# Membership Application

**Kootenai Care Network**

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

**Step 1 – Participating Provider Requirements ‐** Please review the following participation requirements and attest to your eligibility.

* I am currently credentialed and a member in good standing of the Medical Staff of a Participating Hospital\*, or
* I currently am not a member of the Medical Staff of a Participating Hospital, I understand that I must demonstrate that I meet Medical Staff eligibility requirements. Every effort will be made to submit information within 60 days.
* I am committed to improving quality of care and clinical outcomes, improving coordination and continuity of care, improving efficiency of care, eliminating unnecessary clinical care variation, applying evidence‐based medical interventions, and supporting comprehensive clinical care with use of an information integration technology platform.
* I will meet and abide by the terms outlined in the KCN Participation Agreements.
* I agree to participate in all of the contracts of KCN.
* I agree to comply with the clinical performance standards, guidelines, and objectives to be defined by KCN Quality and Health Information Technology Committees.
* I agree to actively promote, gather and report evidence‐based clinical outcome measures as required by the KCN with third party payers and KCN policies and procedures.
  + Upon request of KCN, I agree to provide information in a timely manner in order to allow for analysis of clinical outcomes by KCN.
  + I agree to comply with all requirements and deadlines as defined by KCN for aggregation and reporting of clinical outcomes.

By my signature, I attest that I meet, or that I will meet, the Participating Provider Requirements listed above. I further agree that, if I am accepted as a Participating Member, I will continue to meet all of the Participating Provider Requirements during the term of my membership.

Provider Signature:

Provider Printed Name:

\* Participating Hospitals

Kootenai Health

Date:

# Step 2 – Applicant Information (All Applicants)

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| **General Information**: Enter all information, when applicable, EXACTLY as it appears in the Medicare Provider Enrollment, Chain, and Ownership System (**PECOS**). All fields marked with an asterisk (\*) are required. | | | |
| *\*Last Name* | *\*First Name* | *M.I.* | *\*Date* |
| *Birth Date* | *\*EMR Product / Version* | | |
| *\*Practice Management System / Version* | | |
| *\*Primary Practice Specialty (Board*  *Certification)* | *Secondary Practice Specialty* | | |
| *\*Tax ID # (TIN)* | *\*Individual NPI #* | *\*Group NPI #* | |
| *\*Practice Name (If more than one practice site, please report additional site information on a separate page)* | | | |
| *\* Practice Street Address* | *Suite #* | | |
| *\*City* | *\*State* | *\*Zip* | |
| *\*Practice Phone #* | *Personal Phone #* | *Practice Fax #* | |
| *\*E‐Mail Address* | | | |
| *In‐office Contact Name* | *Title* | *E‐Mail* | |

**Step 3 – Credentialing Pre‐Application** – Complete only if you are currently **not** a member of the Medical Staff of a Participating Hospital.

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

Please answer the questions listed below. The Medical Staff Office of the Participating Hospital will send you a comprehensive credentialing application upon receipt of your completed application request and pre‐ application questionnaire.

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| --- | --- | --- |
| **QUESTIONS** | **YES** | **NO** |
| Are you currently licensed to practice medicine, podiatry or dentistry, as applicable, in Idaho |  |  |
| Are you currently eligible to participate in federally funded health care programs such as Medicare and Medicaid? |  |  |
| Are you currently participating in Medicare? |  |  |
| Are you currently board certified (ABMS/AO for physicians, in your primary area of expected specialty practice? |  |  |
| Do you have a current, unrestricted DEA registration? (If you are a practitioner who is  ineligible based on a non‐medical staff specialty or in a specialty not requiring/utilizing a DEA, answer “Yes”.) |  |  |
| Do you currently have malpractice liability coverage with minimum coverage of $1,000,000  per occurrence/$3,000,000 aggregate? |  |  |

Comments: