StoneSprings Hospital Center
HCA Virginia Health System
An HCA affiliate

24440 STONE SPRINGS BOULEVARD
DULLES, VA 20166
STONESPRINGSHOSPITAL.COM

RE: Request for Application

Dear Provider,

Thank you for your inquiry indicating your interest in applying for Medical Staff or Allied Health membership and clinical privileges at StoneSprings Hospital Center. The following are prerequisites for receiving an application for appointment to the Staff of StoneSprings Hospital Center:

(1) A current, unrestricted license to practice in the Commonwealth of Virginia and no record of past adverse licensure action.

(2) Current Federal DEA. ***A valid DEA with a Virginia address will be required for initial appointment.***

(3) Satisfactory completion of an approved postgraduate residency training program. (ACGME and/or AOA) in the specialty in which you will seek clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association (ADA), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

(4) Board certification by the appropriate specialty Board (ABMS, AOA, the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable); or proof that you are an active candidate for examination for certification by the appropriate specialty Board, and thereafter certified within guidelines of completion of residency training according to your specialty boards.

(5) Current, valid professional liability insurance coverage in the amounts of $2.3M / $6.9M or consistent with current state regulations (effective 7/1/12 and increasing by $50,000 annually until 6/30/2031).

(6) Residence and office location within sufficient geographic proximity to the hospital to fulfill your Medical Staff responsibilities and to provide timely and continuous care for patients.

(7) No record of conviction of Medicare, Medicaid, or insurance fraud and abuse, payment of civil money penalties for same, or exclusion from such programs. You cannot be named on either the OIG or the GSA sanction list.

(8) No record of conviction of any felony, or any misdemeanor related to the practice of your profession, other health care related matter, third-party reimbursement, violence, or controlled substance violations.

(9) No record of denial, revocation, or termination of appointment or clinical privileges by any hospital for reasons related to clinical competence or professional conduct.

(10) Maintain certification and, to the extent required by the applicable specialty/ subspecialty Board, satisfy recertification requirements to be assessed at reappointment.

(11) A completed "delegate form" for online credentialing.

(12) ***A recent National Practitioner Data Bank self-query (printed within the last 30 days). This can now be obtained online and instructions are included in this packet. The website link is:***
http://www.npdb.hrsa.gov/pract/howToGetStarted.jsp

Please complete the enclosed Pre-Screening packet in its entirety and return it with copies of all required documents (listed on the bottom of page 2) within 30 days to the Medical Staff Office at StoneSprings Hospital Center. The Credentials Committee meets the second Tuesday of every month. ***Your pre-screening packet will be reviewed at the first Credentials Committee meeting following your return of the complete packet, including all required attachments.*** After a review of the packet, the Credentials Committee will make a determination as to whether you are eligible to receive an RFC (full application) for Medical Staff appointment and clinical privileges.

In addition, please note that there is a $150.00 application processing fee. Please make check payable to "StoneSprings Hospital Center" and **include it with your request for application**. If your request for application is not approved your check will be returned to you. Thank you for your interest in StoneSprings Hospital. We look forward to working with you!

Sincerely,

Melissa Bourgord
Melissa Bourgord, BS, CPCS, CPMSM
Director, Medical Staff Services

Encl: Request for Medical Staff Application Form

Medical Staff Office
Phone (571) 349-4080
Fax (571) 349-4081

Credentialing Portal

Delegate Letter

Practitioner Name: _____

Group Name of Practitioner: _____

Street Address: _____

City: _____

State: _____

We are excited to partner with your practice through our credentialing services!

The Parallon credentialing process includes a convenient online tool, the Credentialing Portal. This tool serves as a single point of access and is a secure website allowing you to view and manage your portion of the credentialing process, monitor progress at each step, and upload documents to update expiring or missing items at any time.

How To Use the Portal

You will receive an email notification when it is time for you or your delegate to complete your initial appointment or re-appointment packet. This email will provide you with a link to job aids, instructions and training material. If you would like to see this information before it is time for you to complete the forms, you can do so by visiting www.hcacredentialingonline.com.

Benefits and Features

- Enables you to complete the credentialing packet online for multiple entities
- Provides you with electronic access to create, modify and submit your credentialing documents
- Ensures accuracy and completeness of your submitted data
- Provides the ability to establish a delegate to prepare the required forms and documentation for your approval
- Allows access to all practitioners who are associated with or seeking association to our entity
- Enables online attestation form completion

Action Needed from You to Get Started!

To ensure you have the capability to receive and submit information online through the Portal, please complete and return the attached form indicating whether you will provide credentialing information personally or through a delegate. Please note that should a delegate be assigned, the individual will also be considered as your Credentialing Contact and will receive all communication related to the credentialing process.

Please complete the attached authorization form and return within **3 business days** via email or to the fax number or mailing address indicated in Step 3. If you have any questions, please contact our customer service at the telephone number listed below. If you have already returned the form within the last 3 business days, please disregard this notice.

Credentialing Processing Center – Nashville Shared Services Center
552 Metroplex Drive, Nashville, TN 37211
615-886-4318 phone ♦ 866-376-1045 toll free ♦ 877-405-6604 fax
CPCRequests.NSVCPC@Parallon.com
(11.01.19 version)

PARALLON

HCA Credentialing Online – Practitioner's Authorization for Delegate

Step 1:

Please enter your contact information to ensure the information we may already have is accurate in our credentialing system.

Practitioner Name: _____

Practitioner Phone: _____

Practitioner Email (required): _____

NOTE: Practitioner email must be unique to the practitioner; it cannot be the same address as a delegate.

Step 2:

☐ I do not want to select any delegates at this time. I will personally provide credentialing information.
_____ Please initial and skip to Step 3

☐ The individual listed below is my delegate. I hereby authorize (hereinafter, individually referred to as "Delegate") to access the Credentialing Portal to enter data and submit documents for the Request for Considerations (RFC) and Recredentialing Requests for Consideration (RRFCs) requests on my behalf. I understand that I will need to review the data and documents and attest to their accuracy before I submit them to the entity via the Credentialing Portal.

To assign a delegate, please provide the following information for the **delegate**:

Delegate Name	**First**	**Middle**	**Last**	
Address	**Street**	**City**	**State**	**Zip**
Contact Information	**Email**	**Phone**		

Step 3:

Please complete, sign and date. The form may be returned using fax, email or U.S. mail using the contact information provided in the 'Action Needed' section of this communication.

I acknowledge that I have voluntarily provided the above information, and I have carefully read and understand this Authorization. I understand and agree that a facsimile or photocopy of this Authorization shall be as effective as the original.

_____ _____

PRACTITIONER SIGNATURE **NAME (printed)**

_____ _____

LAST 4 of SSN or FULL NPI **DATE (MM/DD/YYYY)**

Credentialing Processing Center – Nashville Shared Services Center
552 Metroplex Drive, Nashville, TN 37211
615-886-4318 phone ♦ 866-376-1045 toll free ♦ 877-405-6604 fax
CPCRequests.NSVCPC@Parallon.com
(11.01.19 version)

INSTRUCTIONS FOR OBTAINING A SELF-QUERY FROM THE NATIONAL PRACTITIONER DATA BANK

Go to: http://www.npdb.hrsa.gov/pract/howToGetStarted.jsp

At this site you will find self-query basics as well as instructions for completing the self-query.

Completing the application takes approximately 25 minutes.

What You Will Need

- Your Social Security Number or Individual Tax Identification Number (ITIN)
- Your state-issued professional license number
- The school or institution where you obtained your professional degree, training or certification
- Email address
- A **PERSONAL** credit card or debit card for the $5.00 fee

After You're Finished

Once your self-query response is processed you can view the results online. The paper copy of the Data Bank response is mailed within one business day after the online response is available. You can check the status of your self-query online at any time.

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MEDICAL STAFF PRE-SCREENING FORM

FULL NAME: _____
First Middle Last Degree

_____ Gender: ○M ○F (circle one)
Maiden name (if applicable)

_____ _____ _____
Date of Birth Social Security # NPI Number

PRACTICE NAME: _____

OFFICE ADDRESS: _____
NUMBER/STREET SUITE #

_____
CITY STATE ZIP

OFFICE PHONE: _____ **FAX**: _____

EMAIL: _____

HOME ADDRESS: _____
NUMBER/STREET APT #

_____
CITY STATE ZIP

HOME PHONE: _____ **CELL:** _____

CLINICAL SPECIALTY: _____

BOARD CERTIFIED? ☐ Yes ☐ No **BOARD:** _____
*(Board certification **is required** for medical staff privileges. If you have just completed your training, you must achieve Board certification within the time frame required by your department in order to remain on staff).*

