and Medicaid Acknowledgement Form  
UPH Initial Application  
UPH Corporate Compliance Form

Upload Documents Forms [Continue](#)

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












**UnityPoint Health**

Basic Information Professional History Education and Training Disclosure Questions Privileges **Required Documents** Review and Submit

**Upload Documents**

A digital image of your current malpractice face sheet can be uploaded here.

**For hospital privileges:** Digital images of provider case logs and current ACLS, ATLS, BLS, NPS, PALS, etc. can be uploaded. They can also submit directly to the Medical Staff Office of the hospital where provider is seeking privileges.

Insurance Certificate Currently In Use			UPLOAD
Case Logs			UPLOAD  WILL SEND
ACLS (Advanced Cardiac Life Support)			UPLOAD
ALSO (Advanced Life Support in Obstetrics)			UPLOAD
APLS (Advanced Pediatric Life Support)			UPLOAD
ARLS (Advanced Radiology Life Support)			UPLOAD
ATLS (Advanced Trauma Life Support)			UPLOAD
BCLS (Basic Cardiac Life Support)			UPLOAD
BTLS (Basic Trauma Life Support)			UPLOAD

[Save and Continue](#)

## 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.

UnityPoint Health

Basic Information Professional History Education and Training Disclosure Questions Privileges **Required Documents** Review and Submit

Upload Documents  
Forms

Save and Continue

### Forms

Please review and complete the following forms. The system will prompt you to provide electronic signature following attestation.

Portal ReCredentialing Application APP 4-23-21

[View Form](#)

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 it the application to successfully submit.

Welcome, Rebecca zzLachenmaier [My Home](#) | [Summary Report](#) | [Logout](#)



Basic Information Professional History Education and Training Disclosure Questions Privileges Required Documents **Review and Submit**

**Review and 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.

[Continue](#)

Welcome, Rebecca zzLachenmaier [My Home](#) | [Summary Report](#) | [Logout](#)



Basic Information Professional History Education and Training Disclosure Questions Privileges Required Documents **Review and Submit**

**Submit**

Successfully completed sections above will appear with a **blue check**.

Please review any areas that do not contain a **blue checkmark** and look for the **red flags that identify missed required information. All red flags must be addressed in order for the portal to successfully submit.**

The final **Submit** button displays once all sections are complete.

[Click to Submit](#)

Status: 100% Complete

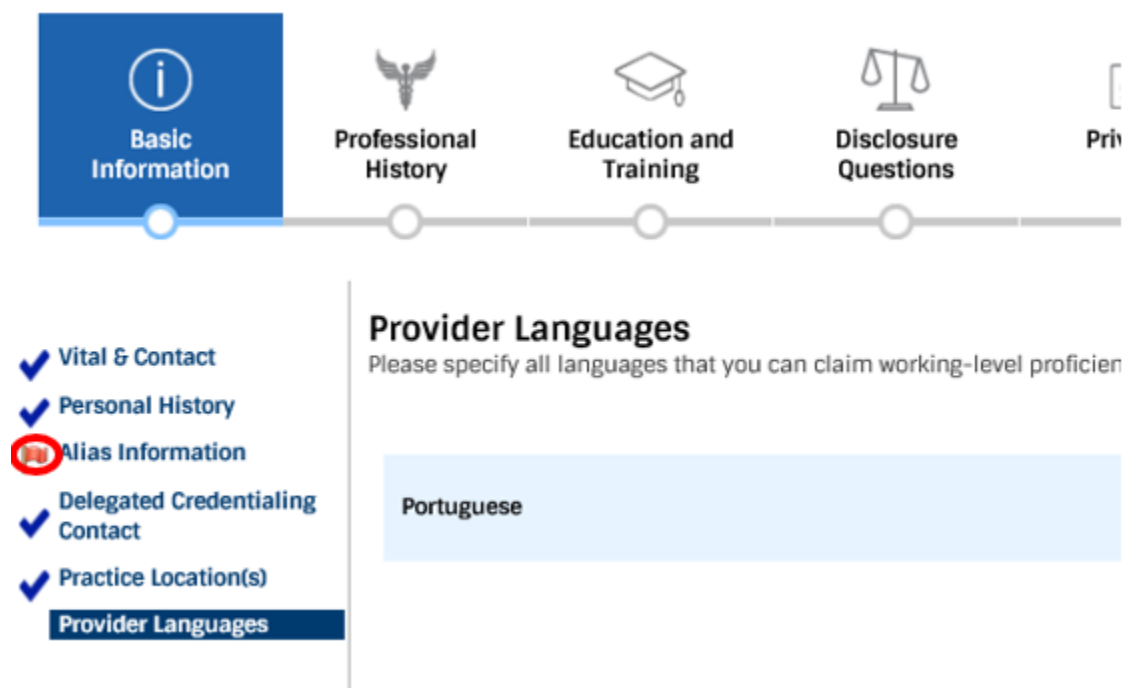
Basic Information	✓
Professional History	✓
Education and Training	✓
Disclosure Questions	✓
Privileges	✓
Required Documents	✓

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.



- ✓ Adverse or other actions
- ✓ Professional Liability Actions
- ✓ Liability Insurance
- ✓ Criminal Actions
- ✓ Medical Conditions
- ✓ Chemical Substances or Alcohol Abuse
- ✓ Investments
- ✓ CME/CEU Credits
- ✓ Flu Vaccine
- ✓ Disclosure Forms

### 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.**













Continue



Click the "Submit" Button

Status: 100% Complete

Click to Submit

	<b>Basic Information</b>		<a href="#">VIEW YOUR RESPONSES</a>
	<b>Professional History</b>		<a href="#">VIEW YOUR RESPONSES</a>
	<b>Education, Training, Board Certification</b>		<a href="#">VIEW YOUR RESPONSES</a>
	<b>Disclosure Questions</b>		<a href="#">VIEW YOUR RESPONSES</a>
	<b>Privileges</b>		<a href="#">VIEW YOUR RESPONSES</a>
	<b>Required Documents</b>		<a href="#">VIEW YOUR RESPONSES</a>

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.



Complete Security Questions for Submission - Work - Microsoft Edge

https://msowportaldocs.unitypoint.org/PractitionerPortal/SecurityQuesti...

Practitioner: Rebecca [REDACTED]

Please answer the security answer below and click continue to verify you are the correct practitioner.

**Questions**

Birth date

Enter answer

Continue Cancel

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](mailto:UPH_CVO@unitypoint.org)

UPH PHO ReCredentialing Application 10/31/2021 - Processing  
Submitted: 11/2/2021

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](mailto:UPH_CVO@unitypoint.org)

[Provider Assistance Line available from 7:00am-5:00pm CST: 515-241-7977](tel: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 \(service-now.com\)](https://www.unitypoint.org/cvo)