Division of Industrial Relations - Workers' Compensation Section

TREATING PANEL OF PHYSICIANS AND CHIROPRACTORS APPLICATION

Physician or Chiropractor

First Name: | Last Name: | Middle Init: | License Type: MD

NV License Nbr: | Expire Date:

Email:

Direct Email Address for Practitioner (will NOT be provided to public) / Credentialing Email NOT Acceptable

Specialties / Area(s) of Practice - Choose all that apply

- ☐ Addiction Medicine
- ☐ Anesthesiology
- ☐ Cardiology
- ☐ Cardio/Thoracic Surgery
- ☐ Chiropractic
- ☐ Gastroenterology
- ☐ Ear/Nose/Throat (ENT)
- ☐ Emergency/Critical Care
- ☐ Dermatology
- ☐ Endocrinology
- ☐ Family/General Practice
- ☐ General Surgery
- ☐ Genitourinary
- ☐ Hospitalist
- ☐ Immunology
- ☐ Infectious Disease
- ☐ Internal Medicine
- ☐ Maxillofacial/Oral Surgery
- ☐ Neurology
- ☐ Neurosurgery
- ☐ Occupational Medicine
- ☐ Ophthalmology
- ☐ Oncology
- ☐ Other (Specify)
- ☐ Orthopedic
- ☐ Pain Management
- ☐ Physiatry/Physical Medicine
- ☐ Psychiatry
- ☐ Pulmonology
- ☐ Radiology
- ☐ Urology

- ☐ Orthopedic Surgery - Spine
- ☐ Orthopedic Surgery - Shoulders
- ☐ Orthopedic Surgery - Elbows
- ☐ Orthopedic Surgery - Wrists
- ☐ Orthopedic Surgery - Hands
- ☐ Orthopedic Surgery - Hips
- ☐ Orthopedic Surgery - Knees
- ☐ Orthopedic Surgery - Ankles
- ☐ Orthopedic Surgery - Feet

Conditions / Disorders Of (by body system) - Choose all that apply

- ☐ Cardiovascular
- ☐ Circulatory/Vascular
- ☐ Digestive/Excretory
- ☐ Endocrine/Exocrine
- ☐ Infections
- ☐ Immune/Lymphatic
- ☐ Maxillofacial
- ☐ Mental/Behavioral Health
- ☐ Musculoskeletal
- ☐ Nervous
- ☐ Renal
- ☐ Reproductive
- ☐ Respiratory
- ☐ Other (Specify)
- ☐ Skin
- ☐ Urinary
- ☐ All (Generalist)

Body Parts Treated - Choose all that apply

- ☐ Arteries/Veins/Blood
- ☐ Brain - Mental/Behavioral
- ☐ Brain - Physical/Neurological
- ☐ Ears
- ☐ Eyes
- ☐ Face/Nose/Mouth Throat/Scalp
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Hand
- ☐ Arm (unspecified)
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Pelvis/Hips/Sacrum
- ☐ Lungs/Respiratory System
- ☐ Heart
- ☐ Trunk/Ribs
- ☐ Abdomen Gastrointestinal Tract, Liver
- ☐ Organs/Glands Pancreas, Spleen, Appendix
- ☐ Skin
- ☐ Skull
- ☐ Nerves
- ☐ Other (Specify)
- ☐ Genitourinary Genitalia, Kidneys, Urinary
- ☐ Reproductive System
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Leg (unspecified)
- ☐ All (Generalist)

TREATING PANEL OF PHYSICIANS AND CHIROPRACTORS APPLICATION

Primary Location

Legal Name of Practice:
Address 1:
City:
State:
Zip:
DBA Name:
Phone Nbr:
Fax Nbr:
County:

Additional Locations

Legal Name of Practice:
Address 1:
City:
State:
Zip:
DBA Name:
Phone Nbr:
Fax Nbr:
County:

Legal Name of Practice:
Address 1:
City:
State:
Zip:
DBA Name:
Phone Nbr:
Fax Nbr:
County:

Legal Name of Practice:
Address 1:
City:
State:
Zip:
DBA Name:
Phone Nbr:
Fax Nbr:
County:

Legal Name of Practice:
Address 1:
City:
State:
Zip:
DBA Name:
Phone Nbr:
Fax Nbr:
County:

Legal Name of Practice:
Address 1:
City:
State:
Zip:
DBA Name:
Phone Nbr:
Fax Nbr:
County:

TREATING PANEL OF PHYSICIANS AND CHIROPRACTORS APPLICATION

Physician/Chiropractor Name: _____ Date: _____

Check Yes or No.

Please explain answers marked with an * on a separate sheet along with supporting documentation including locations and dates.

☐ YES* ☐ NO Have you ever been licensed in a state other than Nevada? Please provide state(s) and dates.

☐ YES* ☐ NO Has your license to practice medicine/chiropractic in any jurisdiction ever been denied, revoked, voluntarily or invountarily terminated, relinquished, suspended, otherwise limited or restricted or been made subject to a program of probation, or have you ever been issued a citation or letter of reprimand by the licensing agency, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced?

☐ YES* ☐ NO Has disciplinary action ever been filed against you by any workers' compensation authority, Medicare or Medicaid (CMS), medical facility, health maintenance organization, or professional practice board/society/association for fraud, medical billing fraud, substance abuse, prescribing controlled substances or quality of patient care?

☐ YES* ☐ NO Have you ever been sanctioned for unprofessional conduct or discriminatory treatment in the care and/or treatment of patients in any state?

☐ YES* ☐ NO Have you ever utilized a treatment which is not sanctioned by your peers, medical authority or accepted treatment guidelines as being beneficial for the injury or disease involved?

☐ YES* ☐ NO Has your Drug Enforcement Agency or other controlled substances authorization ever been denied, revoked, voluntarily or involutarily terminated, suspended, or restricted or have formal or informal proceedings, or investigations toward any of those ends ever been commenced?

☐ YES* ☐ NO Have you ever been convicted of a criminal offense other than a minor traffic violation?

☐ YES* ☐ NO Has the State of Nevada, Division of Industrial Relations ever issued a warning to you or imposed an administrative fine on you?

☐ YES* ☐ NO Have you ever been suspended or removed from the State of Nevada Division of Industrial Relations Panel of Treating Physicians and Chiropractors or any other provider list as a disciplinary measure in Nevada or another state?

Please describe your experience treating injured employees in the area below. (Attach separate sheets of paper as needed).

TREATING PANEL OF PHYSICIANS AND CHIROPRACTORS APPLICATION

Physician/Chiropractor Name: _____ Date: _____

Please read and check each box indicating your understanding and agreement with each statement.

- ☐ The information provided is both complete and accurate to the best of my knowledge. I understand that providing inaccurate information or documentation may result in the denial of this application. Incomplete applications will not be processed.
- ☐ I have a special competency and interest in industrial health to treat injured employees under chapters 616A through 617, inclusive, of Nevada Revised Statutes (NRS) and Nevada Administrative Code (NAC).
- ☐ I agree to comply with Nevada's standards of care and use the ACOEM Guidelines adopted by the State of Nevada, Division of Industrial Relations pursuant to NRS 616C.250 and NAC 616C.123.
- ☐ I agree to comply with the provisions of Chapters 616A through 617, inclusive, of the NRS and NAC. Failure to do so may result in disciplinary action including suspension or removal from the Treating Panel of Physicians and Chiropractors (NAC 616C.006).
- ☐ I agree to notify the State of Nevada, Division of Industrial Relations (DIR) Workers' Compensation Section Medical Unit in writing of any changes to any of the information provided in this application packet including, but not limited to, legal name of practice, office address, specialty, licensing board status, email address, telephone number, and willingness/ability to treat Nevada's injured employees **within 14 calendar days of the change(s)**.
- ☐ I agree to comply with the billing practices and reimbursement described in the NRS and NAC and the Nevada Medical Fee Schedule for Workers' Compensation (available at http://dir.nv.gov/WCS/home/), which is updated annually.

I attest that I have read, and understood this completed application. I also understand and agree that my electronic signature below has the full force of the law of an original signature.

_____ _____

Physician / Chiropractor Signature Date

Save Completed Application As a New PDF. Do Not Scan.

******Completed Treating Panel of Physicians and Chiropractors applications must be emailed to:**

medpanels@business.nv.gov

If you have any questions, please contact the Medical Unit at (702) 486-9080