

UnityPoint Health

Credentials Verification Office

Initial Credentialing Application Portal Tip Sheet

Welcome to UnityPoint Health!

The UnityPoint Health Credentials Verification Office (CVO) will send the applicant the online portal application invites via e-mail based on the onboarding request received via Service Now.

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 hospital membership/privileges are being requested or if it the request is only for PHO (Medimore Payors) participation. Applicants are responsible for the final review, signing and submitting of the portal application.

If you have any questions please contact the CVO:

UPH_CVO@unitypoint.org

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

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

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Invitation E-mail

The CVO will send the applicant, and if applicable the Delegate Credentialing Contact, two (2) emails. The e-mails and logins for the Practitioner and Delegate Credentialing Contacts are NOT interchangeable.

One e-mail will contain the portal link and information regarding credentialing requirements and a link to our background check authorization.

UnityPoint Health requires COVID vaccines for all providers seeking Privileges. The Applicant must provide a copy of their vaccine documentation to the CVO. Any exemptions needed for the COVID vaccines must be approved by the UPH Medical Staff Office(s) to which you are applying.

The UnityPoint Health CVO will be requiring background checks for all providers seeking Privileges and PHO membership. The Applicant must follow the link to PreCheck, Inc. and complete their online disclosure and authorization form:

<https://weborder.precheck.net/Release/release1.aspx?cno=12344>

UnityPoint Health PHO Portal Application

[Redacted]

Expires 2/2/2026

Fri 2/3/2023 7:14 AM

Reply Reply All Forward

Dear Provider A zzDemo, MD,

Welcome to UnityPoint Health ~

At UnityPoint Health we believe in doing what is right for the people we serve. Our entire organization stands behind four uncompromising principles: Foster Unity, Own the Moment, Champion Excellence, and Seize Opportunities. We are pleased to have you join our vision of achieving the best outcome, every patient, every time.

Please complete the following steps to join our team:

FIRST: Review the UnityPoint threshold eligibility criteria to ensure you qualify. A synopsis of our threshold eligibility criteria is listed at the end of this message.

SECOND: Complete the online initial application. UnityPoint Health is pleased to provide you with a convenient and secure online application. We have created a customized portal where you can access your application for completion and electronic submission. Please click the link access our portal:

UnityPoint Health Online Application Link: [Your Portal](#)

Your UnityPoint Health credentialing portal password will be sent in a separate email at approximately the same time you received this email. If you do not receive a password email, you can obtain one by visiting the portal link above and selecting "Forgot Your Password." Or you can contact the Credentials Verification Office for assistance at UPH_CVO@unitypoint.org

Please note in the portal you will be asked to attest to your review and acceptance of UnityPoint Health policies, facility specific bylaws, Policies and Procedures. Please visit here to view these documents:
<https://unitypoint.service-now.com/cvo>

There is a list of items below to have ready when you begin the application process. Completing the application with all the pertinent information available should take approximately 30 minutes for completion. If you should receive an error message while completing the application, that is identifying the system has timed out due to inactivity delays. Simply log out of your internet browser and log back into your portal to complete.

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 and Threshold Eligibility Criteria

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

UPH_CVO@unitypoint.org

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

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

For an initial application, the CVO requests all of your information **dating back to Medical School**, with the exception of malpractice insurance carrier information which we only need the prior 10 years of.

Information:

- Your NPI number
- ECFMG number, if applicable
- 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
NOTE: You will need a digital copy of your current malpractice insurance face sheet as it will be required to be uploaded on the portal.
- 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)
- A digital JPEG copy of a recent professional photo (Initial Privileges only)
- A digital PDF copy of a United States government-issued ID (initial Privileges only)
- COVID-19 vaccination information (initial Privileges only)

The **UnityPoint Health Credentialing and Privileging Policy** outlines the Qualifications and Conditions to be eligible for initial appointment and clinical privileges in **Section 2.A.1 Threshold Eligibility Criteria**

ARTICLE 2
QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

(a) To be eligible to apply for initial appointment, reappointment, and clinical privileges, an individual must demonstrate satisfaction of all of the following threshold eligibility criteria, as applicable:

- (1) have a current, unrestricted license to practice in the state where the Hospital is located that is not subject to any restrictions, conditions, or probationary terms and have never had a license to practice in any jurisdiction denied, revoked, restricted or suspended by any state licensing agency;
- (2) not currently be under investigation by any federal or state agency or healthcare facility for reasons related to (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud (including Medicare, Medicaid or other federal or state governmental or private third-party payer fraud or program abuse); (iv) violent acts; (v) sexual misconduct; (vi) moral turpitude; or (vii) child or elder abuse;
- (3) have a current, unrestricted DEA registration and the appropriate state-controlled substance license, with an office address in the state where patients will be seen, and have never had a DEA registration or state-controlled substance license denied, revoked, or suspended;
- (4) be located (office and residence) close enough, as defined in the Medical Staff Rules and Regulations or other applicable policy, to fulfill staff responsibilities and to provide timely and continuous care for his or her patients in the Hospital;
- (5) have current, valid professional liability insurance coverage, with a company approved to do business in the state where the Hospital is located, or through a program of self-insurance or a combination of self-insurance and commercial insurance, in an amount approved by the Board;
- (6) have current, government-issued photographic identification which verifies the individual's identity;
- (7) have successfully completed the following professional training requirements:
 - (i) a residency and, if applicable, fellowship training program approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, The Royal College of Physicians and Surgeons of Canada, or The College of Family Physicians of Canada, in the specialty in which the applicant seeks clinical privileges;
 - (ii) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association;
 - (iii) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or
 - (iv) for members of the Advanced Practice Provider Staff, have satisfied the applicable training requirements as established by the Hospital;
- (8) satisfy the following board certification requirements:
 - (i) are certified in their primary area of practice at the Hospital by an approved board as

