Children's Community Physicians Association (CCPA) uses the Illinois Department of Public Health's (IDPH) Health Care Professional Recredentialing and Business Data Gathering Form (IL recred application) as the official recredentialing application for the CCPA recredentialing process. Please view detail instructions below on how to complete each section of the IL recred application.

Getting Started

To complete the IL application, you will need the support documents listed below. Please note you are required to submit your support documents to CCPA along with the IL recred application.

- ☐ All Current Professional License(s)
- ☐ Current Federal D.E.A. Certificate
- ☐ Current State Controlled Substance Certificate(s)
- ☐ Current Certificate of Insurance
- ☐ Current Curriculum Vitae
- ☐ Board Certification Certificate or Letter from ABP with Effective Date

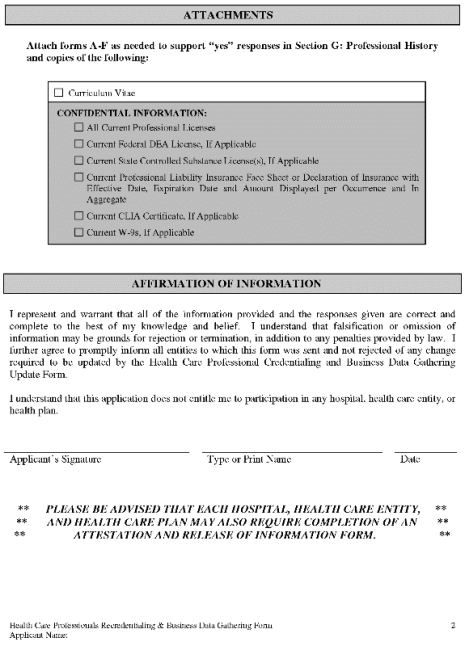
IDPH Health Care Professional Recredentialing and Business Gathering Form

The sections highlighted in yellow or green or outlined in red are to be reviewed for accuracy and updated if applicable. Please note, there are two ways that a recred applicant can complete their recredentailing application. 1) The applicant receives two emails from the Lurie Children's Medical Group (LCMG), one email has a link to the MSOW home page, and a second email includes the login password. Please note that if you have a practice manager assisting with your recredentialing paperwork, they will receive a different password email to access your electronic application. Once the applicant logs into their portal, they will have the ability to review and update their prepopulated IL recred application. 2) The applicant retrieves an IL recred application from the IDPH website and fills it out in it's entirely and submit it via mail or email to CCPA.

Affirmation of Information – pg. 2

Page two (2) of the IL recred application is affirming that all the information listed on the application is complete and true to the best of your knowledge. Once this page is signed and submitted to CCPA, the applicant is the only person who can make changes to the IL recred application. See Figure 1.

Please note: The Illinois recredentialing application received from MSOW is prepopulated with your information. Please review all sections of the application and update all expired and incorrect information.



ATTACHMENTS

Attach forms A-F as needed to support "yes" responses in Section G: Professional History and copies of the following:

☐ Curriculum Vitae

CONFIDENTIAL INFORMATION:

- ☐ All Current Professional Licenses
- ☐ Current Federal DEA License, If Applicable
- ☐ Current State Controlled Substance License(s), If Applicable
- ☐ Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amount Displayed per Occurrence and In Aggregate
- ☐ Current CLIA Certificate, If Applicable
- ☐ Current W-9s, If Applicable

AFFIRMATION OF INFORMATION

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. I understand that falsification or omission of information may be grounds for rejection or termination, in addition to any penalties provided by law. I further agree to promptly inform all entities to which this form was sent and not rejected of any change required to be updated by the Health Care Professional Credentialing and Business Data Gathering Update Form.

I understand that this application does not entitle me to participation in any hospital, health care entity, or health plan.

