



MEDICAL STAFF CREDENTIALING APPLICATION FORM
For MD; DO; DDS; DMD; DC; DPM; PharmD; PhD; PsyD; OD.

APPLICANT NAME: _____ **SPECIALTY:** _____

*In order to expedite the credentialing process, please complete every item on this application. Please **DO NOT** write “see CV” or “refer to CV” in place of completing the information requested. Please enclose copies of the documentation listed below, and sign and date the attestation of accuracy and the consent and release form. Thank you for your assistance! “X” if enclosed*

APPLICATION CHECKLIST

- Current Professional Liability Insurance Certificate;
- Curriculum Vitae/Work History; (must include month & year)
- Areas of Specialization Form; (requirement for Behavioral Health applicants)
- Additional Locations information sheet; (enclosed)
- CLIA Certificate or Waiver; (as applicable)
- W9 Form;
- Signed and dated Consent and Release form.

FOR PLAN USE ONLY - To be completed by Provider Representative:

- Contract Maintenance Form (CMF) attached;
- Site Inspection Evaluation (SIE) (PCP, Ob/Gyn & High Volume Behavioral Health) attached; (if applicable)
- Letter of need (if required) is attached;
- Application information and supporting documentation has been reviewed;
- All information meets Plan criteria and documentation is current and complete.

Signature of Plan Provider Representative

Date

Signature of Plan In-house Representative

Date



Practitioner
Last Name: _____ **First Name** _____ **Middle Initial** ____ **Degree** _____

Primary Physical Office Address _____ City State Zip _____ for Additional Locations *(Please complete next page)*

County _____ Office Phone # _____ Office Fax # _____ Handicap Access (Y/N) Handicap Assistance (Y/N) Bus Rte. (Y/N)

Office Manager or Contact Name _____ Telephone and Extension *(If applicable)* _____ Email address *(for receiving email from Plan)* _____

Office Hours: Mon _____ Tues _____ Wed _____ Thu _____ Fri _____ Sat _____ Sun _____

Practice or Group Name _____

Name to whom checks should be made payable *(if different than Practice/Group name)* _____

Billing Address *(Location where payments will be sent)* _____ City _____ State _____ Zip _____

Billing Office Telephone Number _____ Billing Office Fax Number _____

Correspondence Address *(for credentialing purposes only)* _____ City _____ State _____ Zip _____

Office Phone # _____ Office Fax # _____ Contact Name _____

Patient Age Ranges

- 00 yrs - 21 yrs Pediatrics 00 yrs - 99+ yrs Family Practice 12yrs - 99+ yrs Internal Medicine
 12yrs - 99+ yrs Geriatric Medicine 2yrs - 99+ yrs General Practice 00yrs - 99+ General Practice for Health Dept Only

Other _____

General Information:

Gender: Male _____ Female _____ Date of Birth _____

Language(s) spoken in addition to English _____

For EEOC Compliance Requirements Only: *Please indicate the following:*

- African American Arabic Hispanic American
 Asian American Caucasian Native American



Practitioner Name: _____

Information Sheet Required for Additional Locations

(PLEASE PRINT)

Name of Provider/ Group / Practice Name: _____

List any additional Office Locations: Please include all necessary information listed below.

Second Physical Address: _____

Practice/Group Name: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Tax Identification Number: _____

Contact Name: _____

Handicapped Access Yes ___ No ___ Handicapped Assistance Yes ___ No ___ Bus Rte. Yes ___ No ___

Office Hours _____

Second Billing Address: _____

Checks payable to: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Tax Identification Number: _____

Contact Name: _____

Third Physical Address: _____

Practice/Group Name: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Tax Identification Number: _____

Contact Name: _____

Handicapped Access Yes ___ No ___ Handicapped Assistance Yes ___ No ___ Bus Rte. Yes ___ No ___

Office Hours _____

Third Billing Address: _____

Checks payable to: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Tax Identification Number: _____

Contact Name: _____

Please attach additional location information as necessary.



Practitioner Name: _____

REGULATORY **Please provide copy of document

Tax ID # ** (copy of W-9)		SS #
State License #		DEA #
CDS # (if applicable)		CSR # (if applicable)
Medicare Provider #		Medicaid Provider #
National Provider Identification # - Type 1 must be completed		CLIA Registration or Waiver # **
Type 1 – Individual Practitioner	Type 2 – Group	

SPECIALTY/TAXONOMY

Name of Specialty	Taxonomy Code

BOARD CERTIFICATION STATUS

Name of Specialty Board	Certification Status	Certification Date	Expiration Date

If not Board Certified in specialty requested, please indicate if you Plan on taking Board Certification yes no
 If yes, please indicate the date of the next Board Certification Examination _____

HOSPITAL AFFILIATIONS - Please list your primary admitting facility first. *If you are a PCP without hospital admitting privileges, please provide a completed hospital admitting arrangement form.*

Hospital Name	Hospital Location	Specialty of Privileges	Staff Status	Current & Unrestricted
				Y <input type="checkbox"/> N <input type="checkbox"/>
				Y <input type="checkbox"/> N <input type="checkbox"/>
				Y <input type="checkbox"/> N <input type="checkbox"/>

COVERING PHYSICIAN INFORMATION – If you are in solo practice, please provide name, address, phone and fax number of a Plan practitioner who will provide coverage for our members in your absence, including ability to hospitalize if necessary, and act as a peer reference. If you are a member of a group, please provide a list of group members and their specialty (ies):

_____	_____	_____	_____	_____
Last Name	First	Middle	Degree	Specialty
_____			_____	_____
Office Address, City, State, Zip Code			Office Phone #	Office Fax #



Practitioner Name: _____

ALLIED HEALTH PROFESSIONALS – Please list all Nurse Practitioners and Physician Assistants who may see members on your behalf.