defined in this Policy; or

- (ii) are within five years of completion of residency or fellowship training and achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training; and
 - (iii) maintain board certification in their primary area of practice at the Hospital on a continuous basis, and satisfy all requirements of the relevant specialty/subspecialty board necessary to do so;
- (9) satisfy the following professional practice and experience requirements:
- (i) demonstrate recent clinical activity in their primary area of practice during the last two years;
 - (ii) have never had staff appointment, clinical privileges, or status as a participating provider denied, revoked, suspended for more than 30 days, or terminated by any health care facility, including the Hospital, or health plan for reasons related to clinical competence or professional conduct;
 - (iii) have never resigned staff appointment or relinquished clinical privileges during an investigation or in exchange for not conducting such an investigation at any health care facility, including any UnityPoint Hospital;
 - (iv) have never had an application for appointment or clinical privileges not processed, nor had appointment or privileges administratively relinquished, at the Hospital or any of its affiliates, due to an omission or misrepresentation;
 - (v) have never been terminated from a post-graduate training program for reasons related to clinical competence or professional conduct (residency or fellowship for physicians or a similarly equivalent program for other categories of practitioners), nor resigned from such a program during an investigation or in exchange for the program not conducting an investigation;
 - (vi) not currently be under any criminal investigation or indictment and have not, within the last ten years, been convicted of, or entered a plea of guilty or no contest to, any felony, or to any misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud or abuse; (iv) violent acts; (v) sexual misconduct; (vi) moral turpitude; or (vii) child or elder abuse; and
 - (vii) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (10) satisfy the following Hospital practice requirements:
- (i) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought or granted;
 - (ii) if applying for privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in that contract;
 - (iii) have an appropriate coverage arrangement with another member with appropriate specialty-specific privileges as determined by the Credentials Committee and the Medical Executive Committee, for those times when the individual will be unavailable;
 - (iv) document compliance with all applicable training, educational and practice protocols that may be adopted by the Medical Executive Committee and required by the Board, including, but not limited to, those involving electronic medical records, computerized practitioner order entry, privacy and security of protected health information, infection

prevention, and patient safety;

- (v) agree to fulfill all responsibilities regarding emergency call for their specialty;
 - (vi) not be applying for privileges in an area that is closed pursuant to a Board staff development plan;
 - (vii) document compliance with health screening requirements (i.e., TB testing, mandatory flu vaccines, and infectious agent exposures); and
- (11) if seeking to practice as an advanced practice provider, have a written agreement with a supervising/collaborating physician, which meets any requirements of state law and Hospital policy.
- (b) An individual who does not satisfy an eligibility criterion set forth in this Section may request that it be waived.
 - (c) In order to be eligible for continued appointment and privileges, members must demonstrate satisfaction of the above threshold eligibility criteria, as applicable, on an ongoing basis.

Applicant Portal - Basic Info & Troubleshooting

Note the compatibility requirements.

The UnityPoint Health Practitioner Portal is located here:

[Practitioner Portal](#)

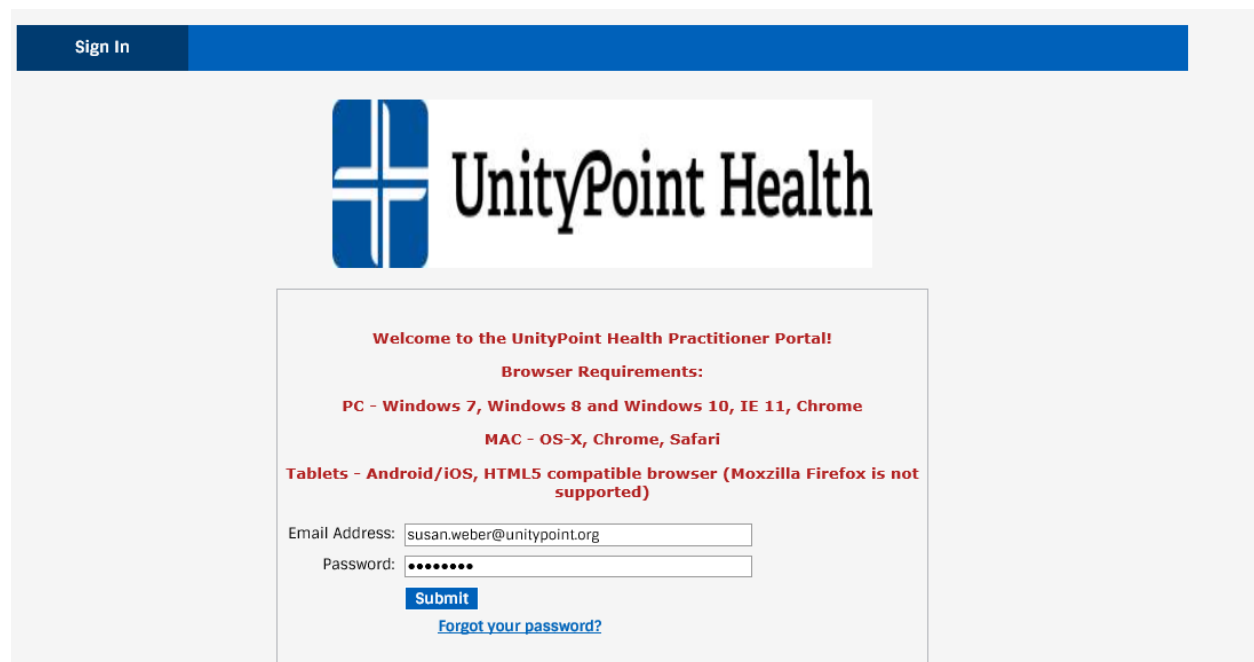
To access the Practitioner Portal as a delegated (credentialing contact) user:

[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



Sign In



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 (Mozilla Firefox is not supported)

Email Address:

Password:


[Submit](#)

[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



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



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.

Welcome, Rebecca zzLachenmaier, MD My Home | [Change Password](#) | [Logout](#)



My Home

Welcome, Rebecca zzLachenmaier, MD!

Your Current Application:

CVO Initial Portal with Privileges 2022

[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 initial credentialing application packet.

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

Your information must be all-inclusive for the following since education to current date:

- * Education/training since medical education
- * All practice locations (current and resigned)
- * All hospital affiliations (current and resigned)
- * All employments (current and resigned)
- * All insurance coverages (current and resigned)
- * Any gaps of time greater than 30 days will require a gap explanation to be provided.

Some features to keep in mind:

- **Navigation:** When finished entering information on a screen click the blue "Save and Continue" or "Save" button 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.
- **Red Flags:** Symbolizes a missed requirement or incorrect format entry. Red Flags must be fixed or the portal will not submit.
- **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

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.

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

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.

Rebecca [redacted]	^	DELETE	EDIT
--------------------	---	--------	------

Alias Type: Other

First, Middle, Last Name: Rebecca [redacted]

Alias: [redacted]

Explain Name Change: [redacted]

[Save and Continue](#)

[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.

You have been granted access to this site to permit the electronic completion of the CVO initial 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 for the following since education to current date:
* Education/training since medical education
* All practice locations (current and resigned)
* All hospital affiliations (current and resigned)
* All employments (current and resigned)
* All insurance coverages (current and resigned)
* Any gaps of time greater than 30 days will require a gap explanation to be provided.

Some features to keep in mind:

- **Navigation:** When finished entering information on a screen click the blue "Save

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.

Welcome, [Redacted] [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: Ms. Degree: D

First Name: Rebecca MI: Last Name: [Redacted]

Date of Birth: [Redacted] Sex: female Social Security Number: 44-00-7777

Current Home Address: [Redacted] Apartment # (if applicable):

City: [Redacted] State: IA Zip: [Redacted]

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

Alternate Email Address: [Redacted]

Cell Phone: [Redacted] Home Phone: [Redacted]

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

U.S. Citizen = No Visa information required

The screenshot shows the 'Personal History' section of the UnityPoint Health portal. The user is identified as 'Welcome, [redacted]'. The navigation bar includes 'My Home', 'Summary Report', and 'Logout'. The main navigation menu has six steps: 'Basic Information', 'Professional History', 'Education and Training', 'Disclosure Questions', 'Required Documents', and 'Review and Submit'. The 'Personal History' section is active, with a 'Save and Continue' button. The form asks for personal history information. Fields include: Marital Status (Married), Birth City, Birth State (If born in the US), Birth Country (with a red asterisk), and 'Are you a US Citizen?' (Yes selected, No unselected, with a red asterisk next to 'Yes'). A red circle highlights the text '* Indicates a required field'.

Not a U.S. Citizen = Visa information required

The screenshot shows the 'Personal History' section of the UnityPoint Health portal for a non-U.S. citizen. The user is identified as 'Welcome, Rebecca'. The navigation bar includes 'My Home', 'Summary Report', and 'Logout'. The main navigation menu has six steps: 'Basic Information', 'Professional History', 'Education and Training', 'Disclosure Questions', 'Required Documents', and 'Review and Submit'. The 'Personal History' section is active, with a 'Save and Continue' button. The form asks for personal history information. Fields include: Marital Status (Married), Birth City, Birth State (If born in the US), Birth Country (Belgium, with a red asterisk), 'Are you a US Citizen?' (No selected, Yes unselected, with a red asterisk next to 'No'), 'Do you have a legal right to reside permanently and work in the U.S.?' (Yes selected, No unselected, with a red asterisk next to 'Yes'), Visa Type (with a red asterisk), and Visa Expiration Date (0/22/2021, with a red asterisk). A red circle highlights the text '* Indicates a required field'.

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

The screenshot shows the UnityPoint Health portal interface. At the top, there is a navigation bar with the UnityPoint Health logo and the text "Welcome, Rebecca zzLachenmaier My Home | Summary Report | Logout". Below this is a horizontal menu with icons and labels for "Basic Information", "Professional History", "Education and Training", "Disclosure Questions", "Privileges", "Required Documents", and "Review and Submit". The "Basic Information" tab is selected.

On the left side, there is a vertical sidebar with a list of menu items: "Vital & Contact", "Personal History", "Alias Information", "Delegated Credentialing Contact", "Practice Location(s)", and "Provider Languages". The "Practice Location(s)" item is highlighted with a red box.

The main content area displays a "Red Flag" message in green text: "You are REQUIRED to provide the name of providers or practice group that covers your patients when unavailable at each practice location." Below this message is a "Please note:" section with instructions: "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", and "One office can have all 3 identifications checked." It also states: "Please select the down arrow then the Edit (pencil) tool for each practice office in this section to review and update data as needed."

At the bottom, there is a table of practice locations. The first row is "Osceola Vision Center, 147 S Main ST, Osceola, IA" with a blue checkmark and a dropdown arrow. The second row is "UnityPoint Clinic Pediatric Gastroenterology At Galesburg, 834 N Seminary ST STE 301, Galesburg, IL" with a red flag icon and a dropdown arrow. The red flag icon is highlighted with a red box.

If you miss a required field, you will receive a warning to go back and fix.

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.

Required Fields

Oops! It looks like you are missing the following required information.

- Last Name, First Name, MI, Degree

If you don't have the necessary information at hand, you can continue forward. The information that you have already entered will be saved. You will be able to complete this page at a later time.

* Indicates a required field

Mailing

Practicing At This Primary Yes No


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.

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


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

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

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

Osceola Vision Center, 147 S Main ST, Osceola, IA 

UnityPoint Clinic Pediatric Gastroenterology At Galesburg, 834 N Seminary ST STE 301, Galesburg, IL

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 since medical education.

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


To add new hospital affiliations, select the gray button "Add another Healthcare Organization" on the bottom of the screen section to enter new hospital/ambulatory surgery center location.

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.

[Cancel](#)
* Indicates a required field

Current or Prior Affiliation

Organization Lookup 

Organization Name *

Address * Suite #

City State Zip


Phone # Fax #

Membership Status *

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.

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

Basic Information

Here's the key information you will need to complete this section:

- Information about you
- Personal history
- Alias names by which you have been known
- Prior address information
- Credentialing contact
- Your current or anticipated practice locations

[Continue](#)

[Vital & Contact](#)
[Personal History](#)
[Alias Information](#)
[Delegated Credentialing Contact](#)
[Practice Location\(s\)](#)
[Provider Languages](#)

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 closer to their practice start date, 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 zLachenmaier [My Home](#) | [Summary Report](#) | [Logout](#)

UnityPoint Health

i
Basic Information

Professional History

Education and Training

Disclosure Questions

Privileges

Required Documents

Review and Submit

Vital & Contact

Please provide the information requested.

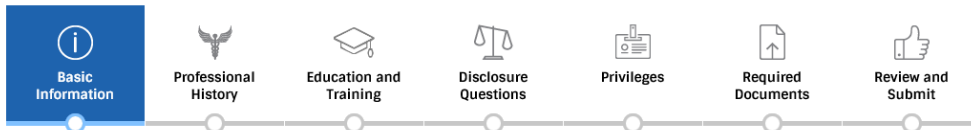
Save and Continue

* Indicates a required field

Title	<input type="text" value="Ms."/>	Degree	<input type="text" value="MD"/>		
First Name	<input type="text" value="Rebecca"/>	MI	<input type="text" value="L"/>	Last Name	<input type="text" value="zLachenmaier"/>
Date of birth	<input type="text"/>	Sex	<input type="text" value="Female"/>	Social Security Number	<input type="text"/>
Current Home Address	<input type="text" value="2965 Troy Mills Blvd"/>		Apartment # (if applicable)	<input type="text"/>	
City	<input type="text" value="Winthrop"/>	State	<input type="text" value="IA"/>	Zip	<input type="text" value="50682"/>
Email Address You Use Most (Note -this will be the e-mail used for communication of any issues and for future re-credentialing.)					
	<input type="text" value="susan.weber@unitypoint.org"/>				
Alternate Email Address	<input type="text"/>				
Cell Phone	<input type="text" value="(319)310-8857"/>	Home Phone	<input type="text" value="(319)310-8857"/>		

Personal History –

Birth Country and Citizenship must be provided



- ✓ 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

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



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

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.

Save and Continue

An Explanation for EACH Alias is REQUIRED

Add an Alias

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.

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

Delegated Credentialing Contact

If your office has a Delegated Credentialer (person who helps complete credentialing applications) please provide us the contacts information. [Save and Continue](#)

This person will then receive emails in the future to assist you with completing online portal application information but will NOT be able to submit the application upon your behalf.

If you do not have such assistance, you will enter your own name, email and phone number you wish to be contacted at for portal questions.

Only enter ONE Delegated Credentialer.

* Indicates a required field

Name of Credentialing Contact

Title

Street Address Suite #

City State Zip

Email Address *

Phone # *

Cell Phone # Fax #

Sample of screen to identify REQUIRED fields identified by Asterisks.

Delegated Credentialing Contact

If your office has a Delegated Credentialer (person who helps complete credentialing applications) please provide us the contacts information. **Only enter ONE Delegated Credentialer.** [Save and Continue](#)

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.

If you do not have such assistance from your office, enter your name and email to be used for future correspondences.

[Cancel](#)

* Indicates a required field

Name of Credentialing Contact

Title

Street Address Suite #

City State Zip

Email Address *

Phone # *

Cell Phone # Fax #

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 must be listed on an initial 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 if any have populated. 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.

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

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

Practice Location(s)

Please list ALL practice locations you have had since education.

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

If you have locations already loaded, do **NOT** delete. If you are 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.

Save and Continue

Osceola Vision Center, 147 S Main ST, Osceola, IA▼

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)
Please list ALL practice locations you have had since education.





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

If you have locations already loaded, do **NOT** delete. If you are 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.


Primary  Additional  Secondary  Tertiary  Billing Mailing

Beginning practice date at This Location: * 9/1/2019

Are You Still Practicing at This Location? * Yes No

[Cancel](#)
* Indicates a required field

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	<input checked="" type="checkbox"/>	▼
UnityPoint Clinic Pediatric Gastroenterology At Galesburg, 834 N Seminary ST STE 301, Galesburg, IL	<input checked="" type="checkbox"/>	▼

Add another Office Location

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

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.

The screenshot shows the UnityPoint Health provider portal interface. At the top right, it says "Welcome, Rebecca zzLachenmaier" with links for "My Home", "Summary Report", and "Logout". The UnityPoint Health logo is in the top left. A navigation bar contains icons and labels for: "Basic Information" (selected), "Professional History", "Education and Training", "Disclosure Questions", "Privileges", "Required Documents", and "Review and Submit". On the left, a sidebar lists: "Vital & Contact", "Personal History", "Alias Information", "Delegated Credentialing Contact", "Practice Location(s)", and "Provider Languages". The main content area is titled "Provider Languages" with the instruction "Please specify all languages that you can claim working-level proficiency." Below this is a large empty text input field. To the right of the input field are two buttons: "Save and Continue" (blue) and "Add a language" (grey).

Professional History Section



Licensure, Registrations and Certification Information

Admitting Privileges

Healthcare Organization Affiliations

Employment History

Current and Past Insurance Carriers

Peer References

Professional History

You must provide ALL current and inactive items for the following items in this section of the portal:

Continue

- All licensures, registrations and certifications (current and resigned)
- Admitting arrangements for UnityPoint Health
- All Healthcare Organization Affiliations (current and resigned)
- All Employment History (current and resigned)
- Gap Explanations for any gaps over 30 days in history
- Military Service
- Peer References
- Current and Past Insurance Carriers

To Add licensures, DEA or CSA click on the gray button "Add State License" and then use the drop down to select the type of additional license you are adding.

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.

Licensure, Registrations, and Certification Information -

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



- Licensure, Registrations and Certification Information**
- Admitting Privileges
- Healthcare Organization Affiliations
- Employment History
- Current and Past Insurance Carriers
- Peer References

Licensure, Registrations and Certification Information

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

Save and Continue

To add additional licenses, registrations or certifications, click the gray button labelled "Add License/NPI/Life Certifications" and then select the item from the drop down you need to add.

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.

You are REQUIRED to have an NPI listed in the licensure section. Enter NA for the state.

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

Example of where to use the drop down to review and edit an item that was prepopulated 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 the license, enter the expiration date and select the option "Not Renewed" in the license drop down list.

You are REQUIRED to have an NPI listed in the licensure section. Enter NA for the state.

State License, A074072, IL 

ID Type 

ID Number - Enter N/A if not applicable State  Expiration Date 

State License Status 

Is the State License Unlimited? Yes No 

Supervising Physician (Note: UnityPoint Health requires a Supervising Physician for ALL ARNPs and PAs. Please contact your Clinic Director if you

Sample of State License Screen

To add additional licenses, registrations or certifications, click the gray button labelled "Add License/NPI/Life Certifications" and then select the item from the drop down you need to add.

Save and Continue

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

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

You are REQUIRED to have an NPI listed in the licensure section. Enter NA for the state.

* 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

Cancel

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

Sample of Controlled Substance Screen

Licensure, Registrations and Certification Information
EACH license, registration and certification must be reviewed and edited.

Save and Continue

To add additional licenses, registrations or certifications, click the gray button labelled "Add License/NPI/Life Certifications" and then select the item from the drop down you need to add.

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.

You are REQUIRED to have an NPI listed in the licensure section. Enter NA for the state.

* Indicates a required field

ID Type *

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

Issue Date Expiration Date *

CSA License Status *

Is the Controlled Substance Unlimited? * Yes No

Cancel

Sample of DEA Screen

Licensure, Registrations and Certification Information

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

Save and Continue

To add additional licenses, registrations or certifications, click the gray button labelled "Add License/NPI/Life Certifications" and then select the item from the drop down you need to add.

