Provider Application

CORRECT NUMBERS AND LETTERS A	BC123 CORRECT X INCORRECT COMMON ABBREVIATIONS, AND ZIP CODE MATCHING, PLEASE MARKS 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.* 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	LAST NAME* SUFFIX (JR, III)	
are part of your legal name.	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)	1
	OTHER FIRST NAME OTHER MIDDLE NAME	_
	DATE STARTED USING OTHER NAME MM D D Y Y Y Y DATE STARTED USING OTHER NAME	
General		
Information	GENDER* MALE FEMALE DATE OF BIRTH* M M D D Y Y Y Y	
Only enter a Foreign National Identification Number if you do not		
have a SSN. Do not enter National Provider Identification (NPI)	CITY OF BIRTH STATE OF COUNTRY OF BIRTH BIRTH	
Number here. Code lists are found on	SSN* FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN) FNIN COUNTRY OF ISSUE	
pages 36-43. Enter the associated 3-digit code in the space provided.	ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK	
	LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE	_
Home Address		
	NUMBER STREET APT NUMBER 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	
ı	3076	

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 1 Personal Information and Professional IDs (Continued) **Professional IDs** FEDERAL DEA NUMBER DEA ISSUE DATE Include all state licenses, DEA Registration and State Controlled Dangerous DEA STATE OF REGISTRATION DEA EXPIRATION DATE Substance (CDS) certification numbers. Provide all current and CDS CERTIFICATE NUMBER previous licenses/ certifications. CDS STATE OF REGISTRATION CDS EXPIRATION DATE Non-licensed professionals should enter certification/ LICENSE ISSUING STATE LICENSE ISSUE DATE registration number in the space provided for IF THIS IS A STATE LICENSE, ARE YOU license number. YES NO **CURRENTLY PRACTICING IN THIS STATE?** If you have additional LICENSE EXPIRATION DATE Professional IDs to Code list is found on page 36; use license status codes. Enter Code list is found on page 36; use provider type codes. Enter report, use the Professional IDs 3-digit code in space provided. 3-digit code in space provided. Supplemental Form on LICENSE TYPE LICENSE STATUS CODE page 19. STATE LICENSE NUMBER LICENSE ISSUING STATE LICENSE ISSUE DATE IF THIS IS A STATE LICENSE, ARE YOU YES NO **CURRENTLY PRACTICING IN THIS STATE?** LICENSE EXPIRATION DATE Code list is found on page 36; Code list is found on page 36; use license status codes. Enter use provider type codes. Enter 3-digit code in space provided. 3-digit code in space provided. LICENSE TYPE LICENSE STATUS CODE Other ID ARE YOU A PART-YES NO ICIPATING MEDICARE **Numbers** PROVIDER?* MEDICARE NUMBER ARE YOU A PART-If you have additional ICIPATING MEDICAID YES NO Professional IDs to PROVIDER?* report, use the MEDICAID NUMBER Professional IDs Supplemental Form on page 19. 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

Section 2	Education and Training
Indergraduate	
School(s)	UNDERGRADUATE SCHOOL
rrovide the appropriate information for the chool that issued your indergraduate degree	OFFICIAL NAME OF UNDERGRADUATE SCHOOL
nd all schools ttended.	ADDRESS
Professional	CITY STATE ZIP/POSTAL CODE
School(s)	COUNTRY CODE TELEPHONE FAX
Provide the appropriate information for the chool that issued your	MMYYYYY MMYYYY
rofessional degree.	START DATE END DATE (GRADUATION DATE) DEGREE AWARDED
ifth Pathway Graduates lease complete the ollowing sections: U.S. school that issued your	DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL? YES NO
ertificate, the Non-U.S. School where you ttended, and the Fifth	GRADUATE TYPE*:
athway institution here you completed	U.S. OR CANADIAN GRADUATE NON-U.S./CANADIAN GRADUATE FIFTH PATHWAY GRADUATE
our training on supplemental Page 20.	U.S. OR CANADIAN SCHOOL
code lists are found on ages 36-43. Enter the ssociated 3-digit code	SCHOOL CODE (U.S./ CANADIAN ONLY) NAME OF U.S./ CANADIAN SCHOOL:
n the space provided.	MMYYYY
you have additional Indergraduate or	START DATE* END DATE (GRADUATION DATE)* DEGREE AWARDED
Professional Schools to eport, use the Education Supplemental Form on page 20.	DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? YES NO
ann an paga Lai	NON - U.S. OR CANADIAN SCHOOL
	OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL
	ADDRESS
	CITY CODE POSTAL CODE
	M M Y Y Y Y M M M Y Y Y Y
	START DATE* END DATE (GRADUATION DATE)* DEGREE AWARDED
	DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? YES NO