Applicant's Signature | Type or Print Name | Date

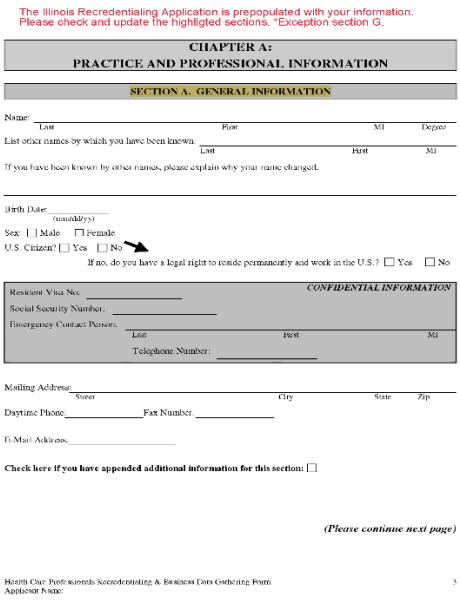
** *PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY, AND HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN ATTESTATION AND RELEASE OF INFORMATION FORM.* **

Health Care Professionals Recredentialing & Business Data Gathering Form 2
Applicant Name:

Figure 1 - IL Recred App. Pg. 2

Chapter A: Practice and Professional Information – pg. 3

Page three (3) is the collection of general information about the physician. All areas of this section must be completed, even the *CONFIDENTIAL INFORMATION* section. If there is information on this page that you do not want to include because you are emailing it to CCPA, please call a CCPA team member and they will take the sensitive information over the telephone. See Figure 2.



The Illinois Recredentialing Application is prepopulated with your information. Please check and update the highligted sections. *Exception section G.

CHAPTER A:
PRACTICE AND PROFESSIONAL INFORMATION

SECTION A. GENERAL INFORMATION

Name: _____
Last First MI Degree

List other names by which you have been known. _____
Last First MI

If you have been known by other names, please explain why your name changed.

_____

Birth Date:_____
(mm/dd/yy)

Sex: [ ] Male ☐ Female

U.S. Citizen? ☐ Yes ☐ No

If no, do you have a legal right to reside permanently and work in the U.S.? ☐ Yes ☐ No

CONFIDENTIAL INFORMATION

Resident Visa No: _____

Social Security Number: _____

Emergency Contact Person: _____
Last First MI

Telephone Number: _____

Mailing Address: _____
Street City State Zip

Daytime Phone: _____ Fax Number: _____

E-Mail Address: _____

Check here if you have appended additional information for this section: ☐

(Please continue next page)

Health Care Professionals Recredentialing & Business Data Gathering Form 3
Applicant Name:

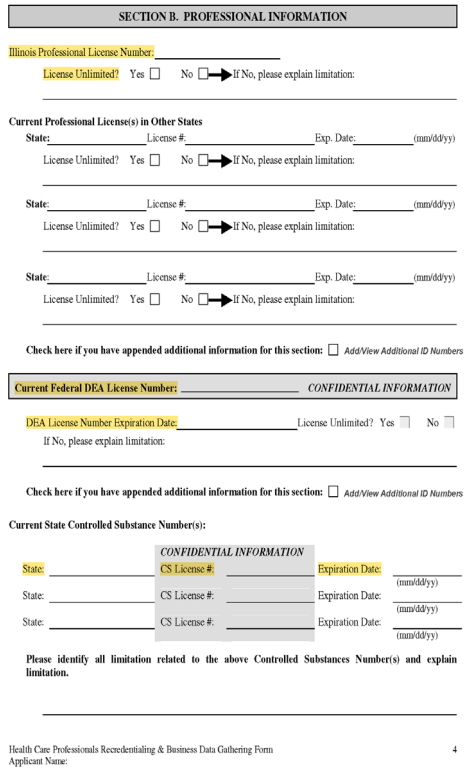
Figure 2 – IL Recred App. Pg. 3

Section B. Professional Information pgs. 4 - 6

Section B of the application is for IL professional license, DEA, and state control substance information. All Indiana physicians, who do not have an IL professional license, please add your state professional license information in the *Current and Previous Professional License(s) in Other States.* See Figure 3. **Note: This section is prepopulated, please double check that the expiration dates for DEA and controlled substance licenses are correct.**

Complete for each *Specialty Section*, please be sure to answer the question about when you are taking the boards certification test if you currently are not board certified.

