Provider Application

CORRECT NUMBERS AND LETTERS	A	BC	1 2	3	CORRECT MARK		NCORRECT MARKS	M	\checkmark	•	соммо	N ABBF	REVIATIO	NS, AN		DE MAT	FORMATTII CHING. PLI LP DESK.			
Instructions Read all instructions carefully prior to submitting your application.		2. Use a 3. Print le 4. Do no 5. Comp 6. Some	lete onl blue or egibly a t enter lete all fields u	y this a black nd insi more t sectior ise "co	g delays application ar ink ball-poini ide the boxes han 1 charac han 1 charac han 1 charac han 2 charac han 2 charac han 3 charac han	t pen o s provio ter per oplicabl you ea	nly. Do led base box. If r e to you sily repo	not use ed upoi necess i. ort info	e a pe n the ary, v rmati	encil exar vrite on (e	or a felt- nples giv outside f e.g., scho	-tipper ven at the pro cols, la	n. bove. ovided anguaç	space ges). C	es. Code list	s are t	found on			
SECTION 1		Persona	al Info	rmati	on and Pr	ofess	ional	IDs												
Provider Type			asso		ound on page 30 digit code in th		he		YES		NO (E.G.	PATHO	LOGISTS	, ANES	THESIOLO	GISTS,	THE INPAT , ER PHYSI N ASSISTA	CIANS,	NURSE	
Name Do not use nicknames or initials, unless they are part of your legal name.		LAST NAME*																SUFF	IX (JR, III))
		FIRST NAME* HAVE YOU E	VER USE	DANOTI	HER NAME?*	YE	s	NO	I	F YES		LIST A		R NAME	ES USED A	AND TH	EIR DATES	OF US	EBELO	N.
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General Information Only enter a Foreign National Identification Number if you do not		GENDER*	M	ALE	FEMALE			DATE	OF BI	RTH∗	MM	D	D	ΥY	, Y	Y				
have a SSN. Do not enter National Provider Identification (NPI) Number here.	r	CITY OF BIRTH	1												STATE OF BIRTH	-	COUNTRY BIRTH	ſ OF		
Code lists are found or pages 36-43. Enter the	e	SSN*						FC	REIGN	ΝΑΤΙΟ	DNAL IDEN	TIFICATIO	ON NUMB	ER (FNIN)		FNIN C	OUNTRY	OF ISSU	IE
associated 3-digit code in the space provided.	9	ENTER ALL NO			LANGUA	GE CODE	LAN	GUAGE (CODE	L	ANGUAGE	CODE	LA	NGUAGE	CODE	LAN	GUAGE COL	DE		
Home Address	5	NUMBER			STREET												APT NUM	BER		
		СІТҮ	-												STATE		ZIP CODE	E		
NOTE: CAQH will use this method for application follow-up.		E-MAIL								PR	REFERRED	METHO	DD OF CO	ONTACT	-*	E-MAIL		FAX		
L								3	07	6										┥

I	* 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	FEDERAL DEA NUMBER M M D Y Y Y DEA STATE OF REGISTRATION DEA EXPIRATION DATE
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 Durfoceing IDS	CDS CERTIFICATE NUMBER M M D D Y Y Y Y CDS CERTIFICATE NUMBER CDS ISSUE DATE CDS STATE OF REGISTRATION CDS EXPIRATION DATE STATE LICENSE NUMBER LICENSE ISSUING STATE IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO M M D D Y Y Y Y LICENSE STATUS CODE Code list is found on page 36; use license status codes. Enter
Professional IDs Supplemental Form on page 19.	3-digit code in space provided. 3-digit code in space provided. 3-digit code in space provided. M M D D Y Y Y Y LICENSE ISSUING STATE LICENSE ISSUE DATE LICENSE ISSUE DATE M M D D Y Y Y Y LICENSE ISSUE DATE M M D D Y Y Y Y LICENSE ISSUE DATE LICENSE STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO LICENSE STATE
Other ID Numbers If you have additional Professional IDs to report, use the Professional IDs	Code list is found on page 36; use license status codes. Enter 3-digit code in space provided. LICENSE STATUS CODE ARE YOU A PART- ICIPATING MEDICARE YES NO PROVIDER?* ARE YOU A PART- ICIPATING MEDICAID YES NO PROVIDER?* MEDICAID NUMBER MEDICAID NUMBER MEDICAID NUMBER MEDICAID NUMBER MEDICAID NUMBER MEDICAID STATE
Supplemental Form on page 19.	NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER USMLE NUMBER (WITHOUT HYPHENS) WORKERS COMPENSATION NUMBER O C C C C C C C C C C C C C
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Section 2	Education and Training					
Undergraduate	UNDERGRADUATE SCHO	OL				
School(s)						
Provide the appropriate information for the	OFFICIAL NAME OF UNDERGRADUATE SCH					
school that issued your undergraduate degree						
and all schools						
attended.	ADDRESS					
	СІТҮ		STATE	ZIP/POSTAL CO	DE	
Professional School(s)						
Provide the appropriate	COUNTRY CODE	TELEPHONE		FAX		
information for the	MMYYYY	MMYYYY				
school that issued your professional degree.	START DATE	END DATE (GRADUATION DATE)	DI	EGREE AWARDED		
Fifth Pathway Graduates						
please complete the following sections: U.S.	UNDERGRADUATE EDUCATION YES AT THIS SCHOOL?	S NO				
School that issued your						
certificate, the Non-U.S. School where you	GRADUATE TYPE*:					
attended, and the Fifth Pathway institution						
where you completed	U.S. OR CANADIAN GRADUATE	NON-U.S./CANADIAN GRADUATE		FIFTH PA	THWAY GRADUATE	
your training on Supplemental Page 20.	U.S. OR CANADIAN SCHO	OL				
Code lists are found on	SCHOOL CODE (U.S./	NAME OF U.S./				
pages 36-43. Enter the associated 3-digit code	CANADIAN ONLY)	CANADIAN SCHOOL:				
in the space provided.	MMYYYY	ΜΜΥΥΥΥ				
If you have additional	START DATE*	END DATE (GRADUATION DATE)*	DI	EGREE AWARDED		
Undergraduate or Professional Schools to	DID YOU COMPLETE YOUR					
report, use the Education Supplemental	GRADUATE EDUCATION AT THIS YES SCHOOL?	S NO				
Form on page 20.						
	NON - U.S. OR CANADIAN	SCHOOL				
	OFFICIAL NAME OF NON-U.S. PROFESSIONAL	SCHOOL				

