



Provider Application

CORRECT NUMBERS AND LETTERS

A B C 1 2 3

CORRECT MARK X

INCORRECT MARKS ~~W~~ ✓

CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING, COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Instructions

Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays

1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1

Personal Information and Professional IDs

Provider Type

Code list is found on page 36. Enter the associated 3-digit code in the space provided.*

YES

NO

DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name

Do not use nicknames or initials, unless they are part of your legal name.

LAST NAME*

SUFFIX (JR, III)

FIRST NAME*

MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?*

YES

NO

IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME

SUFFIX (JR, III)

OTHER FIRST NAME

OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME

DATE STOPPED USING OTHER NAME

General Information

Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

GENDER*

MALE

FEMALE

DATE OF BIRTH*

CITY OF BIRTH

STATE OF BIRTH

COUNTRY OF BIRTH

SSN*

FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN)

FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

Home Address

NUMBER

STREET

APT NUMBER

CITY

STATE

ZIP CODE

TELEPHONE

NOTE: CAQH will use this method for application follow-up.

E-MAIL

FAX

PREFERRED METHOD OF CONTACT*

E-MAIL

FAX

3076

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1

Personal Information and Professional IDs (Continued)

Professional IDs

Include all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/certifications.

Non-licensed professionals should enter certification/registration number in the space provided for license number.

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

FEDERAL DEA NUMBER			DEA ISSUE DATE		
DEA STATE OF REGISTRATION			DEA EXPIRATION DATE		
CDS CERTIFICATE NUMBER			CDS ISSUE DATE		
CDS STATE OF REGISTRATION			CDS EXPIRATION DATE		
STATE LICENSE NUMBER			LICENSE ISSUING STATE	LICENSE ISSUE DATE	
IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE?	YES	NO		LICENSE EXPIRATION DATE	
LICENSE STATUS CODE	Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.		LICENSE TYPE	Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.	
STATE LICENSE NUMBER			LICENSE ISSUING STATE	LICENSE ISSUE DATE	
IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE?	YES	NO		LICENSE EXPIRATION DATE	
LICENSE STATUS CODE	Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.		LICENSE TYPE	Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.	

Other ID Numbers

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

ARE YOU A PARTICIPATING MEDICARE PROVIDER?*	YES	NO	MEDICARE NUMBER	UPIN	
ARE YOU A PARTICIPATING MEDICAID PROVIDER?*	YES	NO	MEDICAID NUMBER		MEDICAID STATE
NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER			USMLE NUMBER (WITHOUT HYPHENS)		
WORKERS COMPENSATION NUMBER					

0	ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)	ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY)
---	--	--

3077

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2**Education and Training****Undergraduate School(s)**

Provide the appropriate information for the school that issued your undergraduate degree and all schools attended.

Professional School(s)

Provide the appropriate information for the school that issued your professional degree.

Fifth Pathway Graduates please complete the following sections: U.S. School that issued your certificate, the Non-U.S. School where you attended, and the Fifth Pathway Institution where you completed your training on Supplemental Page 20.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Undergraduate or Professional Schools to report, use the Education Supplemental Form on page 20.

UNDERGRADUATE SCHOOL

OFFICIAL NAME OF UNDERGRADUATE SCHOOL

ADDRESS

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

START DATE

END DATE (GRADUATION DATE)

DEGREE AWARDED

DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL?

YES

NO

GRADUATE TYPE*:

U.S. OR CANADIAN GRADUATE

NON-U.S./CANADIAN GRADUATE

FIFTH PATHWAY GRADUATE

U.S. OR CANADIAN SCHOOL

SCHOOL CODE (U.S./CANADIAN ONLY)

NAME OF U.S./CANADIAN SCHOOL:

START DATE*

END DATE (GRADUATION DATE)*

DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?

YES

NO

NON - U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL

ADDRESS

CITY

COUNTRY CODE

POSTAL CODE

START DATE*

END DATE (GRADUATION DATE)*

DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?

YES

NO

3078

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2

Education and Training (Continued)

Training

List all training programs you attended. Use one section per institution.

If you have additional post-graduate training programs, use the Supplemental Training Form on page 21.

Please explain on the Supplemental Professional / Work History Gap Form on page 33 any training gap(s) of three (3) months or greater, or any gap(s) of a shorter duration if required by the organization for which you are being credentialed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)

INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION?

YES

NO

(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)

List each department separately, if applicable.

INTERNSHIP/
RESIDENCY

FELLOWSHIP

OTHER

START DATE

END DATE

List Internship/Residency, Fellowship and Other programs separately.