Note: If you have failed your board test, answer yes to question #8 on the *Disclosure Question* page 12 and complete Form A. See Figures 4-6.



SECTION B. PROFESSIONAL INFORMATION

Illinois Professional License Number: _____

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation:

_____

Current Professional License(s) in Other States

State: _____ License #: _____ Exp. Date: _____ (mm/dd/yy)

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation:

_____

State: _____ License #: _____ Exp. Date: _____ (mm/dd/yy)

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation:

_____

State: _____ License #: _____ Exp. Date: _____ (mm/dd/yy)

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation:

_____

Check here if you have appended additional information for this section: ☐ *Add/View Additional ID Numbers*

Current Federal DEA License Number: _____ *CONFIDENTIAL INFORMATION*

DEA License Number Expiration Date: _____ License Unlimited? Yes ☐ No ☐

If No, please explain limitation:

_____

Check here if you have appended additional information for this section: ☐ *Add/View Additional ID Numbers*

Current State Controlled Substance Number(s):

CONFIDENTIAL INFORMATION

State: _____ CS License #: _____ Expiration Date: _____ (mm/dd/yy)

State: _____ CS License #: _____ Expiration Date: _____ (mm/dd/yy)

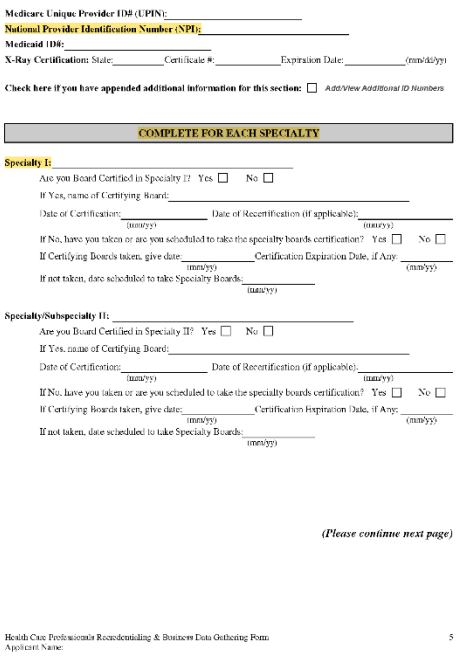
State: _____ CS License #: _____ Expiration Date: _____ (mm/dd/yy)

Please identify all limitation related to the above Controlled Substances Number(s) and explain limitation.

_____

Health Care Professionals Recredentialing & Business Data Gathering Form 4
Applicant Name:

Figure 3 - IL Recred App. Pg. 4



Medicare Unique Provider ID# (UPIN):

National Provider Identification Number (NPI):

Medicaid ID#:

X-Ray Certification: State:_____Certificate #:_____Expiration Date:_____(mm/dd/yy)

Check here if you have appended additional information for this section: ☐ Add/View Additional ID Numbers

COMPLETE FOR EACH SPECIALTY

Specialty I:

Are you Board Certified in Specialty I? Yes ☐ No ☐

If Yes, name of Certifying Board:

Date of Certification:_____ (mm/yy) Date of Recertification (if applicable):_____ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date:_____ (mm/yy) Certification Expiration Date, if Any:_____ (mm/yy)

If not taken, date scheduled to take Specialty Boards:_____ (mm/yy)

Specialty/Subspecialty II:

Are you Board Certified in Specialty II? Yes ☐ No ☐

If Yes, name of Certifying Board:

Date of Certification:_____ (mm/yy) Date of Recertification (if applicable):_____ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

