1102 S. Hillside / Wichita, KS 67211
1-800-801-9772 / Fax 316-683-6255
www.ProviDRsCare.Net

Application for Locum Tenens Physicians

UNDERWRITING APPLICATION:

Locum Tenens Coverage is provided for a temporary substitute physician. This coverage can be provided only when the ProviDRs Care participating physician is not practicing.

LOCUM TENENS REQUEST FORM:

Written request for this coverage must be made in advance on the attached form. Locum Tenens coverage cannot be provided on a retroactive basis if the request is made late. ProviDRs Care policy will provide up to 180 days of coverage during the policy period for duly licensed substitute physicians working on behalf of the physician on a temporary basis due to vacation, illness, or other absence.

General Information – Substitute Physician

Name ____

Mailing Address ____

Office Phone # ______________________ Fax # ______________________

Social Security # ______________________ Provider NPI # ______________________

KS License # ______________________ Provider Effective Date ______________________

Billing Information

Billing Name ______________________ Billing Address ______________________

Practice Tax ID # ______________________ Practice Location NPI # ______________________

Insurance Information

Do you have Medical Malpractice Insurance? Yes No Malpractice Policy # ______________________

Name of Insurance Company ______________________ Policy Limits ______________________

Policy Term ______________________
(Effective/Expiration Dates)

1. Are you registered with the Kansas Board of Healing Arts? Yes No

2. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony? Yes No

3. Has any hospital ever denied, suspended, or revoked your privileges? Yes No

4. Has your DEA or medical license ever been suspended, restricted, revoked or voluntarily surrendered or has probation been invoked? Yes No

5. Have you ever been denied a medical license or been denied certification by a specialty board? Yes No

6. Do you have any unpaid obligations on any professional liability policies? Yes No

If your answer is yes to any of questions 2 – 6 please explain:

What is your specialty? ____

Are you Board Certified? Yes No

By signature of this Locum Tenens Physician Application, I agree that the statements contained herein are my agreements and representations and if coverage is extended in reliance upon the truth of such representations any willful misstatement of fact may invalidate Locum Tenens coverage with ProviDRs Care Network.

______________________________ ____

Date Signature of Applicant

Please send completed forms to:

Email: ProviderRelations@ProviDRsCare.net

or

Fax: (316) 683-6255

Contact Information:

Provider Relations: (800) 801-9772