 $* \ \mathsf{REQUIRED} \ \mathsf{RESPONSE}. \ \mathsf{NO} \ \mathsf{RESPONSE} \ \mathsf{MAY} \ \mathsf{CAUSE} \ \mathsf{PROCESSING} \ \mathsf{DELAYS} \ \mathsf{AND} \ \mathsf{REQUIRE} \ \mathsf{FOLLOW-UP}.$

Education	on and Trai	ning	(Contin	ued)															
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																			CHOO
INSTITUTION/HO	OSPITAL NAME (USE	E BOTH L	INES IF REC	(UIRED)															-
NUMBER		OTDEE															L		
NUMBER		STREET	· 														3	UITE/B	UILL
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COUNTRY COD			TELEPH		1 1							FAX							
DID YOU COMP INSTITUTION?	PLETE THIS TRAININ	G PROGE	RAM AT THIS		YES	NO													
(IF NOT, PLEAS	SE USE THE SPACE I	BELOW T	O EXPLAIN.)																_
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List each	INTERNSHIP/		FELLOWSHI	P	OTHER	М	М	V	V	V	V		M	М	V	V	V	V	1
department separately, if	RESIDENCY		, LLLOWOIII		OTHER	START		_	1		I		END I					1	
applicable.																			
List Internship/	DEPARTMENT/SPE	CIALTY (DO NOT ABE	BREVIATE)															
Residency, Fellowship																			
and Other programs	NAME OF DIRECTO	OR																	
separately.	INTERNSHIP/ RESIDENCY	'	FELLOWSHI	P	OTHER	М	М	Υ	Υ	Υ	Υ		M	М	Υ	Υ	Υ	Υ	
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	DEPARTMENT/SPE	CIALTY (DO NOT ABE	REVIATE)															
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	NAME OF DIRECTO	OR																	
	INTERNSHIP/ RESIDENCY	'	FELLOWSHI	P	OTHER	M	M	Υ	Υ	Υ	Υ		M	M	Υ	Υ	Υ	Υ	
						START	DATE						END I	DATE					_
	DEPARTMENT/SPE	CIALTY (DO NOT ABE	REVIATE)															

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

Primary Specialty		,a.	Medical	l Speci	alty	Infor	ma	tion															
	SPECIALTY			CER	INIT TIFICAT D		/1	M E				/		1	DO YOU BE LIS THE DI UNDER	TED I RECT	N ORY	ı	но		YES		NO
ode lists are found on ages 36-43. Enter the	BOARD CERTIFIED?	YES	NO		TIFICAT D PPLICAE	ATE \	/ 1	M E) [)		/	/	/	SPECIA			ı	PPO		YES		NO
ssociated 3-digit code the space provided.	CERTIFYING BOARD CODE				ATION DA		/	M [)	<u> </u>	Y	Y \	Y				F	os		YES		NO
	IF NOT BOARD CERTIFIED	I HAVE EXAM, PENDIN	RESULTS					NTENE XAM O		IT FOF	R AN								TO TAK				
	(SELECT ONE)					ľ	Л	М] [)	<u> </u>	Y	Y	/									
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	FOLLOWING SP	ACE TO E	EXPLAIN, OTH	ERWISE LE	AVE THE	SPACE	BLA	NK.															
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Secondary	SPECIALTY				I ERTIFIC	NITIAL	N/I	N/I	<u> </u>	Ь			V			YOU V	WISH T	ГО	НМО		YES		
Specialty	CODE BOARD				ERTIFIC	DATE	IVI	IVI	D					1	THE		CTOR	Υ			_		
Code lists are found on pages 36-43. Enter the associated 3-digit code	CERTIFIED?	YES	NO		APPLIC		IVI	IVI	D	Ы	<u> </u>	Y	Y	Y					PPO	L	YES		_ N
in the space provided. If you have additional	BOARD CODE				IRATION APPLIC		М	M	D	D	Υ	Υ	Υ	Υ	_				POS		YES		١
Professional / Medical Specialties to report, use the Additional	IF NOT BOARD CERTIFIED (SELECT	EXA	VE TAKEN M, RESULTS DING FOR					I INTE EXAM		SIT F	OR AN	·							ND TO T BOARD		l.		
Specialties Supplemental Form on page 22.	ONE)	ERTIFYIN	IG BOARD CO	IDE			M	M	D	D	Υ	Υ	Υ	Υ									
page 22.	IF YOU INDICAT	ED THAT	YOU DID NOT	INTEND TO					D EXA	M, PL	EASE	USE T	HE										