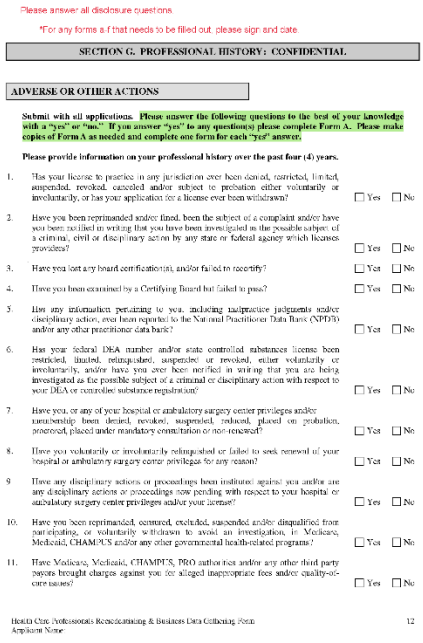
If Certifying Boards taken, give date:_____ (mm/yy) Certification Expiration Date, if Any:_____ (mm/yy)

If not taken, date scheduled to take Specialty Boards:_____ (mm/yy)

(Please continue next page)

Health Care Professionals Recredentialing & Business Data Gathering Form 5
Applicant Name:

Figure 4 - IL Recred App. Pg. 5



Please answer all disclosure questions.

*For any forms a f that needs to be filled out, please sign and date.

SECTION G. PROFESSIONAL HISTORY: CONFIDENTIAL

ADVERSE OR OTHER ACTIONS

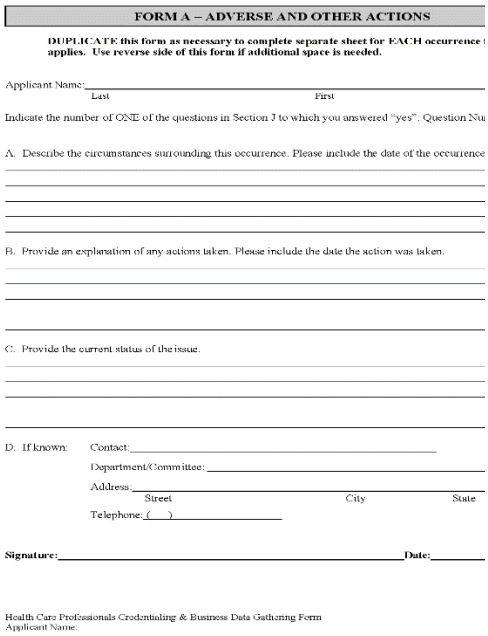
Submit with all applications. Please answer the following questions to the best of your knowledge with a "yes" or "no." If you answer "yes" to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each "yes" answer.

Please provide information on your professional history over the past four (4) years.

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? ☐ Yes ☐ No
2. Have you been reprimanded and/or fined, been the subject of a complaint and/or have not been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers? ☐ Yes ☐ No
3. Have you lost any board certification(s), and/or failed to recertify? ☐ Yes ☐ No
4. Have you been examined by a Certifying Board but failed to pass? ☐ Yes ☐ No
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? ☐ Yes ☐ No
6. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? ☐ Yes ☐ No
7. Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, preserved, placed under mandatory consultation or non-renewed? ☐ Yes ☐ No
8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? ☐ Yes ☐ No
9. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license? ☐ Yes ☐ No
10. Have you been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs? ☐ Yes ☐ No
11. Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues? ☐ Yes ☐ No

Health Care Professionals Recredentialing & Business Data Gathering Form 12
Applicant Name:

Figure 5 - IL Recred App. Pg. 12



FORM A – ADVERSE AND OTHER ACTIONS

DUPLICATE this form as necessary to complete separate sheet for EACH occurrence t applies. Use reverse side of this form if additional space is needed.

Applicant Name:_____
Last First

Indicate the number of ONE of the questions in Section J to which you answered "yes". Question Nu

A. Describe the circumstances surrounding this occurrence. Please include the date of the occurrence

B. Provide an explanation of any actions taken. Please include the date the action was taken.

C. Provide the current status of the issue.

D. If known: Contact:_____

Department/Committee:_____

Address:_____
Street City State

Telephone: (___)_____

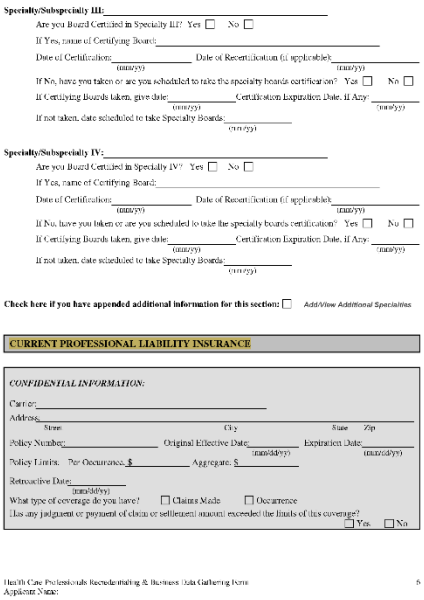
Signature:_____**Date:**_____

Health Care Professionals Credentialing & Business Data Gathering Form
Applicant Name:

Figure 6 - Form A

Current Professional Liability Insurance pg. 6

The current professional liability insurance section requires that you list your current malpractice insurance coverage.
See Figure 7.



Specialty/Subspecialty III:_____
Are you Board Certified in Specialty III? Yes ☐ No ☐
If Yes, name of Certifying Board:_____
Date of Certification:_____ (mm/yy) Date of Recertification (if applicable):_____ (mm/yy)
If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐
If Certifying Boards taken, give date:_____ (mm/yy) Certification Expiration Date, if Any:_____ (mm/yy)
If not taken, date scheduled to take Specialty Boards:_____ (mm/yy)

Specialty/Subspecialty IV:_____
Are you Board Certified in Specialty IV? Yes ☐ No ☐
If Yes, name of Certifying Board:_____
Date of Certification:_____ (mm/yy) Date of Recertification (if applicable):_____ (mm/yy)
If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐
If Certifying Boards taken, give date:_____ (mm/yy) Certification Expiration Date, if Any:_____ (mm/yy)
If not taken, date scheduled to take Specialty Boards:_____ (mm/yy)

Check here if you have appended additional information for this section: ☐ *Add/View Additional Specialties*

CURRENT PROFESSIONAL LIABILITY INSURANCE

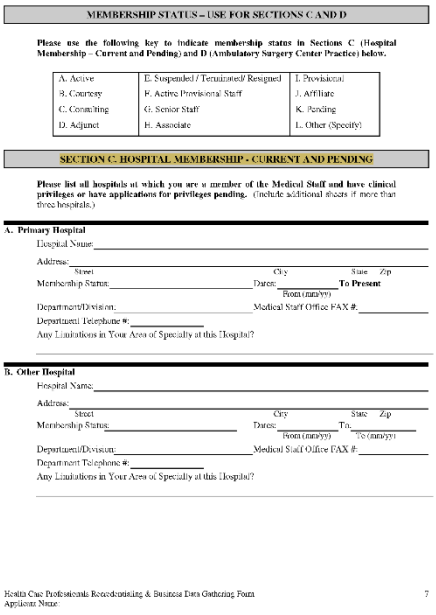
CONFIDENTIAL INFORMATION:
Carrier:_____
Address:_____
Street City State Zip
Policy Number:_____ Original Effective Date:_____ (mm/dd/yy) Expiration Date:_____ (mm/dd/yy)
Policy Limits: Per Occurrence, $_____ Aggregate, $_____
Retroactive Date:_____ (mm/dd/yy)
What type of coverage do you have? ☐ Claims Made ☐ Occurrence
Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage? ☐ Yes ☐ No

Health Care Professionals Recredentialing & Business Data Gathering Form 6
Applicant Name:

Figure 7- IL Recred App. Pg. 6

Membership Status – Use for Section C. pgs. 7-8

Please complete all the sections in the hospital membership status areas as it pertains to your current privileges. See Figure 8.