LICENSURE: _____
STATE LICENSE NUMBER EXPIRATION DATE

_____
STATE LICENSE NUMBER EXPIRATION DATE

(if more licenses held, please add additional sheet)

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PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY:

1. Are you joining any physician who is a current member of StoneSprings Hospital Center's Medical Staff? ☐ Yes ☐ No

   If yes, please name the practitioner or group:_____

   If no, who will be your cross-covering physician on our staff? **(required for medical staff membership not for allied health practitioners)**

   _____

2. Are you currently appointed to the medical staff of any other hospital?
   ☐ Yes ☐ No If yes, please list below (if more than 2 please add additional sheet):

   Hospital:_____ Category:_____

   Hospital:_____ Category:_____

3. Has your license to practice medicine (or allied health profession) in any state ever been denied, limited, suspended, revoked, placed on probation, or voluntarily/involuntarily relinquished?

   ☐ Yes ☐ No

4. Are there currently any restrictions on your DEA and/or state controlled substance licenses?

   ☐ Yes ☐ No If yes, please attach a detailed explanation.

5. Have you ever been convicted of Medicare, Medicaid, or other governmental or third-party payor fraud or program abuse, been required to pay civil money penalties for the same or, excluded or precluded from participation in Medicare or Medicaid?

   ☐ Yes ☐ No

6. Have you ever been convicted of any felony or any misdemeanor?

   ☐ Yes ☐ No If yes, please attach a detailed explanation.

7. Have you ever had your medical staff appointment or any clinical privileges denied, revoked, suspended or terminated by any hospital for reasons related to clinical competence or professional conduct?

   ☐ Yes ☐ No If yes, please attach a detailed explanation.

8. Are you presently under investigation by any hospital, state or federal agency/authority, or have you resigned while under investigation from a medical staff?

   ☐ Yes ☐ No If yes, please attach a detailed explanation.

9. Have any professional liability claims, suits or judgments **ever** been filed against you? **If yes, please complete the attached form and provide a detailed explanation including current status of all claims.**

   ☐ Yes ☐ No

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THIS FORM MUST BE RETURNED WITH COPIES OF THE FOLLOWING DOCUMENTS:

A. Current license(s) to practice your profession;
B. Current DEA registration with a Virginia address;
C. Certificate of coverage from professional liability insurance carrier with Virginia limits;
D. Evidence of Board Certification status;
E. Current curriculum vitae listing all education, training and employment dates **in mm/yyyy format**;
F. A copy of a self-query with the National Practitioner Data Bank (see enclosed instructions);
G. A completed "delegate form" for online credentialing.
H. $150 application fee made payable to "StoneSprings Hospital Center"

I REQUEST AN APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF OF STONESPRINGS HOSPITAL CENTER.

I understand that the information requested on this pre-screening form is sought to enable the hospital to make an administrative determination as to whether or not I am eligible to receive an application. The pre-screening form does NOT constitute an application.

I hereby release from any and all liability, and agree not to take any legal action against, the hospital or its representatives for their actions in connection with evaluating the information provided on this form and determining whether or not I am eligible to receive an application. I understand that a determination that I am ineligible to receive an application does not give rise to any hearing rights under the Medical Staff Bylaws and/or Credentials Policy, and does not require a report the National Practitioner Data Bank.

Applicant Signature _____ Date _____

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MALPRACTICE HISTORY

(*Please copy and use a separate sheet for each claim/suit)*

Patient/Plaintiff_____

Physician/Defendant:_____

Date of Incident:_____

Date of Claim/Suit:_____

Allegations:_____

_____

What is (was) your involvement in the event? _____

How long is (was) the patient in your care? _____

What is (was) your status? Primary Defendant: _____
Co-Defendant: _____
Other: _____ _____

Identify other defendants: _____

Status of Claim/Suit:_____

Case number (if applicable):_____

If resolved, date resolved:_____

Resolution:_____

Settlement amount (if applicable):_____

If pending list dates for the following:
Settlement proceedings: _____
Mediation: _____
Trial: _____

Name/phone of involved carrier:_____

Other information in regard to this claim/suit:_____