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.

You are REQUIRED to have an NPI listed in the licensure section. Enter NA for the state.

[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

Sample of NPI Screen

Licensure, Registrations and Certification Information

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

Save and Continue

To add additional licenses, registrations or certifications, click the gray button labelled "Add License/NPI/Life Certifications" and then select the item from the drop down you need to add.

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.

You are REQUIRED to have an NPI listed in the licensure section. Enter NA for the state.

[Cancel](#)

* Indicates a required field

ID Type *

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


Issue Date Expiration Date

Admitting Privileges –

The UnityPoint Health PHO-Medimore needs to know admitting arrangements for reporting to payers. If a provider is not seeking hospital admitting privileges a group must be identified for covering hospital admissions. A UPH hospital needs to be identified too. This does NOT mean you can only send patients to that hospital.


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.

If you have questions on this requirement, please submit your question to uph_medimorecred@unitypoint.org




UnityPoint Health


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




Basic Information




Professional History




Education and Training




Disclosure Questions



Privileges



Required Documents



Review and Submit

- Licensure, Registrations and Certification Information
- Admitting Privileges**
- Healthcare Organization Affiliations
- Employment History
- Current and Past Insurance Carriers
- Peer References

Admitting Privileges

DIRECT PATIENT CARE PROVIDERS - Participation in the UPH-Medimore PHO requires either hospital admitting privileges or a documented patient care arrangement for hospital admitting of your patients and an identified primary hospital utilized.

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

* Indicates a required field

Do you have hospital admitting privileges? * Yes No

Save and Continue

Sample of screen when answer is "Yes"

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

Admitting Privileges Save and Continue

Licensure, Registrations and Certification Information
Admitting Privileges
 Healthcare Organization Affiliations
 Employment History
 Current and Past Insurance Carriers
 Peer References

DIRECT PATIENT CARE PROVIDERS - Participation in the UPH-Medimore PHO requires either hospital admitting privileges or a documented patient care arrangement for hospital admitting of your patients and an identified primary hospital utilized.

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

* Indicates a required field

Do you have hospital admitting privileges? * Yes No Click "Save and Continue" to move to the next section, Healthcare Organization Affiliation

Sample of screen when answer is "No"

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

Admitting Privileges Save and Continue

Licensure, Registrations and Certification Information
Admitting Privileges
 Healthcare Organization Affiliations
 Employment History
 Current and Past Insurance Carriers
 Peer References

DIRECT PATIENT CARE PROVIDERS - Participation in the UPH-Medimore PHO requires either hospital admitting privileges or a documented patient care arrangement for hospital admitting of your patients and an identified primary hospital utilized.

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

* Indicates a required field

Do you have hospital admitting privileges? * Yes No

You are REQUIRED to Provide the Following Information

Provide Name of Admitting Physician or Group * *i*

Provide Name of Primary Hospital Where Sending Admits * *i*


Click "Save and Continue" to advance to the next section, Healthcare Organization Affiliations

Healthcare Organization Affiliations -

You must enter all hospital and ambulatory surgery center affiliations – 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.


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

Basic Information

Professional History

Education and Training

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Privileges

Required Documents

Review and Submit

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

Healthcare Organization Affiliations

You are **REQUIRED** to list **ALL Current, Pending, and Prior Hospital affiliations** you have had since medical education.

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

To add new hospital affiliations, select the gray button "Add another Healthcare Organization" on the bottom of the screen section to enter new hospital/ambulatory surgery center location.

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.

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.

* Indicates a required field

Current or Prior Affiliation

Organization Lookup

Organization Name

Is this your primary hospital? Yes No

Address Suite #

City State Zip

Enter Membership Status Specialty

Start Date at Hospital (mm/yyyy)

Click box to the right if you don't have admitting privileges and coordinate admits with a provider/group in the area.

Medical Staff Office Contact Name

Medical Staff Office Email address

Medical Staff Office Phone # Medical Staff Office Fax #

[Save and Continue](#)

[Save and Continue](#)

[Cancel](#)

Any Limitations in Your Area of Specialty at this Hospital? Yes No

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

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.

The screenshot shows a multi-step process for adding healthcare organization affiliations. The steps are: Basic Information, Professional History (selected), Education and Training, Disclosure Questions, Privileges, Required Documents, and Review and Submit. The main content area is titled "admitting privileges or a way to admit patients at a Medicare participating hospital." It contains a list of four affiliations, each with a dropdown arrow:

- 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

Below the list, a gray button labeled "Ambulatory Surgery Center" is circled in red. Below the button is a blue link that reads "I don't have any Ambulatory Surgery Center privileges".

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. Save and Continue

* Indicates a red

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 #

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

Save and Continue

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

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

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

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

MEDIMORE PHO REQUIREMENT:

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

[Cancel](#)

* Indicates a required field

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

Current or Prior Affiliation

Organization Lookup [i](#)

Organization Name * Primary?

Address * Suite #



Employment History -

You are REQUIRED to list all employment engagements since completion of Medical School.

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 Employer

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.



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

- ✓ Licensure, Registrations and Certification Information
- ✓ Admitting Privileges
- ✓ Healthcare Organization Affiliations
- Employment History**
- Current and Past Insurance Carriers
- Peer References

Employment History

List chronologically (most recent first) ALL work engagements, including self-employment, service as an independent contractor, and military service you have had since medical education.

If there is any gap of greater than 30 days in the chronology, select the gray button, "Add Employment/Gap/Military" and use the drop to select the Gap Explanation option.

If you have multiple practice locations associated with an employer - only list the main employer in this section. Practice locations are to be listed in the prior section called Practice Locations.

Select the drop-down option for the Type of New Entry.

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

Save and Continue

Add another Employer/Gap Explanation

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 *

Company Name/Reason for Gap *

Address * Suite #

City * State * Zip *

Phone # Fax #

Position held Primary Activity



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

Position held Primary Activity

Currently Employed? * Yes No

From Date (mm/yyyy) * Thru Date (mm/yyyy) *

Contact Name Contact Title

Contact Phone

Contact email

Current and Past Insurance Carriers –

All current and prior malpractice insurance carriers must be entered for the timeframes requested on your portal application, including coverage during training programs and with prior employers. 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 recruiter to validate the entity that will be providing current malpractice coverage for you, so that you can add that info here. You will likely list your coverage as “UnityPoint Health Self Insured”

Due to the various employing entities within UPH the CVO will request the appropriate Self Insured Policy you will be covered under and request the Certificate upon receipt of the portal application.