MEMBERSHIP STATUS – USE FOR SECTIONS C AND D

Please use the following key to indicate membership status in Sections C (Hospital Membership – Current and Pending) and D (Ambulatory Surgery Center Practice) below.

A. Active	E. Suspended / Terminated/ Resigned	I. Provisional
B. Courtesy	F. Active Provisional Staff	J. Affiliate
C. Consulting	G. Senior Staff	K. Pending
D. Adjunct	H. Associate	L. Other (Specify)

SECTION C. HOSPITAL MEMBERSHIP - CURRENT AND PENDING

Please list all hospitals at which you are a member of the Medical Staff and have clinical privileges or have applications for privileges pending. (Include additional sheets if more than three hospitals.)

A. Primary Hospital
Hospital Name:_____
Address:_____
Street City State Zip
Membership Status:_____ Dates:_____ From (mm/yy) **To Present**
Department/Division:_____ Medical Staff Office FAX #:_____
Department Telephone #:_____
Any Limitations in Your Area of Specialty at this Hospital?

B. Other Hospital
Hospital Name:_____
Address:_____
Street City State Zip
Membership Status:_____ Dates:_____ From (mm/yy) To (mm/yy)
Department/Division:_____ Medical Staff Office FAX #:_____
Department Telephone #:_____
Any Limitations in Your Area of Specialty at this Hospital?

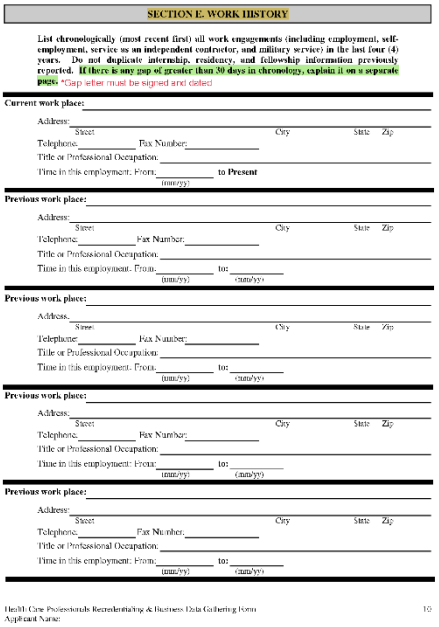
Health Care Professionals Recredentialing & Business Data Gathering Form 7
Applicant Name:

Figure 8 – IL Recred App. Pg. 7

Section E: Work History pg. 10

Include current and previous workplace, in the last four (4) years, do not include your internship, residency, or fellowship information. If you have a 30-day or more gap in your work history, please sign and date a letter to explain any gaps in employment. See Figure 9.

The dates of employments should include the month and year. Example: *From 01/1977 to 10/1984*. The dates on your CV should also be listed in the month/year format for your school and employment history.



SECTION E. WORK HISTORY

List chronologically (most recent first) all work engagements (including employment, self-employment, service as an independent contractor, and military service) in the last four (4) years. Do not duplicate internship, residency, and fellowship information previously reported. If there is any gap of greater than 30 days in chronology, explain it on a separate page. *Gap letter must be signed and dated

Current work place:
Address: Street City State Zip
Telephone: Fax Number:
Title or Professional Occupation:
Time in this employment: From: (mm/yy) to Present

Previous work place:
Address: Street City State Zip
Telephone: Fax Number:
Title or Professional Occupation:
Time in this employment: From: (mm/yy) to: (mm/yy)