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/
RESIDENCY

FELLOWSHIP

OTHER

START DATE

END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/
RESIDENCY

FELLOWSHIP

OTHER

START DATE

END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

3080

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3

Professional / Medical Specialty Information

Primary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE			INITIAL CERTIFICATION DATE			DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO	YES	NO
BOARD CERTIFIED?	YES	NO	RECERTIFICATION DATE (IF APPLICABLE)				PPO	YES	NO
CERTIFYING BOARD CODE			EXPIRATION DATE (IF APPLICABLE)				POS	YES	NO
IF NOT BOARD CERTIFIED (SELECT ONE)	I HAVE TAKEN EXAM, RESULTS PENDING FOR		I INTEND TO SIT FOR AN EXAM ON		I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.				
CERTIFYING BOARD CODE									
IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.									

Secondary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Professional / Medical Specialties to report, use the Additional Specialties Supplemental Form on page 22.

SPECIALTY CODE			INITIAL CERTIFICATION DATE			DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO	YES	NO
BOARD CERTIFIED?	YES	NO	RECERTIFICATION DATE (IF APPLICABLE)				PPO	YES	NO
CERTIFYING BOARD CODE			EXPIRATION DATE (IF APPLICABLE)				POS	YES	NO
IF NOT BOARD CERTIFIED (SELECT ONE)	I HAVE TAKEN EXAM, RESULTS PENDING FOR		I INTEND TO SIT FOR AN EXAM ON		I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.				
CERTIFYING BOARD CODE									
IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.									

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3 Professional / Medical Specialty Information (Continued)

Certifications

Do you hold the following certifications? If yes, provide expiration dates.

	EXPIRATION DATE			EXPIRATION DATE	
BASIC LIFE SUPPORT?*	YES	NO	ADV LIFE SUPPORT IN OB?*	YES	NO
CPR?*	YES	NO	ADV TRAUMA LIFE SUPPORT?*	YES	NO
ADV CARDIAC LIFE SPT?*	YES	NO	PEDIATRIC ADVANCED LIFE SPT?*	YES	NO
NEONATAL ADVANCED LIFE SPT?*	YES	NO			

Practice Interests

Provide additional areas of professional practice interest, activities, procedures, diagnoses or populations.

Primary Credentialing Contact

CHECK HERE TO USE THE OFFICE MANAGER AND ADDRESS OF THE PRIMARY PRACTICE LOCATION AS THE CREDENTIALING INFORMATION.

LAST NAME

FIRST NAME M.I.

NUMBER STREET SUITE/BUILDING

CITY STATE ZIP CODE

TELEPHONE FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the e-mail address, if available.

3082

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information

Primary Practice Location

NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT QUESTION ABOVE. SECTION 4 MAY BE LEFT BLANK. YOU MAY PROCEED TO SECTION 5 ON PAGE 11.

If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 25-29.

NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

CURRENTLY PRACTICING AT THIS ADDRESS?*	YES	NO	IF NO, WHAT IS YOUR EXPECTED START DATE?
PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*			
GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)			
NUMBER*	STREET*		SUITE/BUILDING
CITY*	STATE*		ZIP CODE*
SEND GENERAL CORRESPONDENCE HERE?*	YES	NO	
	TELEPHONE*		FAX
OFFICE E-MAIL ADDRESS			
INDIVIDUAL TAX ID		GROUP TAX ID	PRIMARY TAX ID (ONE ONLY)* USE INDIVIDUAL TAX ID USE GROUP TAX ID

Office Manager or Business Office Staff Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME*			
FIRST NAME*			M.I.
TELEPHONE*		FAX	
E-MAIL ADDRESS			

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Billing Contact.

LAST NAME*			
FIRST NAME*			M.I.
NUMBER*	STREET*		SUITE/BUILDING
CITY*	STATE*		ZIP CODE*
TELEPHONE*		FAX	
E-MAIL ADDRESS			

3083

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information (Continued)

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* YES NO
 BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS PAYEE INFORMATION

LAST NAME* M.I.
 FIRST NAME*
 NUMBER* STREET* SUITE/BUILDING
 CITY* STATE* ZIP CODE*
 TELEPHONE* FAX
 E-MAIL ADDRESS

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Payee Contact.