The screenshot shows the UnityPoint Health portal interface. At the top, there is a navigation bar with the UnityPoint Health logo and the text "Welcome, Rebecca zzLachenmaier | My Home | Summary Report | Logout". Below the navigation bar is a horizontal menu with seven items: "Basic Information", "Professional History", "Education and Training", "Disclosure Questions", "Privileges", "Required Documents", and "Review and Submit". The "Professional History" item is currently selected and highlighted in blue. Below the menu is a vertical sidebar with a list of navigation options: "Licensure, Registrations and Certification Information", "Admitting Privileges", "Healthcare Organization Affiliations", "Employment History", "Current and Past Insurance Carriers", and "Peer References". The "Current and Past Insurance Carriers" option is highlighted in blue. The main content area is titled "Current and Past Insurance Carriers" and contains the following text: "List ALL professional liability insurance carriers from who you have received coverage in the past 10 years (including education program coverage during the past 10 years) and even if the coverage has ended." Below this text is a red warning: "EACH carrier must be REVIEWED and EDITED to answer required questions." Further down, it says: "Select the down arrow and then the edit (pencil) tool for each entry to review, update and answer the required questions." At the bottom of the main content area, there is a grey button labeled "Current Malpractice Insurance Carrier". On the right side of the main content area, there is a blue button labeled "Save and Continue".

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.

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

UnityPoint Health

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

Current and Past Insurance Carriers

List ALL professional liability insurance carriers from who you have received coverage in the past 10 years (including education program coverage during the past 10 years) and even if the coverage has ended.

EACH carrier must be REVIEWED and EDITED to answer required questions.

Select the **down arrow** and then the **edit (pencil) tool** for each entry to review, update and answer the required questions.

The CVO welcomes copies of both current and prior insurance facesheets to assist in identifying the carrier proper name.

[Cancel](#)
* Indicates a required field

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 five peers.

Peer References

Please list the names of 5 individuals who have personal knowledge within the past 12 months of your current clinical abilities, ethical character and interpersonal skills and who would be willing to provide this information upon request.

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

If you completed a training program within the last 5 years, one of your references MUST be your program director.

REQUIRED PEERS:

- 1 - Department Chair/Medical Director from your current, primary hospital affiliations with first-hand knowledge of your competence within the last 12 months.
- 2 - Peer from your specialty and same discipline (physician-physician, dentist-dentist, etc.) with first-hand knowledge of your competence within the 12 months.
- 3 - Training Director, if training was completed within the last 5 years.
- 4 - 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

Reference Type: Professional Reference

* Indicates a required field

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

You will add your medical education and training program information, we do not need Pre-Med or High School information.

You must include an explanation of any gaps in your medical training greater than 30 days or 60 days as requested in your portal.

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



[Basic Information](#) [Professional History](#) **[Education and Training](#)** [Disclosure Questions](#) [Privileges](#) [Required Documents](#) [Review and Submit](#)

Medical Education/Clinical Training Update

Board/National Certification

Education and Training

This section has **2 parts**. Here's the key information you will need to complete this section applicable to your specialty:

- Medical education and residency/fellowship training
- Board certification

Education timeline should begin with highest level of education. **Do NOT include undergraduate education.**

[Continue](#)

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

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Review and Submit

Medical Education/Clinical Training Update

Board/National Certification

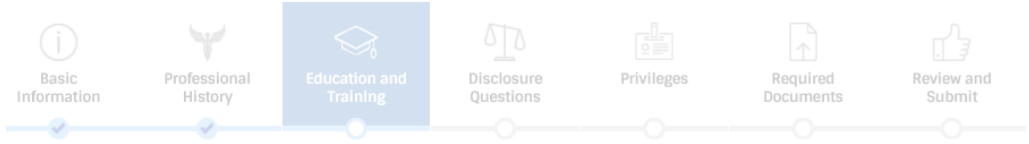
Medical Education/Clinical Training Update

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?



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 -


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.


 UnityPoint Health


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



Basic Information



Professional History


Education and Training


Disclosure Questions


Privileges


Required Documents


Review and Submit

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

Board/National Certification

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

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

[Save and Continue](#)

[Add a Board/National Certification](#)

Board/National Certification

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

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

[Save and Continue](#)

[Cancel](#)
* Indicates a required field

Are you Board certified? * Yes No

If yes, Certifying Board Name

Find Specialty Look Up


Board Certification Specialty *

Practicing this Specialty? * Yes No

Lifetime Cert? * Yes No

Certification Issued Date *

In MOC Program? * Yes No

Certification Number:  Date of Recertification (mm/yy)

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 **history since Medical Education**. 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. It includes a 'Continue' button and a list of categories: Adverse or Other Actions, Professional Liability Actions, Liability Insurance, Criminal Actions, Medical Condition, and Chemical Substances or Alcohol Abuse. A green highlighted note states: 'Please Note: If you answer "Yes" in any of the above Disclosure Sections, you need to provide explanations.' Another green highlighted note lists additional information requested: CME Attestation, Flu Vaccine Attestation, and COVID Vaccine or Waiver Information. A sidebar on the left lists 'IOWA Quality Focused Questions' with sub-items: Liability Claims Information - Addendum A, Investments, CME/CEU Credits, and Flu Vaccine.

- 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 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. It includes a 'Continue' button and a list of categories: Adverse or Other Actions, Professional Liability Actions, Liability Insurance, Criminal Actions, Medical Condition, and Chemical Substances or Alcohol Abuse. A green highlighted note states: 'Please Note: If you answer "Yes" in any of the above Disclosure Sections, you need to complete a matching Disclosure Form (Forms A-F) for EACH incident you need to explain located in the Disclosure Section of the portal.' Another green highlighted note lists additional information requested: CME Attestation, Flu Vaccine Attestation, and COVID Vaccine or Waiver Information. A sidebar on the left lists various categories: Adverse or other actions, Professional Liability Actions, Liability Insurance, Criminal Actions, Medical Conditions, Chemical Substances or Alcohol Abuse, Investments, CME/CEU Credits, Flu Vaccine, COVID Vaccination, and Disclosure Forms.

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 **since Medical Education**:

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.

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

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 **since Medical Education**:

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.