3078

END DATE (GRADUATION DATE)*

COUNTRY CODE

POSTAL CODE

DEGREE AWARDED

YES

NO

ADDRESS

START DATE*

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?

CITY

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In the space provided. Use in the space provided. Pos YES In the space provided. Intervention Intervention Intervention Intervention In the space provided. Intervention Intervention Intervention Intervention Intervention Secondary Secondary <td>pages 36-43. Enter the</td> <td>BOARD CERTIFIED?</td> <td>YES</td> <td>NO</td> <td>DATE</td> <td>M</td> <td>M</td> <td>D</td> <td>) Y</td> <td></td> <td></td> <td></td> <td>(</td> <td></td> <td></td> <td></td> <td></td> <td>PF</td> <td>oo</td> <td>YES</td> <td></td> <td>NO</td>	pages 36-43. Enter the	BOARD CERTIFIED?	YES	NO	DATE	M	M	D) Y				(PF	oo	YES		NO
BOARD CERTIFICD EXAM ON ID ON THE NUMBER OF OR BOARD CREED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAN, OTHERWISE LEAVE THE SPACE BLANK. IM M D D Y Y Y Y CERTIFYING BOARD CODE IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAN, OTHERWISE LEAVE THE SPACE BLANK. Im M D D Y Y Y Y Secondary Speciality SPECIALTY CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAN, OTHERWISE LEAVE THE SPACE BLANK. Im M D D Y Y Y Y Code lists are found on pages 38-43. Enter the space BLANK RECERTIFICATION DATE M D D Y Y Y Y PO O YOU WISH TO BE LISTED IN THIS SPECIALTY PPO VES Pages 38-43. Enter the sassociated 3-digit code EXAM RESULTS EXAM RESULTS PPO VES If you have additional Professional/ Medical YES NO RECERTIFICATION DATE M D D Y Y Y Y POS YES If you have additional Professional/ Medical FAD EXAM RESULTS INTEND TO TAKE A CERTIFYING BOARD CODE ID ONOT INTEND TO TAKE A CERTIFYING BOARD CODE If you have additional Specialities for profin profile IM D D Y Y Y Y POS YES ID ONOT INTEND TO TAKE A CERTIFYING BOARD CODE If you have additional Specialities for profile IM D D Y Y Y Y ID ONOT INTEND TO TAKE A CERTIFYING BOARD CODE ID ONOT INTEND TO TAKE A CERTIFYING BOAR		BOARD					Μ	D [Y	Y	(PC	s	YES		NO
ONE Image: CERTIFYING BOARD CODE F 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 Image: Certifying Board Code Speciality Image: Certifying Board Code Code lists are found on pages 36-43. Enter the space provided. Speciality If you have additional Professional / Medical Specialities to report, use the Additional Professional / Medical Specialities to report, use the Additional Professional / Medical Specialities to report, use the Additional Professional / Medical Specialities to report, use the Additional Professional / Medical Specialities to report, use the Additional Professional / Medical Speciality Image: Image		BOARD CERTIFIED	EXAM, R	RESULTS					T FOR	AN												
FYOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE POLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK. Image: Secondary Specialty Code lists are found on the space provided. BOARD Certifying Describe Visit Professional Medical Specialties to report, use the Additional Specialties to report.						Μ	М	D			Y	Y	(
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Specialty Code								EXAM,	PLEAS	E USE	THE											
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Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided. NO RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y PPO YES If you have additional Professional / Medical Specialties to report, use the Additional Specialties Image: Certifying Board code Image					CERTIFICATIO	DN 🚺	M	D	D	Y	Y	Y	Y		BE LI THE C	STED IN	1		нмо	YES		N
pages 30-43. Entire the Entire the associated 3-digit code in the space provided. If you have additional Professional / Medical Specialties to report, IF NOT Use the Additional If Not Specialties Internet the Supplemental Form on Page 22. If You Indicated That you did not intend to take A CERTIFYING BOARD code		CERTIFIED?	YES	NO	DA	TE 🚺	M	D	D	Y	Y	Y	Y						PPO	YES		N