Section 3	* REQUIRED RE																								
Certifications	Do you hold t																								
				EXPIR	RATIO	N DATI	E											EXP	IRATIO	N DAT	E				
	BASIC LIFE SUPPORT?*	YES	NO	M	M	D	D	Υ	Υ	Υ	Υ		V LIF PPOR ?*		YES	3	NO	M	M	D	D	Υ	Υ	Υ	Υ
	CPR?*	YES	NO	M	M	D	D	Υ	Υ	Υ	Υ	LIF		AUMA	YES	5	NO	M	M	D	D	Υ	Υ	Υ	Υ
	ADV CARDIAC LIFE SPT?*	YES	NO	M	M	D	D	Υ	Υ	Υ	Υ	AD'	DIATE	ED	YES	3	NO	M	М	D	D	Υ	Υ	Υ	Υ
	NEONATAL ADVANCED LIFE SPT?*	YES	NO	М	M	D	D	Υ	Υ	Υ	Υ	LIF	E SP	17											
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Practice Interests																							Ш		
Provide additional areas of professional practice interest,																									
activities, procedures, diagnoses or copulations.																									
opulations.																									
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Primary Credentialing																									
Contact	LAST NAME																								
CHECK HERE TO ISE THE OFFICE MANAGER AND	FIRST NAME																								M.I.
DDRESS OF THE RIMARY PRACTICE OCATION AS THE																									
REDENTIALING NFORMATION.	NUMBER			STRE	ET																SUITE	/BUILE	DING		
	CITY							_									l 	STA	TE		ZIP C	ODE			
NOTE: Even if you checked	TELEPHONE]					FAX					-											
the boxes above, please provide the e-mail address, if																									
available.	E-MAIL ADDRES	55																							
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* RECHIRED RESPONSE	NO RESPONSE MAY CALISE DR	OCESSING DELAYS AND	RECHIRE FOLLOW-LIP

Section 4	Practice Location Information	
Primary	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.	
Practice		
Location	CURRENTLY PRACTICING AT THIS ADDRESS?* YES NO OR FUTURE START DATE? M M D Y Y Y Y Y	
If you have additional practice locations, use the Supplemental Practice Location	PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*	
Information Form on pages 25-29.	GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)	
NOTE: "General Correspondence" refers	GROUP / CORPORATE NAME AS IT AFFEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)	
to any correspondence that might be sent to the provider that does not	NUMBER* STREET* SUITE/BUILDING	
solely relate to creden- tialing or billing information.	CITY* STATE* ZIP CODE*	_
TIP Your Individual Tax ID is assumed to be	CORRESPON- DENCE HERE?* YES NO TELEPHONE* FAX	
your Primary Tax ID unless you specify otherwise to the right.	OFFICE E-MAIL ADDRESS	
3 ·	PRIMARY TAX ID INDIVIDUAL TAX ID GROUP TAX ID GROUP TAX ID	ou
Office Manager		_
or Business Office Staff Contact	LAST NAME*	
List each contact separately. You may	FIRST NAME*	I.
use the check boxes below for convenience. Do not write	TELEPHONE* FAX	
instructions like "see above". These responses will be rejected and will require follow-up.	E-MAIL ADDRESS	
Billing Contact		_
CHECK HERE TO USE OFFICE	LAST NAME*	
MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION	FIRST NAME*	_
	NUMBER* STREET* SUITE/BUILDING	
NOTE:	CITY* STATE* ZIP CODE*	
Even if you checked the box above, please provide the E-mail Address of the Billing Contact.	TELEPHONE*	
-	E-MAIL ADDRESS	
	3083	