UnityPoint Health

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

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 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 Adverse and Other Actions

Question Number 8

Describe the circumstances surrounding this occurrence. Voluntarily resigned from Hospital Name due to changing employers and moving and was in good

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 credentialed at hospitals for membership/privileges 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.

The screenshot shows the UnityPoint Health portal interface. At the top, there is a navigation bar with the text "Welcome, Rebecca zzLachenmaier | My Home | Summary Report | Logout". Below this is the UnityPoint Health logo. A horizontal progress bar contains seven steps: Basic Information, Professional History, Education and Training, Disclosure Questions, Privileges (highlighted in blue), Required Documents, and Review and Submit. Below the progress bar, the "Privileges" section is active. On the left, there is a "Request Privileges" link. The main content area contains the following text:

Privileges
NOTE: Delegated Credentialers cannot view or complete privilege requests.

Hospital privilege forms should be linked in this section from the facilities you are seeking privileges. IF you do not see any privileges linked, please contact the CVO.

Be sure you meet all criteria listed in privileging sections before selecting privileges.

If documentation is required to meet the listed clinical requirements, you may upload as part of the Required Documents section of the portal or submit directly to the Medical Staff Office of the hospital where you are seeking privileges.

Click on the Request Privileges Option on left side of the screen to proceed.

On the right side of the content area, there is a blue "Continue" button.

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

The screenshot shows a form titled "Department Chair Recommendation - FPPE Requirements". The form area is currently empty. At the bottom center of the form, there is a grey "Submit" button, which is highlighted with a red rounded rectangle.

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

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

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

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

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

Continue

The **Red Asterisk*** identifies required documents. IF you would like to upload additional documentation on the list, the CVO will save them in the credentialing system.

Welcome, Rebecca zzLachenmaier | My Home | Summary Report | Logout

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

Upload Documents

The following documents are **REQUIRED** to be uploaded:

- A pdf, or jpeg file of a passport sized head and shoulder professional photo
- A pdf, or jpeg file copy of a current U.S. Government issued ID with viewable photo
- A pdf, or jpeg file copy of a current CV/Resume
- A pdf, or jpeg file copy of your current malpractice facesheets
 - UPH Employed Providers - The CVO will be obtaining your upcoming COI facesheet, you do NOT need to wait for a copy to be submitted with your portal.
 - If you have copies of your prior facesheets for the past 10 years with employer names identified, the CVO will also accept them to assist in the validation of coverage.
- A pdf, or jpeg file copy of COVID vaccination proof
- IF REQUESTING PRIVILEGES - A pdf, or jpeg file summary of case logs/patient volumes (without PHI) from the past 2 years.
- A pdf, or jpeg file copy of Life support certifications to support privilege requests.

*Practitioner Photo	UPLOAD	
*U.S. Government Issued ID (Driver's License or VISA or Passport)	UPLOAD	
*CV/Resume - Must be Current	UPLOAD	
COVID Documentation	UPLOAD	WILL SEND
*Insurance Certificate Currently In Use	UPLOAD	
Prior Insurance Certificate	UPLOAD	WILL SEND
State Medical License, Optional	UPLOAD	WILL SEND

Save and 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
Forms

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

Save and Continue

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

Forms -

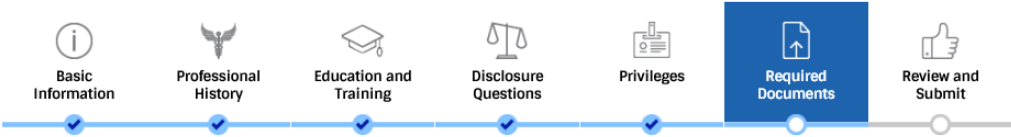
The forms will populate with the information supplied thus far in the portal and are viewable by clicking on the blue “View Form” button.

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.

The screenshot shows the UnityPoint Health portal interface. At the top, there is a navigation bar with the UnityPoint Health logo and a progress indicator with seven steps: Basic Information, Professional History, Education and Training, Disclosure Questions, Privileges, Required Documents (highlighted in blue), and Review and Submit. Below the progress bar, there is a sidebar with 'Upload Documents' and 'Forms' (highlighted in blue). The main content area is titled 'Forms' and contains the following text: 'Please review and complete the following forms. The system will prompt you to provide electronic signature following attestation.' Below this is the title 'Portal ReCredentialing Application APP 4-23-21'. There is a blue 'View Form' button. Below the button is a red circle around a checkbox, followed by the text: '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.' At the bottom of the form section is a blue 'Previous' button. On the right side of the main content area, there is a blue 'Save and Continue' button.



- Upload Documents
- Forms**

Forms

The following forms require your review and attestation of accuracy. The system will automatically place your electronic signature on the form when you check the attestation box under each form viewing option when the application is submitted to the CVO.

NOTE - When selecting "View Forms" the forms will pull up in pdf, if your information is extensive, the forms may take a bit to appear for viewing.

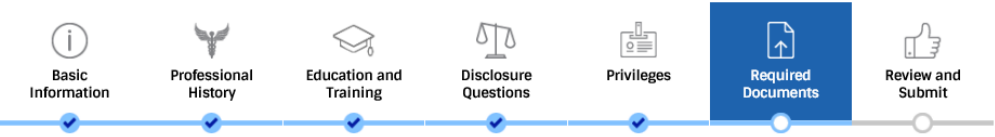
APP Medicare and Medical Acknowledgement (Universal)

[View Form](#)

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

[Previous](#)

[Next](#)



- Upload Documents
- Forms**

Forms

The following forms require your review and attestation of accuracy. The system will automatically place your electronic signature on the form when you check the attestation box under each form viewing option when the application is submitted to the CVO.

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APP Consent and Release (Initial)

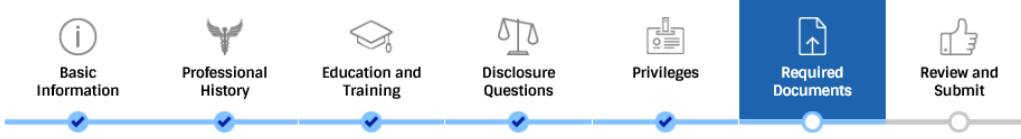
[View Form](#)

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

[Previous](#)

[Next](#)





Upload Documents
Forms

Save and Continue

Forms

The following forms require your review and attestation of accuracy. The system will automatically place your electronic signature on the form when you check the attestation box under each form viewing option when the application is submitted to the CVO.