If you have additional Professional / Medical Specialties to report, use the Additional Supplemental Form on page 22.	associated 3-digit code	CERTIFYING BOARD			EXPIRATION DAT	re .	I M	D	D	Y	Y	Y	Y						POS	YES	;	N
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Section 3	Professi	ional / M	ledio	cal S	Spe	cial	ty l	nfor	mat	ion	(Co	ntinued	l)											
Certifications	Do you hold t	he following	certifi	cation	ns? If	yes, p	orovid	le exp	iratior	n date	s.													
	BASIC LIFE		_	EXPI	RATIO	N DAT	E					ADV LI	FE	_			EXP	IRATIC	N DAT	E				
	SUPPORT?*	YES	NO	М	Μ	D	D	Y	Y	Y	Y	SUPPO OB?*			YES	NO	Μ	M	D	D	Y	Y	Y	Y
	CPR?*	YES	NO	Μ	Μ	D	D	Y	Y	Y	Y	ADV TF LIFE SUPPO			YES	NO	Μ	Μ	D	D	Y	Y	Y	Υ
	ADV CARDIAC LIFE SPT?*	YES	NO	Μ	М	D	D	Y	Y	Y	Y	PEDIA1 ADVAN LIFE SF	ICED		YES	NO	Μ	Μ	D	D	Y	Y	Y	Y
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Practice Interests																								
Provide additional areas of professional practice interest,																								
activities, procedures, diagnoses or populations.																								
Primary																								
Credentialing Contact	LAST NAME																							
CHECK HERE TO USE THE OFFICE	FIRST NAME																							M.I.
MANAGER AND ADDRESS OF THE PRIMARY PRACTICE]																					
LOCATION AS THE CREDENTIALING INFORMATION.	NUMBER			STRE	ET															SUITE	/BUILDI	ING		
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available.	E-MAIL ADDRES	55																						
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Section 4	Practice Loc	ation In	orma	tion																
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Location	CURRENTLY PRACTICING AT THIS ADDRESS?*	YES	NO	PREVIO OR FUT START		Μ	Μ	D	D	Y	Y	Y	Y							
If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 25-29.	PHYSICIAN GROUP / PR							-												
NOTE: "General Correspondence" refers to any correspondence that might be sent to the	GROUP / CORPORATE N		STREET*							SKEVI	ATC)							SUITE/B	JILDING	
provider that does not solely relate to creden- tialing or billing	СІТҮ*														STAT	E*		ZIP COD	E*	
information. TIP Your Individual Tax	SEND GENERAL CORRESPON- DENCE HERE?*	YES	NO	TELEPHO	DNE*								FAX	(-			-		
ID is assumed to be your Primary Tax ID unless you specify																				
otherwise to the right.	OFFICE E-MAIL ADDRES	55						-		-				PRIM/ TAX II			USE TAX	individu/ Id		USE GROU TAX ID
Office Menower	INDIVIDUAL TAX ID				GRO	UP TAX	ID							(ONE	UNLT)"					
Office Manager or Business Office Staff	LAST NAME*																			
Contact	FIRST NAME*																			M.I.
separately. You may use the check boxes below for convenience.	-		-			FAX		-				-								
Do not write instructions like "see above". These responses will be	E-MAIL ADDRESS																			
rejected and will require follow-up.	E-MAIL ADDRESS																			
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CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS	LAST NAME*																			
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Even if you checked the box above, please	CITY*														STA	TE*		ZIP COD	E*	
provide the E-mail Address of the Billing Contact.	TELEPHONE*					FAX														
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ection 4	Practice	Locatio	on Info	rmati	on (C	ontin	ued)													
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tion 4	Practice L	ocatio	n Infor	mati	on (0	Contin	ued)									
l-Level ctitioners	DO MID-LEVEL PF ASSISTANTS, ETC	C.) CARE FOI	R PATIENTS	IN YOUR	R PRACT		N	YES	NO							
	(IF YES, PLEASE I		EINFORMAI	ION BEL	.Ow)											
	PRACTITIONER L	AST NAME														
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Section 4	Practice Lo	cation I	nform	ation (Cont	inueo	d)																I.