<i>Name</i>	<i>Degree /License Type</i>	<i>License #</i>	<i>Specialty</i>

PEER REFERENCE INFORMATION – Please provide the name, address, phone and fax number of two practicing peers who are able to provide a reference as to your recent clinical practice.

Last Name	First	Middle	Degree	Specialty
Office Address, City, State, Zip Code			Office Phone #	Office Fax #

Last Name	First	Middle	Degree	Specialty
Office Address, City, State, Zip Code			Office Phone #	Office Fax #

EDUCATION - Please provide full address

Professional School	Degree Type	Year of Graduation

TRAINING - Please complete separate sheet if necessary

Internship/Residency/Fellowship Training	Specialty of Training	Dates of Training
Internship - Name and campus location of Facility		
Residency - Name and campus location of Facility		
Fellowship - Name and campus location of Facility		



Practitioner Name: _____

Liability Insurance Attestation

Name of Insurer: _____

Address: _____

City, State: _____

Telephone number: _____

Facsimile: _____

Policy Number: _____

Effective date: _____

End date: _____

Retroactive Date ; _____

Policy Limits: Occurance _____

Aggregate _____

The above information is true and correct as of the signature date listed below.

Provider Name (print)

Provider Name (signature)

Date



Practitioner Name: _____

QUESTIONNAIRE - If the answer to any question is yes, please provide details on a separate sheet.

<i>Please answer the following questions by checking the appropriate box:</i>	YES	NO
Do you have any physical or mental health problems or limitations in ability that may affect your ability to practice medicine and provide health care with reasonable skill and safety?		
Do you have any history of chemical dependency/substance abuse?		
Have you been the subject of an investigation, or have proceedings <i>ever</i> been initiated to have your license to practice limited, suspended, revoked, denied, sanctioned or subject to probationary conditions, or have you voluntarily or involuntarily relinquished your license in this or any other state?		
Has your narcotics registration certificate <i>ever</i> been voluntarily or involuntarily relinquished, limited, suspended, sanctioned or revoked, or are any such actions pending?		
Have you been the subject of an investigation, or have you <i>ever</i> been suspended, sanctioned or otherwise restricted from participating in any private, state, or federal health insurance program, for example Medicare or Medicaid?		
Have you <i>ever</i> been named a defendant in a criminal proceeding?		
Has your medical staff membership, employment, or medical staff status at any health care institution, <i>ever</i> been rejected, limited, suspended, revoked, not renewed or subject to probationary conditions, or have you been the subject of an investigation, or, relinquished medical staff membership or clinical privileges while under investigation or disciplinary action, or are any such actions pending?		
In the last five years, have you been a defendant in a malpractice/professional liability suit, or are there currently any pending or potential suits against you, or, have any judgments been made or settlements paid on your behalf?		
Have you <i>ever</i> been denied professional liability insurance coverage or had your professional liability insurance coverage cancelled by your carrier for reasons other than the carrier's termination of operation in your state?		
Have you <i>failed</i> to meet the State Licensure requirements for continuing medical education?		
Have you opted out of Medicare?		

AFFIRMATION OF ACCURACY AND COMPLETENESS

I understand I have the responsibility for producing adequate information for proper evaluation of my qualifications and for addressing any concerns about such qualifications. I understand that a condition of this application is that any misrepresentation or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and it shall not be processed any further. In the event credentialing information received from other sources substantially varies from that provided by me, I will be notified by the Company, and I understand I will be given the opportunity to correct such information. In the event that my application is rejected for this reason, I may not be entitled to any hearing, appeal or other due process rights as may otherwise be provided in the Policies and Procedures of the Company. I affirm that information provided in or attached to this application is correct and complete. I affirm that I adhere to the principles of ethics of the American Medical Association, the American Osteopathic Association or other appropriate professional organization. I affirm the ability to perform or directly supervise the ambulatory primary care services of members (as applicable). I affirm that nurse practitioners or physician assistants (if any) under my supervision are performing within the scope of their licensure.

7-2008 – HI - MS



Practitioner Name: _____

APPLICANT’S RELEASE AND HOLD HARMLESS

By applying for provider participation, I accept the following conditions. These conditions shall remain in effect for the duration of any term of participation I may be granted.

I acknowledge that the Company may at its sole discretion share or disclose the information provided in the credentialing and re-credentialing process to affiliates and subsidiaries or other related entities of the Company.

- (1) I release and hold harmless the Company, its authorized representatives and third parties, as defined below, for any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken or received by the Company or its authorized representatives in good faith, relating to matters or inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; or any other matter that might directly or indirectly have an effect on my competence, on patient care, or on the orderly operation of this health care organization.
- (2) I authorize the Company and its authorized representatives to consult with any third party who may have information bearing on my professional qualifications (credentials). This authorization includes the right to inspect or obtain clinical privileges, documents, recommendations, reports, statements or disclosures relating to such questions. I also authorize said third parties to release this information to the Company and its authorized representatives upon request.
- (3) The term “Company and its authorized representatives” means any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application:
 - a. members of the Board and its appointed representatives;
 - b. the Chief Executive Officer or his/her designee;
 - c. all appointees to committees;
 - d. Company employees;
 - e. consultants to the Company;
 - f. the Company’s attorney and members of his/her firm, associates or designee;
 - g. delegated or sub-delegated agency with which the Company contracts for credentialing purposes.
- (4) The term “third parties” means the following:
 - a. government agencies;
 - b. professional liability insurance carriers;
 - c. peer references;
 - d. hospital affiliations;
 - e. delegated or sub-delegated agency with which the Company contracts for credentialing purposes.

SIGNATURE OF APPLICANT

DATE

PRINTED NAME