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE?* IF YES AFTER HOURS BACK OFFICE TELEPHONE

YES	NO	ANSWERING SERVICE	VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE	VOICE MAIL WITH OTHER INSTRUCTIONS
-----	----	-------------------	--	------------------------------------

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?*	YES	NO	ACCEPT ALL NEW PATIENTS?*	YES	NO
ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?*	YES	NO	ACCEPT NEW MEDICARE PATIENTS?*	YES	NO
ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?*	YES	NO	ACCEPT NEW MEDICAID PATIENTS?*	YES	NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN (USE BOTH LINES IF REQUIRED)

ARE THERE ANY PRACTICE LIMITATIONS?*

YES	NO	IF YES	GENDER LIMITATIONS MALE ONLY NONE FEMALE ONLY	AGE LIMITATIONS MINIMUM AGE MAXIMUM AGE	LIST OTHER LIMITATIONS
-----	----	--------	--	---	------------------------

3084

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information (Continued)

Mid-Level Practitioners

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE? * YES NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

3085

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Practice Location Information (Continued)

Languages

Code lists are found on pages 37. Enter the associated 3-digit code in the space provided.

LANGUAGES
NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

		LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE
INTERPRETERS AVAILABLE?*	YES	NO	LANGUAGES INTERPRETED	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

		DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?*	YES	NO	ACCESSIBLE BY PUBLIC TRANSPORTATION?*	YES	NO	
BUILDING?*	YES	NO	TEXT TELEPHONY (TTY)*	YES	NO	BUS*	YES	NO
PARKING?*	YES	NO	AMERICAN SIGN LANGUAGE*	YES	NO	SUBWAY*	YES	NO
RESTROOM?*	YES	NO	MENTAL/PHYSICAL IMPAIRMENT SERVICES*	YES	NO	REGIONAL TRAIN*	YES	NO

OTHER HANDICAPPED ACCESS **OTHER DISABILITY SERVICES** **OTHER TRANSPORTATION ACCESS**

Services

Does this location provide any of the following services?

LABORATORY SERVICES?	YES	NO	IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)								
RADIOLOGY SERVICES?	YES	NO	IF YES, PROVIDE X-RAY CERTIFICATION TYPE								
EKG'S?	YES	NO	ALLERGY INJECTIONS?	YES	NO	ALLERGY SKIN TESTING?	YES	NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)?	YES	NO
DRAWING BLOOD?	YES	NO	AGE APPROPRIATE IMMUNIZATIONS?	YES	NO	FLEXIBLE SIGMOIDOSCOPY?	YES	NO	TYMPANOMETRY/ AUDIOMETRY SCREENING?	YES	NO
ASTHMA TREATMENT?	YES	NO	OSTEOPATHIC MANIPULATION?	YES	NO	IV HYDRATION/ TREATMENT?	YES	NO	CARDIAC STRESS TEST?	YES	NO
PULMONARY FUNCTION TESTING?	YES	NO	PHYSICAL THERAPY?	YES	NO	CARE OF MINOR LACERATIONS?	YES	NO			

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO **IF YES, WHAT CLASS/CATEGORY DO YOU USE?**

IF YES, WHO ADMINISTERS IT?

		LAST NAME	FIRST NAME
TYPE OF PRACTICE (SELECT ONE ONLY)*	SOLO PRACTICE	SINGLE SPECIALTY GROUP	MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

3086

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information (Continued)

**Partners/
Associates**

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME	FIRST NAME	M.I.	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	PROVIDER TYPE (CODE PG 38)

**Covering
Colleagues**

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME	FIRST NAME	M.I.	SPECIALTY CODE	PROVIDER TYPE (CODE PG 38)

Section 5

Hospital Affiliations

**Admitting
Arrangements**

DO YOU HAVE HOSPITAL PRIVILEGES?*	YES	NO	IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?
-----------------------------------	-----	----	--

3087

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 5

Hospital Affiliations (Continued)

Hospital Privileges

If applicable, list all hospital affiliations. List primary hospital, then other current affiliations, followed by previous affiliations in chronological order.

If you have additional hospital privileges, use the Supplemental Hospital Privileges Form on page 30.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

PRIMARY HOSPITAL

HOSPITAL NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP CODE

TELEPHONE

FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME

M.I.

AFFILIATION START DATE

AFFILIATION END DATE

FULL, UNRESTRICTED PRIVILEGES?

YES

NO

ARE PRIVILEGES TEMPORARY?

YES

NO

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?

%

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

OTHER HOSPITAL

HOSPITAL NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP CODE

TELEPHONE

FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME

M.I.

AFFILIATION START DATE

AFFILIATION END DATE

FULL, UNRESTRICTED PRIVILEGES?

YES

NO

ARE PRIVILEGES TEMPORARY?

YES

NO

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?

%

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

PLEASE EXPLAIN TERMINATED AFFILIATION

3088

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6

Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

IMPORTANT
IF YOU DO NOT
CARRY
MALPRACTICE
INSURANCE, CHECK
THIS BOX AND SKIP
THIS SECTION.