Languages	LANGUAGES					-,								_								1
Code lists are found on pages 37. Enter the associated 3-digit code	SPOKEN BY OFFICE	PERSONNEL	LAN	IGUAGE CODE	LANG	JAGE (ODE		LANGUAG	E CODE		LANGU	GE CO	ODE		LANGU	AGE	CODE				
in the space provided.	INTERPRETERS AVAILABLE?*	YES	NO	LANGUAGES INTERPRETED	LANG	UAGE	CODE		LANGUA	GE CODE	:	LANGUA	GE CO	DDE		LANGU	AGE	CODE				
Accessibilities	DOES THIS OFFICE M	EET ADA ACC	ESSIBILITY	(REQUIREMENTS?*		YES		NO														-
	DOES THIS SITE OFF ACCESS FOR THE FO		PED	DOES TH SERVICE						YES	N	ю			LE BY	ORTAT	ION?*		YES	;	NO	
	BUILDING?*	YES	NO	ТЕХ	(T TELEF	рному	(TTY)*			YES	'	10		E	BUS*				YES		NO	
	PARKING?*	YES	NO	АМ	ERICAN	SIGN L	ANGUA	GE*		YES	'	10		s	SUBW/	AY*			YES		NO	
	RESTROOM?*	YES	NO		NTAL/PH RVICES*	YSICAI	. IMPAIF	RMEN	ІТ	YES	1	10		R	REGIO	NAL TR	AIN*		YES		NO	
	OTHER HANDICAPPE				R DISAB		EDVICE						отн		RANSP	ORTAT		CCESS				
		D ACCESS		OTHE	K DISAE	ALIIT 3	ERVICE	3					0111		ANOP	UNIAI		CCLOO				_
Services	Does this location	provide any	of the fo	-																		
	LABORATORY SERVICES?	YES	NO	IF YES, PROVIDE CERTIFYING PRO (E.G., CLIA, COLA	GRAM	DITING/																
	RADIOLOGY SERVICES?	YES	NO	IF YES, PROVIDE CERTIFICATION 1																		
	EKGS?	YES	NO	ALLERGY INJECTIONS?		YES	M	10	ALLE TESTI	RGY SKIN NG?		YES		NO		ROUTI GYNE (PELV	COLO	GY		YES		NO
	DRAWING BLOOD?	YES	NO	AGE APPROPRIATE IMMUNIZATIONS?	,	YES	1	10	FLEXI SIGMO	BLE DIDOSCOI	PY?	YES		NO		TYMPA Y/ AUE SCRE	OME	TRY		YES		NO
	ASTHMA TREATMENT?	YES	NO	OSTEOPATHIC MANIPULATION?		YES	ľ	10		DRATION/ TMENT?	'	YES		NO		CARD STRES		ST?		YES		NO
	PULMONARY FUNCTION TESTING?	YES	NO	PHYSICAL THERAPY?		YES	•	10		OF MINO RATIONS		YES		NO								
	IS ANESTHESIA ADMINISTERED IN YOUR OFFICE?	YES	NO	IF YES, WHAT CLASS/CATEGOR DO YOU USE?	۲Y																	-
	IF YES, WHO ADMINISTERS IT?																					
		LAST NAME										FIRST	NAM	E								
	TYPE OF PRACTICE (SELECT ONE ONLY)		SOLO P	RACTICE		SING	LE SPE	CIAL	TY GROUF	5		MULI	I-SPEC	CIALT	Y GRO	UP						
	ADDITIONAL OFFICE	PROCEDURES	PROVIDE	D (INCLUDING SURG	ICAL PR	OCEDU	RES)															
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Section 4	Practice Location Information (Continued)			
Partners/	LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE			
Associates				
Code lists are found on				
pages 36-43. Enter the			SPECIALTY CODE	COVERING
associated 3-digit code in the space provided.				(Y/N)?
	FIRST NAME	М.І.	PROVIDER TYPE (CC	DE PG 36)
If you have additional partners/associates at				
THIS location, use the Partner/Associate				
Supplemental Form on			SPECIALTY CODE	COVERING
page 23. Photocopy as necessary. Be certain				(Y/N)?
to check "Primary	FIRST NAME	M.I.	PROVIDER TYPE (CC	DE PG 36)
Location" at the top of the page.				
	LAST NAME		SPECIALTY CODE	COVERING
				(Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CO	DE PG 36)
0				
Covering Colleagues	LIST ALL COVERING COLLEAGUES THAT ARE <u>NOT</u> PARTNERS/ASSOCIATES AT THIS PRACTICE			
Colleagues				
Code lists are found on			SPECIALTY CODE	
pages 36-43. Enter the associated 3-digit code				
in the space provided.				
If you have additional	FIRST NAME	M.I.	PROVIDER TYPE (C	DDE PG 36)
covering colleagues that are not partners at				
THIS location, use the				
Covering Colleagues Supplemental Form on			SPECIALTY CODE	
page 24. Photocopy as necessary. Be certain				
to check "Primary	FIRST NAME	M.I.	PROVIDER TYPE (C	DDE PG 36)
Location" at the top of the page.				
	LAST NAME		SPECIALTY CODE	
	FIRST NAME	M.I.	PROVIDER TYPE (C	DDE PG 36)
Section 5	Hospital Affiliations			
	•			
Admitting	DO YOU HAVE IF YOU DO NOT ADMIT PATIENTS, WHAT HOSPITAL YES NO TYPE OF ADMITTING ARRANGEMENTS DO PRIVILEGES?*			
Arrangements	PRIVILEGES?* YOU HAVE?			
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Supplemental Work History Form on page																													

