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,

Dana Brooks

Director
Medical Staff Services

Encl: Request for Medical Staff Application Form

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

Online Credentialing for StoneSprings Hospital Center

Our online application process will provide you the capability to submit your credentialing requests with the HCA Credentialing Online (HCO) tool.

The HCO tool takes the manual paperwork and data entry credentialing processes and transforms them into an easy to use electronic process.

HCO Benefits

- Enable you to complete credentialing packet online for multiple HCA facilities
- Provide you with electronic access to create, modify, and submit your credentialing documents
- Electronic credentialing processes ensure accuracy and completeness of your data being considered

HCO Features

- Ability to establish a delegate to prepare the required forms and documentation for your approval
- Accessible to all providers having association to or seeking association to our facility
- Online attestation form completion

Learning about HCO and how to use it

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

Action Needed!

To ensure you have capability to receive and submit information online through the HCA Credentialing Online system, please complete and return the attached form notifying us that you will provide credentialing information personally or through a delegate.

Please complete the attached authorization form and return it with your Medical Staff pre-screening form to the Medical Staff Office at StoneSprings Hospital Center.

Hospital Corporation of America Providing Credentialing Services for HCA Affiliated Hospitals

Step 1

Please complete the contact information requested below.

Provider Name:_____

Provider Phone:_____

Provider Email (**required**):_____

NOTE: Provider email must be unique to the provider; 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 re-credentialing information. _____ *initial and skip to Step 3*

☐ I understand that one delegate for all entities is preferred; however, I have different people handle my credentialing at different entities. The delegate listed below is my primary delegate for HCA access.

☐ The delegate listed below is my delegate for all entities.

☐ I hereby authorize:

Delegate	
	name:
	email:
	phone: ( ) - ext.

(hereinafter, individually referred to as "Delegate") to access the HCA Credentialing Online web portal to enter data and submit documents for the HCA Requests for Considerations (RFC) and HCA Reappointment Requests for Information (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 HCA via the HCA Credentialing Online web portal.

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.

_____ _____

PROVIDER SIGNATRUE PRINTED NAME

_____ _____

SOCIAL SECURITY NUMBER or NPI DATE (MM/DD/YYYY)

Step 3

Please complete, sign and date. The form may be returned via:

1. Scanned and e-mailed to Dana.Brooks2@hcahealthcare.com
2. Faxed to 571-349-4081
3. U.S. mail to the following address:

StoneSprings Hospital Center
Medical Staff Office
24440 Stone Springs Blvd.
Dulles, VA 20166

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

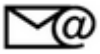
Go to: http://www.npdb.hrsa.gov/pract/howToGetStarted.jsp

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.

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 Claims/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 regards to this claim/suit:_____

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)

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

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 _____

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:_____