				SELF-INSURED?*		YES	NO
CARRIER OR SELF-INSURED NAME*							
NUMBER*	STREET*		SUITE/BUILDING				
CITY*			STATE*	ZIP CODE*			
		TYPE OF COVERAGE?*		INDIVIDUAL	SHARED		
ORIGINAL EFFECTIVE DATE*	EFFECTIVE DATE*		EXPIRATION DATE				
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?*		YES	NO	AMOUNT OF COVERAGE PER OCCURRENCE		AMOUNT OF COVERAGE AGGREGATE	
POLICY INCLUDES TAIL COVERAGE?		YES	NO				
POLICY NUMBER*							

Professional Liability Insurance Carrier

List other current, future, or previous carrier(s) if current carrier is less than ten (10) years.

NOTE: A longer period may be required by your healthcare entity.

If you have additional insurance, use the Supplemental Insurance Form on page 31.

				SELF-INSURED?		YES	NO
CARRIER OR SELF-INSURED NAME							
NUMBER*	STREET*		SUITE/BUILDING				
CITY*			STATE*	ZIP CODE*			
		TYPE OF COVERAGE?*		INDIVIDUAL	SHARED		
ORIGINAL EFFECTIVE DATE*	EFFECTIVE DATE*		EXPIRATION DATE				
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?*		YES	NO	AMOUNT OF COVERAGE PER OCCURRENCE		AMOUNT OF COVERAGE AGGREGATE	
POLICY INCLUDES TAIL COVERAGE?		YES	NO				
POLICY NUMBER*							

Section 7

Work History and References

Military Duty

Are you currently on active military duty or military reserve?*

YES NO

Work History

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity.

If you have additional work history, use the Supplemental Work History Form on page 32.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER STREET SUITE/BUILDING

CITY STATE ZIP/POSTAL CODE

3089

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7

Work History and References (Continued)

Work History

Do not list current positions. Those should be listed in Section 4.

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity

If you have additional work history, use the Supplemental Work History Form on page 32.

TELEPHONE

FAX

COUNTRY CODE

START DATE

END DATE

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

TELEPHONE

FAX

COUNTRY CODE

START DATE

END DATE

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

TELEPHONE

FAX

COUNTRY CODE

START DATE

END DATE

REASON FOR DEPARTURE (IF APPLICABLE)

3090

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7

Work History and References (Continued)

Gaps in Professional / Work History

PLEASE EXPLAIN ANY TIME PERIODS OR GAPS IN TRAINING OR WORK HISTORY THAT HAVE OCCURRED SINCE GRADUATION FROM PROFESSIONAL SCHOOL AND ARE LONGER THAN THREE MONTHS IN DURATION OR OF A SHORTER DURATION IF REQUIRED BY THE ORGANIZATION FOR WHICH YOU ARE BEING CREDENTIALLED.

GAP START DATE GAP END DATE

If you have additional professional / work history gaps, use the Supplemental Professional Work History Gaps Form on page 33.

Professional References

Provide three professional references to whom you are not related or are not partners in your practice.

Code lists are found on pages 36-43. Enter the associated 3-digit code for provider type.

NOTE:

You are required to provide exactly 3 references. Your application will not be complete without this information.

LAST NAME*

FIRST NAME*

PROVIDER TYPE (CODE PG 38)

NUMBER*

STREET*

APT/SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE

FAX

LAST NAME*

FIRST NAME*

PROVIDER TYPE (CODE PG 38)

NUMBER*

STREET*

APT/SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE

FAX

LAST NAME*

FIRST NAME*

PROVIDER TYPE (CODE PG 38)

NUMBER*

STREET*

APT/SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE

FAX

3091

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8

Disclosure Questions

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

Allied Health Providers

If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".

LICENSURE

- 1. YES NO Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?*
- 2. YES NO Has there been any challenge to your licensure, registration or certification?*

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

- 3. YES NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*
- 4. YES NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*
- 5. YES NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*

EDUCATION, TRAINING AND BOARD CERTIFICATION

- 6. YES NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*
- 7. YES NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*
- 8. YES NO Have any of your board certifications or eligibility ever been revoked?*
- 9. YES NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

- 10. YES NO Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

- 11. YES NO Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*

OTHER SANCTIONS OR INVESTIGATIONS

- 12. YES NO Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
- 13. YES NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*
- 14. YES NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*
- 15. YES NO Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*
- 16. YES NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

- 17. YES NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*
- 18. YES NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

3092

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.