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

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

ection 7	Work Histo	ory and F	Referenc	es (Co	ontinued)							
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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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		carrier, based on your individual liability history?
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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. KAPER-1 (11/2019)

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

Section 8	Disclosure Questions (Continued)
Disclosure Questions	MALPRACTICE CLAIMS HISTORY
Answer all questions. For any "Yes"	19. YES NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?*
response, provide an explanation on the	CRIMINAL/CIVIL HISTORY
Supplemental Disclosure Question Explanation Form on page 34.	20. YES NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*
IMPORTANT If you answered "Yes" to question #19 , you	21. YES In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor NO traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
nust complete the Supplemental Malpractice Claims	22. YES NO Have you ever been court-martialed for actions related to your duties as a medical professional?*
Explanation Form on bage 35 for each malpractice claim.	Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.
	ABILITY TO PERFORM JOB
	 23. YES NO ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on
	one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of applica- tion, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses author- ized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)
	24. YES NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the func- tions of your job with reasonable skill and safety?*
	25. YES NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*
	26. YES NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, energy - ees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designat ed professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation prior to the conclusion of any disciplinary pro - ceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity. I agree that information obtained in accordance with th

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely informa - tion for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participatior; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree shall be as effective as the original.

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Professional IDs Supplemental Form

Section 1	Personal Information and Professional IDs	
Professional IDs Include all additional state licenses, DEA Registration and State Controlled Dangerous	FEDERAL DEA NUMBER	M M D D Y Y Y Y DEA ISSUE DATE M M D D Y Y Y Y DEA EXPIRATION DATE
Substance (CDS) certification numbers. Provide all current and previous licenses/ certifications. If you need to report additional Professional IDs, photocopy this	FEDERAL DEA NUMBER DEA STATE OF REGISTRATION	M M D D Y Y Y Y DEA ISSUE DATE M M D D Y Y Y Y DEA EXPIRATION DATE
page as needed and submit as instructed.	CDS CERTIFICATE NUMBER	M M D D Y Y Y Y CDS ISSUE DATE M M D D Y Y Y Y CDS EXPIRATION DATE
	CDS CERTIFICATE NUMBER	M M D D Y Y Y Y CDS ISSUE DATE M M D D Y Y Y Y CDS EXPIRATION DATE
	STATE LICENSE NUMBER IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE?	LICENSE ISSUING STATE M M D D Y Y Y Y LICENSE ISSUE DATE M M D D Y Y Y Y LICENSE EXPIRATION DATE
	Code list is found on page 36; use license status codes. Enter 3-digit code in space provided. LICENSE STATUS CODE	Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.
	STATE LICENSE NUMBER IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE?	LICENSE ISSUING STATE
	Code list is found on page 36; use license status codes. Enter 3-digit code in spaceprovided. LICENSE STATUS CODE	Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.
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Other Relevant Education Supplemental Form

Section 2	REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Education and Training
Fifth Pathway	FIFTH PATHWAY GRADUATES ONLY
Education	
	INSTITUTION/HOSPITAL WHERE U.S. CLINICAL TRAINING WAS PERFORMED (DO NOT ABBREVIATE)
	ADDRESS
	CITY STATE ZIP CODE
	CITY STATE ZIP CODE
	TELEPHONE
	DID YOU COMPLETE YOUR EDUICATION AT THIS SCHOOL 2 YES NO M M Y Y Y Y M M M Y Y Y Y
	EDUCATION AT THIS SCHOOL?
Other Relevant	
ducation	INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)
you need to report	
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	CITY STATE ZIP/POSTAL CODE
	TELEPHONE
	M M Y Y Y Y M M Y Y Y Y
	COUNTRY CODE START DATE END DATE (GRADUATION DATE) DEGREE AWARDED
	EDUCATION AT THIS SCHOOL?
	INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)
	NUMBER STREET SUITE/BUILDING
	CITY STATE ZIP/POSTAL CODE
	TELEPHONE FAX
	COUNTRY CODE START DATE END DATE (GRADUATION DATE) DEGREE AWARDED
	DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO
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Other Training Supplemental Form

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Additional Specialty Supplemental Form

Section 3	Profe	essi	ona	al / I	Mec	dica	l Sp	ecia	lty I	nfoi	ma	tio	n													
dditional pecialty	SPECIALTY CODE]		CI	ERTIFIC	INITIAL ATION DATE	М	Μ	D	D	Y	Y	Υ	Υ			DO YO BE LIS THE D UNDE	TED I	N ORY	I	НМО	YES	NC
de lists are found on ges 36-43. Enter the	BOARD CERTIFIED?		YES		NO				CATION DATE CABLE)	M	Μ	D	D	Y	Y	Y	Y	, 		SPECI	ALTY	?	I	PPO	YES	NC
sociated 3-digit code he space provided.	CERTIFYING BOARD CODE]				N DATE CABLE)		М	D	D	Y	Y	Y	١	1					F	POS	YES	N
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	IF YOU INDIG FOLLOWING	CATED		YOU								DEXA	M, PLE	ASE U	SE TH	ŧΕ			I	1	1		1			
lditional pecialty	SPECIALTY CODE]			ERTIFIC	DATE	Μ	Μ	D	D	Y	Y	Y	Y			DO YO BE LIS THE D UNDE	RECT	N ORY S	I	HMO	YES	NC
de lists are found on les 36-43. Enter the ociated 3-digit code ne space provided. ou need to report	BOARD CERTIFIED?		YES		NO				CATION DATE CABLE)	M	Μ	D	D	Y	Y	Y	Y	, 		SPECI	ALTY'	?	I	PPO	YES	N
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litional Specialties, btocopy this page as eded and submit as ructed.	IF NOT BOARD CERTIFIED (SELECT ONE)		EXAM	E TAKI 1, RESU DING FO	ULTS						I INTE EXAN		O SIT F	OR AN										TO TAK ARD EX		
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Partners/Associates Supplemental Form

Section 4	Practice Location Information		
Partner/ Associates	SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHI	CH YOU ARE ASSOCIATING THESE PROVIDERS.	
Use this page to report additional	► LOCATION # PRIMARY PRACTICE	PRACTICE NAME	
partners/associates at the designated practice location.		PRACTICE ADDRESS	
IMPORTANT			
In the box provided, indicate to which			SPECIALTY CODE COVERING COLLEAGUE
practice location this page belongs.	FIRST NAME		(Y/N)? PROVIDER TYPE (CODE PG 36)
Check "Covering Colleague?" if he/she provides coverage for			
you at THIS location.			SPECIALTY CODE COVERING COLLEAGUE (Y/N)?
Code lists are found on pages 36-43. Enter the associated 3-digit	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
code in the space provided.			
If you need to report additional			SPECIALTY CODE COVERING COLLEAGUE (Y/N)?
rtners/associates, otocopy this page needed and submit	FIRST NAME	M.	PROVIDER TYPE (CODE PG 36)
as instructed.			
	LAST NAME		SPECIALTY CODE COVERING COLLEAGUE
	FIRST NAME	M.	(Y/N)? PROVIDER TYPE (CODE PG 36)
	LAST NAME		SPECIALTY CODE COVERING
			COLLEAGUE (Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
			SPECIALTY CODE COVERING COLLEAGUE
	FIRST NAME	M.I.	(Y/N)? PROVIDER TYPE (CODE PG 36)
			SPECIALTY CODE COVERING COLLEAGUE (Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
	LAST NAME		SPECIALTY CODE COVERING
			COLLEAGUE (Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
	. 309	8	

Covering Colleagues Supplemental Form

Section 4	Practice Location Information		
Covering	SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.		
	PRACTICE NAME		
Include all colleagues providing regular	LOCATION # PRIMARY PRACTICE		
coverage and his/her specialty, including if	PRACTICE ADDRESS		
he/she is a partner in one or more of your			
practice locations.			
IMPORTANT			SPECIALTY CODE
In the box provided, indicate to which			PROVIDER TYPE (CODE PG 36)
practice location this page belongs.	FIRST NAME	M.I.	FROMBER TIPE (CODE PG 30)
Code lists are found on			
pages 36-43. Enter the associated 3-digit code	LAST NAME		SPECIALTY CODE
in the space provided.			
If you need to report additional Covering	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
Colleagues, photocopy			
this page as needed and submit as	LAST NAME		SPECIALTY CODE
instructed.			SPECIALITICODE
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
			SPECIALTY CODE
			PROVIDER TYPE (CODE PG 36)
	FIRST NAME	M.I.	
	LAST NAME		SPECIALTY CODE
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
	LAST NAME		SPECIALTY CODE
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
	LAST NAME		SPECIALTY CODE
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
			SPECIALTY CODE
			PROVIDER TYPE (CODE PG 36)
•	FIRST NAME	M.I.	
	3099		

Section 4	Practice Locatio	n Informatio	on - Page	1 of 5					
Additional Practice Location									
Location	CURRENTLY PRACTICING AT THIS ADDRESS?*	ES NO	PREVIOUS OR FUTURE START DATE?	M M D	DYY	ΥY			
IMPORTANT	PHYSICIAN GROUP / PRACTIC	E NAME TO APPEAR	IN DIRECTORY (DO	NOT ABBREVIATE)	*				
In the box provided, indicate to which practice location this page belongs.	GROUP / CORPORATE NAME A	S IT APPEARS ON W	1-9, IF DIFFERENT F	ROM ABOVE (DO N	OT ABBREVIATE)				
For example, if you practice at three locations, the primary									
location is reported in the main application and remaining	NUMBER*	STREET*						SUITE/BUILDING	
locations would be reported on	CITY*						STATE*	ZIP CODE*	
Supplemental Forms as Location 2 and Location 3.	SEND GENERAL CORRESPON- Y DENCE HERE?*	ES NO	ELEPHONE*		-	FAX	-	-	
TIP Your Individual Tax ID is assumed to be your Primary Tax ID	OFFICE E-MAIL ADDRESS								USE GROUP
unless you specify otherwise to the right.	INDIVIDUAL TAX ID		GROL	JP TAX ID			NE ONLY)*	rax id	TAX ID
Office Manager									
or Business Office Contact	LAST NAME*								
List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These	FIRST NAME*			FAX					м.і.
responses will be rejected and will									
require follow-up.	E-MAIL ADDRESS								
Billing Contact									
CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING	LAST NAME*								M.I.
INFORMATION									
NOTE:	сіту*						STATE*	ZIP CODE*	
Even if you checked the boxes above, please provide the e-mail address of the	TELEPHONE*			FAX					
Billing Contact, if available.	E-MAIL ADDRESS								
	-							-	