Previous work place:
Address: Street City State Zip
Telephone: Fax Number:
Title or Professional Occupation:
Time in this employment: From: (mm/yy) to: (mm/yy)

Previous work place:
Address: Street City State Zip
Telephone: Fax Number:
Title or Professional Occupation:
Time in this employment: From: (mm/yy) to: (mm/yy)

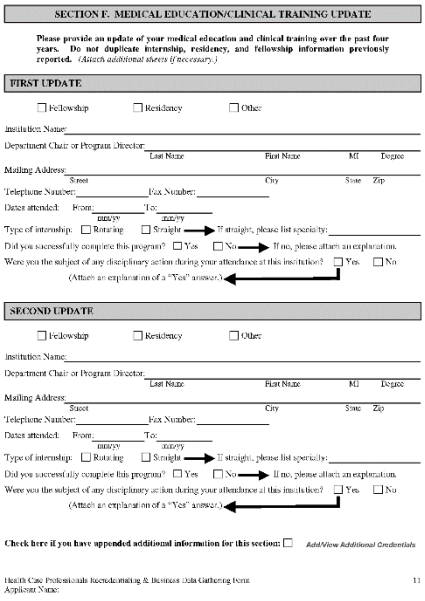
Previous work place:
Address: Street City State Zip
Telephone: Fax Number:
Title or Professional Occupation:
Time in this employment: From: (mm/yy) to: (mm/yy)

Health Care Professionals Recredentialing & Business Data Gathering Form 10
Applicant Name:

Figure 9 – IL Recred App. Pg. 10

Section F: Medical Education/Clinical Training Update pg. 11

If applicable, please complete any education and training within the last four (4) years. Do not duplicate internship, residency, and fellowship information previously reported. See Figure 10.



SECTION F. MEDICAL EDUCATION/CLINICAL TRAINING UPDATE

Please provide an update of your medical education and clinical training over the past four years. Do not duplicate internship, residency, and fellowship information previously reported. *(Attach additional sheets if necessary.)*

FIRST UPDATE

☐ Fellowship ☐ Residency ☐ Other
Institution Name:
Department Chair or Program Director: Last Name First Name MI Degree
Mailing Address: Street City State Zip
Telephone Number: Fax Number:
Dates attended: From: (mm/yy) To: (mm/yy)
Type of internship: ☐ Rotating ☐ Straight → If straight, please list specialty:
Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.
Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No
(Attach an explanation of a "Yes" answer.)

SECOND UPDATE

☐ Fellowship ☐ Residency ☐ Other
Institution Name:
Department Chair or Program Director: Last Name First Name MI Degree
Mailing Address: Street City State Zip
Telephone Number: Fax Number:
Dates attended: From: (mm/yy) To: (mm/yy)
Type of internship: ☐ Rotating ☐ Straight → If straight, please list specialty:
Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.
Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No
(Attach an explanation of a "Yes" answer.)

Check here if you have appended additional information for this section: ☐ *Add/View Additional Credentials*

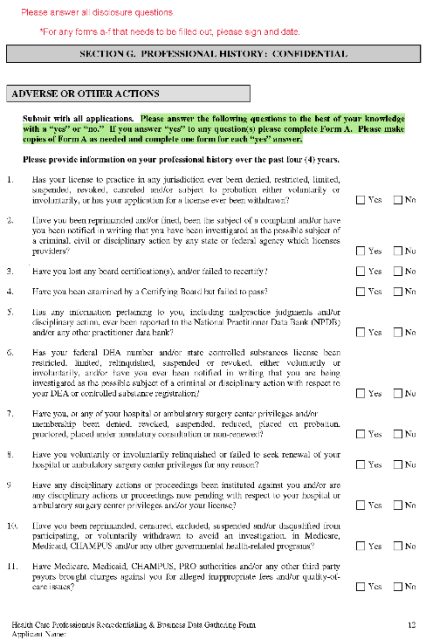
Health Care Professionals Recredentialing & Business Data Gathering Form 11
Applicant Name:

Figure 10 - IL Recred App. Pg. 11

Section G: Professional History Confidential pgs. 12-14

Answer all the questions with a yes or no. If you answer yes to any of the questions, please complete a corresponding Form A – F. If you fill out any of the A-F forms, please sign, date, and email them to CCPA. All forms can be found at the end of the application. See Figure 11.