NOTE - When selecting "View Forms" the forms will pull up in pdf, if your information is extensive, the forms may take a bit to appear for viewing.

Corporate Compliance Form

[View Form](#)

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

[Previous](#)




Review and Submission Section

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

You must have all sections of the portal checked off in order for 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

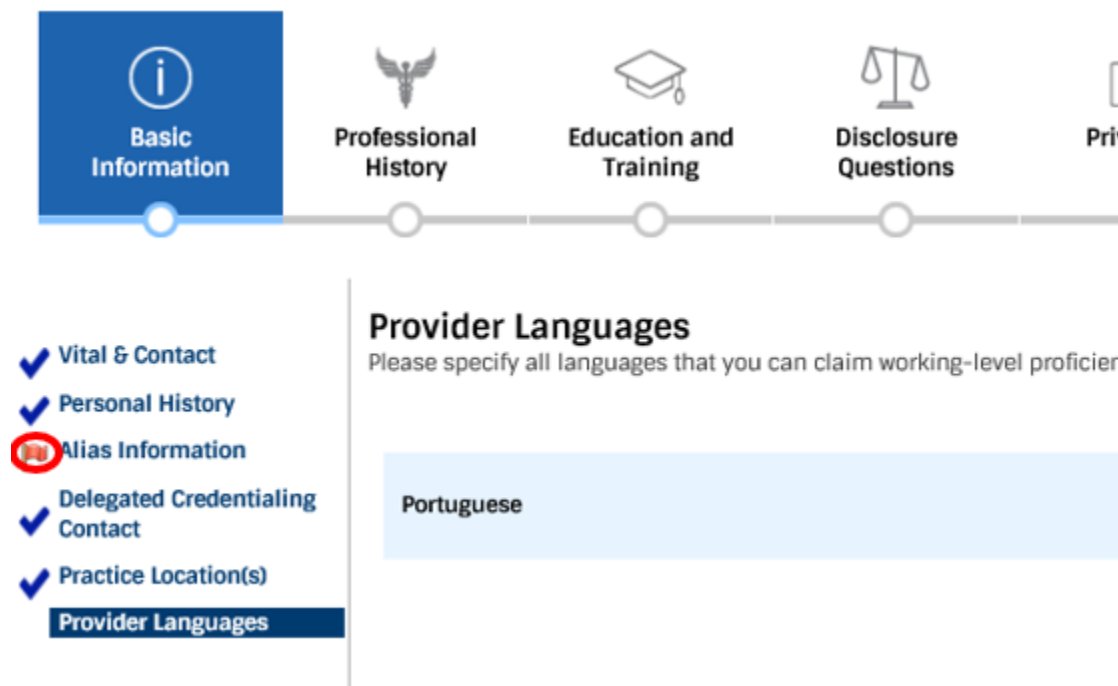
Basic Information	✓
Professional History	✓
Education and Training	✓
Disclosure Questions	✓
Privileges	✓
Required Documents	✓

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



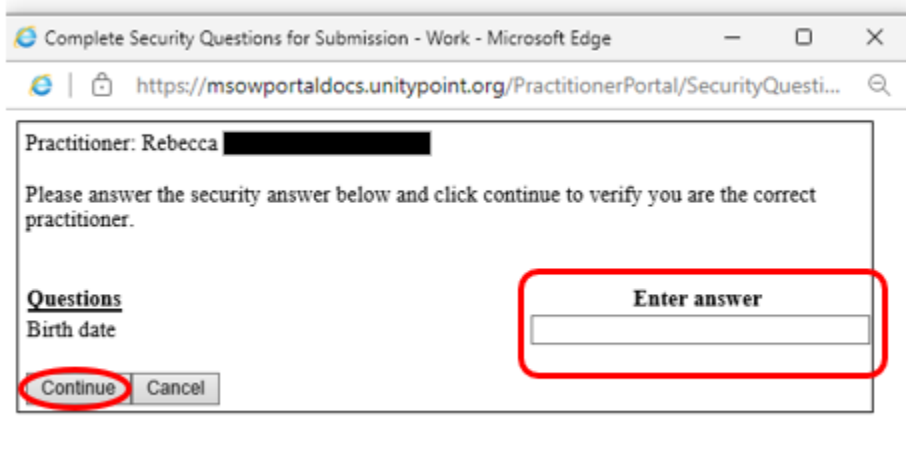
Click the "Submit" Button

Status: 100% Complete

Click to Submit

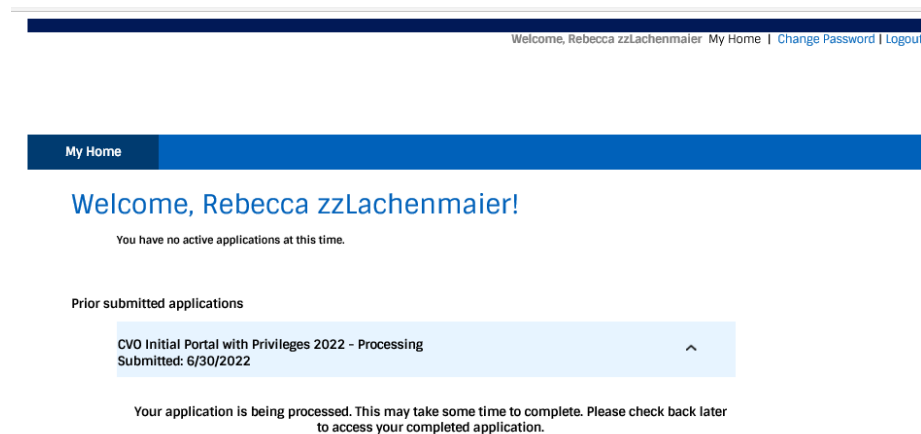
	Basic Information		VIEW YOUR RESPONSES
	Professional History		VIEW YOUR RESPONSES
	Education, Training, Board Certification		VIEW YOUR RESPONSES
	Disclosure Questions		VIEW YOUR RESPONSES
	Privileges		VIEW YOUR RESPONSES
	Required Documents		VIEW YOUR RESPONSES

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



Upon successful submission the main page of the portal will show a submission message.

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



Next Steps

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

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

If you have any questions please contact the CVO:

UPH_CVO@unitypoint.org

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

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

You can check status of your application using the CAT (Credentialing Application Tracker) on the CVO service now website: [Credentials Verification Office Portal \(service-now.com\)](https://www.unitypoint.org/cvo)