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAS CAUGE ROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4	Practice	Locatio	n Infor	matio	n - Pa	ige 2	2 of {	5														
Add'l Practice Location (Cont.)	LOCA	TION* #																				
Payment and	ELECTRONIC							_	_													
Remittance	BILLING CAPABILITIES?	* YES	NO																			
YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.	CHECK PAYABL	E TO*		B	ILLING DE	EPARTM	IENT (IF	HOSPIT	AL-BASE	ED)												
CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION	LAST NAME*																					м.і.
NOTE:																						
Even if you checked	CITY*														STAT	TE*		ZIP C	ODE*			
the boxes above, please provide the E-mail Address, Department Name,	TELEPHONE*	-	-				FAX		-		-					-		2.11 0	ODL			
Electronic Billing and Check Payable To, if applicable.	E-MAIL ADDRES	s																				
Office Hours	(USE HHMM	FORMAT AN		о то тн	E NEAR	EST H	IALF-H	IOUR)														
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	MONDAT									TRIBA] [
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NOTE:	WEDNESDAY							۱C		SUNDA	(
After hours back office telephone will be used only by the health plan	THURSDAY				v	OICE M		н]				AFTEF	HOUR	S BACI	K OFFI	CE TE	LEPHO	NE			
and will not be published under any	24/7 PHONE COV	'ERAGE?*	IF YES							VOICE	IAIL											_
circumstances.	YES	NO		SWERING				TO CALL		WITH O												
			02.		A	NSWER	ING SE	RVICE		INSTRU	CTIONS											
Open Practice Status	ACCEPT NEW P	ATIENTS INTO	THIS PRACT	ICE?*		, ,	YES	NO		ACC	EPT ALL M	NEW PA	TIENT	S?*						YES		NO
Clurdo	ACCEPT EXISTI	NG PATIENTS	WITH CHANG	E OF PAY	OR?*	<u>ا</u>	YES	NO		ACC	EPT NEW	MEDIC	ARE P	ATIENT	S?*					YES		NO
	ACCEPT NEW P	ATIENTS WITH	PHYSICIAN	REFERRA	L?*		YES	NO		ACCI	EPT NEW	MEDIC	AID PA	TIENTS	5?*					YES		NO
	IF ANY OF THE ABOVE VARIES PLAN, EXPLAIN	ВҮ																				
	ARE THERE ANY PRACTICE LIMIT YES		IF YES	GEN	IDER LIMI MALE ONLY FEMAL		IS	NONE	O N L Y				11									
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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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Section 4	Practice Location Information - Page 3 of 5	
Additional Practice Location		
(Continued)	DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?*	
IMPORTANT In the box provided, indicate to which	(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)	
practice location this page belongs.	PRACTITIONER LAST NAME	
Midleyal	PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)	
Mid-Level Practitioners	PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE	
	PRACTITIONER LAST NAME	
	PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA,	
	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,	
	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	
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Section 4	Practice Lo	cation I	nform	ation - Page	e 4 of 5								
Additional)N* #											
Practice	PLOOAIR												
Location (Continued)	LANGUAGES		_										
IMPORTANT	NON-ENGLISH LANG SPOKEN BY OFFICE	UAGES PERSONNEL											
In the box provided,	INTERPRETERS		-	NGUAGE CODE	LANGUAGE	CODE	LANGUAGE CODE	LANGU	AGE CODE	LANGUAG	E CODE		
indicate to which practice location this page belongs.	AVAILABLE?*	YES	NO	INTERPRETED	LANGUAG	E CODE	LANGUAGE CODE	LANGU	AGE CODE	LANGUAG	E CODE		
Accessibilities	DOES THIS OFFICE N	IEET ADA ACC	ESSIBILIT	Y REQUIREMENTS?*	YE	s NO							
	DOES THIS SITE OFF ACCESS FOR THE F		PED		IIS SITE OFFE		YES	NO	ACCESSIBL PUBLIC TRA	E BY	?*	YES	NO
	BUILDING?*	YES	NO	ТЕХ	T TELEPHON	Y (TTY)*	YES	NO	в	US*		YES	NO
	PARKING?*	YES	NO	АМЕ	ERICAN SIGN	LANGUAGE*	YES	NO	SL	JBWAY*		YES	NO
	RESTROOM?*	YES	NO		NTAL/PHYSIC	AL IMPAIRME	NT YES	NO	RE	EGIONAL TRAIN*	· 🗌	YES	NO
								1					٦.
	OTHER HANDICAPP	ED ACCESS		OTHE	R DISABILITY	SERVICES			OTHER TR	ANSPORTATION	ACCESS		
Services	Does this locatior	n provide an	y of the fo	ollowing services?									
	LABORATORY		_	IF YES, PROVIDE		G/							
	SERVICES?	YES	NO	CERTIFYING PRO (E.G., CLIA, COLA									
	RADIOLOGY SERVICES?	YES	NO	IF YES, PROVIDE									
	EKGS?	YES	NO	ALLERGY INJECTIONS?	YES	NO	ALLERGY SKIN TESTING?	YES	B NO	ROUTINE GYNECOL (PELVIC/P	LOGY	YES	N
	DRAWING BLOOD?	YES	NO	AGE APPROPRIATE IMMUNIZATIONS?	YES	NO	FLEXIBLE SIGMOIDOSCOPY	? YES	S NO	TYMPANO Y/ AUDION SCREENII	METRY	YES	N
	ASTHMA TREATMENT?	YES	NO	OSTEOPATHIC MANIPULATION?	YES	NO	IV HYDRATION/ TREATMENT?	YES	s NO	CARDIAC STRESS		YES	N
	PULMONARY FUNCTION TESTING?	YES	NO	PHYSICAL THERAPY?	YES	NO	CARE OF MINOR LACERATIONS?	YES	S NO				
	IS ANESTHESIA ADMINISTERED IN YOUR OFFICE?	YES	NO	IF YES, WHAT CLASS/CATEGOR' DO YOU USE?	Y]
	IF YES, WHO ADMINISTERS IT?												7
		LAST NAME						FIRS	T NAME				
	TYPE OF PRACTICE (SELECT ONE ONLY)	*	SOLO F	PRACTICE	SIN	IGLE SPECIAI	LTY GROUP	MUL	TI-SPECIALTY	GROUP			
	ADDITIONAL OFFICE	PROCEDURE	S PROVIDI	ED (INCLUDING SURGI	CAL PROCED	OURES)							
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Section 4	Practice Location Information - Page 5 of 5		
Additional	→ LOCATION* #		
Practice			
Location (Continued)	LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE		
IMPORTANT			
In the box provided,	LAST NAME		SPECIALTY CODE COVERING
indicate to which practice location this			COLLEAGUE (Y/N)?
page belongs.	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
If you have additional			
partners/associates at THIS location, use the			
Partner/Associate	LAST NAME		SPECIALTY CODE COVERING COLLEAGUE
Supplemental Form on page 23. Photocopy as			(Y/N)?
necessary. Be certain to indicate the Practice	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
Location Number at the top of the page.			
Code lists are found on	LAST NAME		
pages 36-43. Enter the associated 3-digit code			SPECIALTY CODE COVERING COLLEAGUE (Y/N)?
in the space provided.		M.I.	
	FIRST NAME	WI.I.	PROVIDER TYPE (CODE PG 36)
	LAST NAME		SPECIALTY CODE COVERING
			COLLEAGUE (Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
Covoring	LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE		
Covering Colleagues			
Code lists are found on pages 36-43. Enter the			SPECIALTY CODE
associated 3-digit code in the space provided.			
If you have additional	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
covering colleagues			
that are not partners at THIS location, use the	LAST NAME		SPECIALTY CODE
Covering Colleagues Supplemental Form on			
page 24. Photocopy as necessary. Be certain	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
to indicate the Practice Location Number at the			
top of the page.	LAST NAME		SPECIALTY CODE
	FIRST NAME		PROVIDER TYPE (CODE PG 36)
	FIK51 NAME	M.I.	PROVIDER TTPE (CODE PG 36)
	LAST NAME		SPECIALTY CODE
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
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Hospital Privileges (Current) Supplemental Form