Please answer all disclosure questions.



Please answer all disclosure questions.

*For any forms a-f that needs to be filled out, please sign and date.

SECTION G. PROFESSIONAL HISTORY: CONFIDENTIAL

ADVERSE OR OTHER ACTIONS

Submit with all applications. Please answer the following questions to the best of your knowledge with a "yes" or "no." If you answer "yes" to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each "yes" answer.

Please provide information on your professional history over the past four (4) years.

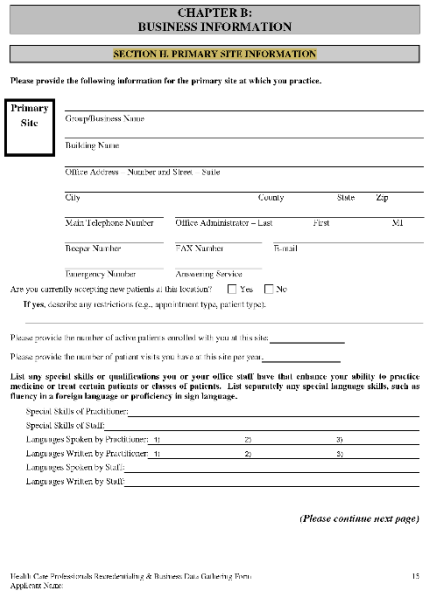
1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? ☐ Yes ☐ No
2. Have you been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers? ☐ Yes ☐ No
3. Have you lost any board certification(s), and/or failed to recertify? ☐ Yes ☐ No
4. Have you been examined by a Certifying Board but failed to pass? ☐ Yes ☐ No
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? ☐ Yes ☐ No
6. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? ☐ Yes ☐ No
7. Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, monitored, placed under ambulatory consultation or non-renewed? ☐ Yes ☐ No
8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? ☐ Yes ☐ No
9. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license? ☐ Yes ☐ No
10. Have you been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs? ☐ Yes ☐ No
11. Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues? ☐ Yes ☐ No

Health Care Professionals Recredentialing & Business Data Gathering Form 12
Applicant Name:

Figure 11 - IL Recred App. Pg. 12

Chapter B: Business Information Section H & I Primary and Additional Site Information pgs. 15-18

Fill out the business portion in its entirety. There is a section for primary site and any additional sites where you will provide treatment that is owned by the practice. This information is used for linking physicians to managed care contracts. See Figure 12.



CHAPTER B: BUSINESS INFORMATION

SECTION II. PRIMARY SITE INFORMATION

Please provide the following information for the primary site at which you practice.

Primary Site

Group/Business Name

Building Name

Office Address – Number and Street – Suite

City County State Zip

Main Telephone Number Office Administrator – Last First MI

Beeper Number FAX Number E-mail

Emergency Number Answering Service

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

If yes, describe any restrictions (e.g., appointment type, patient type).

Please provide the number of active patients enrolled with you at this site: _____

Please provide the number of patient visits you have at this site per year: _____

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special Skills of Practitioner:

Special Skills of Staff:

Languages Spoken by Practitioner: 1) 2) 3)

Languages Written by Practitioner: 1) 2) 3)

Languages Spoken by Staff:

Languages Written by Staff:

(Please continue next page)

Health Care Professionals Recredentialing & Business Data Gathering Form 15
Applicant Name:

Figure 12 - IL App. Pg. 15

Miscellaneous Things to Know

When correcting/updating any portion of the application, please date and initial near each correction.

Please complete each section to the best of your knowledge.