	* REQUIRE					PAGE	IS US	ED). N	IO RE	SPON	SE MA	Y CAL	JSE F	ROCE	SSIN	G DEL	AYS A	ND R	EQUIR	E FO	LLOW	-UP.					
Section 5	Hospi	tal /	Affil	iatic	ons																						
Hospital Privileges	OTHER H	IOSP	ITAL																								
Use this form to continue listing	HOSPITAL	NAME																					1			1	
hospitals where you currently have	NUMBER					STREE	ET																	SUITE	/BUILD	DING	
privileges.																											
If you need to report additional space for	CITY																				STA	TE		ZIP (CODE		
Hospital Privileges, photocopy this page as]]_[Γ			-			-										
needed and submit as instructed.	TELEPHON	IE									FA	x															
TIP Be certain your admission percentages	DEPARTME	ENT NA	ME	11												1							1			1	
add up to 100% for current hospitals.																											
Otherwise, you will have to correct this	DEPARTME	ENT DI	RECTO	R'S LAS	ST NAI	ме													11								
error.																											
	DEPARTME	INT DI	RECTO	r's fif	RST N.	AME		_											_						_		M.I.
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Professional Liability Insurance Carrier Supplemental Form

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Other																									1	
Professional																					s	SELF-IN	SURED?		YES	N
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Insurance																										
Carrier	NUMBER	*			STR	REET*																	SUITE/	BUILDIN	G	
List secondary /																						1				
second layer / future or	CITY*																			STAT	ГE*		ZIP CO	DDE*		
previous carrier(s).																			т	YPE OF	-		1			
For second layer coverage list name of	MN		Y	Y	Y	Μ	IVI	Y	Y	Y	Y		Μ	IVI	Y	Ŷ	Y	Y	Ċ	OVERA	GE?*	•	INDIVI	DUAL		SHARED
hospital/organization	ORIGINAI	L EFFEC	TIVE DA	ATE*		EFFE	CTIVE	DATE	*				EXPIR	ATION	N DATE											
providing coverage	DO YOU H WITH THIS						YES		NO	\$									\$							
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Professional Liability	CARRIER		I F-INSU		AME																					
Insurance	ORIGIER																					1				
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List secondary / second layer / future or																										
previous carrier(s).	CITY*																			STAT	ΓE*		ZIP C	DDE*		
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coverage list name of hospital/organization	ORIGINA	L EFFEC	CTIVE D.	ATE*		EFF	CTIVE	DATE	*				EXPI	RATIO	N DAT	E										
providing coverage	DO YOU H		NLIMITE	DCOVE	RAGE						2								\$							
If you need additional	WITH THIS						YES		NO				COVE	AGE			ENCE					COVE	RAGE A	GOREO	ATE	
space for Insurance Coverage, photocopy							1		1		ANIOC		COVE	AGE	FERO	CCORN	ENCE		,	ANICON		COVE	RAGE A	JGREG	112	
this page as needed	POLICY I	NCLUDE	ES TAIL	COVER	RAGE?		YES		NO																	
and submit as instructed.																										
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Work History Supplemental Form

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WORK	HISTORY															 				 			
PRACTICE	/ EMPLOYE	R NAME																		<u> </u>			
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Work History Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Std. App. v.5.0

Professional Training / Work History Gaps Supplemental Form

				JOE JOING DELATS AND IN	
Section 7	Professio	onal Training / Work Histo	ory Gaps		
Professional Training / Work History Gaps	GAP START DATE	E M M Y Y Y Y	GAP END DATE	A Y Y Y Y	
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 month in duration or of a shorter duration if required by the	GAP START DATE	E M M Y Y Y Y	GAP END DATE	M Y Y Y Y	
organization for which you are being credentialed.					
	GAP START DATE	E M M Y Y Y Y	GAP END DATE	A Y Y Y Y	
	GAP START DATE	E M M Y Y Y Y	GAP END DATE	M Y Y Y	
	GAP START DATE	EMMYYYY	GAP END DATE	M Y Y Y	
	Ι				

Disclosure Questions Supplemental Form

Section 8	Disclosu	re Ques	tions														
Disclosure	QUESTION #	EXPLANAT	ION														
Questions																	
Use this form to report any "Yes" response to one or more of the																	
Disclosure Questions in Section 8. Your response should not																	
exceed the spaces provided.																	
Record the question number in the first column, then your																	
explanation in the second column.																	
If you need additional space to explain a Yes																	
response, photocopy this page as needed and submit as instructed.																	
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Malpractice Claims Explanation Supplemental Form

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Malpractice Claims Explanation Use this form to report any "Yes" response to Disclosure Question #19.		URREN	CLAIM	M I* (NOT			D S PEND	Y ING, S	Y	Y OPEN)	Y	IF	SETTLI CLAII	WA		D*	M	M	D	D	Y	Y	Y	Y					
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