	* REQUIRED RE								AYS AI	ND REG	QUIRE	FOLL	OW-U	P.										
Section 4	Practice	Location	ı Infor	matic	on (C	ontin	uec	1)																
Payment and Remittance	ELECTRONIC BILLING CAPABILITIES?*	YES	NO						DODIT!		ED)													
YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR				В	ILLING	DEPART	MENI	(IF H	JSPITA	AL-BAS	ED)													
W-9.	CHECK PAYABLE	E TO*																						
CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS	LAST NAME*																							
AS PAYEE INFORMATION																								
	FIRST NAME*																						, n	W.I.
	NUMBER*		STRE	ET*	_															SUIT	E/BUILI	DING	Ш	
NOTE:																								
Even if you checked the box above, please provide the	CITY*	_	_							-			-				STA	TE*		ZIP (CODE*			
E-mail Address of the Payee Contact.	TELEPHONE*						FAX																	
	E-MAIL ADDRES	s																						
Office Hours	(USE HHMM I	FORMAT AN	D ROUN		HE NE	AREST	HAL	F-HC		1														
		STAR	Т	A=AM P=PM		END			A=AN P=PM					STA	RT		A=A P=P			EN	D		A=AM P=PM	_
	MONDAY										FRIDA	AY												
	TUESDAY			Ш	Щ	_	4			S	ATURDA	AY					L			Щ				
NOTE:	WEDNESDAY			Ш	Щ						SUNDA	AY												
After hours back office telephone will be used	THURSDAY																							_
only by the health plan and will not be	24/7 PHONE COV	'ERAGE?*	IF YES			VOICE	MAIL \	WITH			VOICE	MAIL	L	,	AFTER	HOU	RS BA	CK O	FFICE	TELEP	HONE			
published under any circumstances.	YES	NO		WERING VICE		ANSWE					WITH													
Open Practice Status	ACCEPT NEW PA	ATIENTS INTO	THIS PRAC	TICE?*			YES		NO		ACC	CEPT	ALL N	EW P	ATIEN'	TS?*						YES		NO
	ACCEPT EXISTI	NG PATIENTS \	WITH CHAN	GE OF P	AYOR?*		YES		NO		ACC	CEPT	NEW I	MEDIC	ARE P	PATIEN	ITS?*					YES		NO
	ACCEPT NEW PA	ATIENTS WITH	PHYSICIAN	REFERF	RAL?*		YES		NO		ACC	CEPT	NEW I	MEDIC	AID P	ATIEN	TS?*				L	YES		NO
	IF ANY OF THE ABOVE INFORM VARIES BY PLA	N,					L	L											L					
	EXPLAIN (USE E LINES IF REQUIF ARE THERE AN	RED)		GEN	IDER !!	MITATIO	ONS.		AGE	LIMITAT	IONS		LIST	OTHE	S [IMI	TATIO	NS							
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 $[\]star$ REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

	Practice	Locatio	11 11110111	iation (Contir	nued)										
ers	DO MID-LEVEL ASSISTANTS, E					CIAN	YES	NO								
	(IF YES, PLEAS	E PROVIDE TH	E INFORMATI	ON BELOW)												
	PRACTITIONER	LAST NAME														
	PRACTITIONER	FIRST NAME									M.I.	P	RACTITIO	NFR TY	PF (F (3 P
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	PRACTITIONER	LICENSE / CE	RTIFICATE NU	MBER				PRAC	TITIONE	R STATE						
	PRACTITIONER	LAST NAME														
	PRACTITIONER	FIRST NAME									M.I.	P	RACTITIO	NER TY	PE (E.C	3., P. P, NI
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ists are found on	LANGUAGES			(0011011	 														
	NON-ENGLISH LANGU																		
	SPOKEN BY OFFICE F	PERSONNEL	LAN	IGUAGE CODE LAN	GUAGE (CODE	LANG	SUAGE C	ODE	LA	NGUA	GE CC	DDE		LANG	JAGE	CODE		
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bace provided.	AVAILABLE?*	YES	NO	INTERPRETED	IGUAGE	CODE	LAN	CHACE	CODE		NGUA	GE CC	NDE		ANG	IACE	CODE		
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	BUILDING?*	YES	NO	TEXT TEI	EPHONY	(TTY)*		YES		NO			BL	JS*				YES	5
	BoileBilled.			TEXT TEX		(,			_								L		H
	PARKING?*	YES	NO	AMERICA	N SIGN I	.ANGUA	GE*	YES	s	NO			SL	JBWA	\Y*			YES	3
	RESTROOM?*	YES	NO	MENTAL/	PHYSICA	L IMPAIR	MENT	YES		NO			RF	FGIOI	NAL T	R A I N *		YES	
	RESTROOM?	IES	NO	SERVICE				15.	<u> </u>	NO						TAIN	L		
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ces	Does this location	nrovide anv	of the f	following services?															
003		provide arry		IF YES, PROVIDE ACC	REDITING	,													
	LABORATORY SERVICES?	YES	NO	CERTIFYING PROGRAI (E.G., CLIA, COLA, MLI															
	RADIOLOGY			IF YES, PROVIDE X-RA	v														
	SERVICES?	YES	NO	CERTIFICATION TYPE															
	EKGS?	YES	NO	ALLERGY				ALLERGY	SKIN		1		1		ROUT	INE C	FFICE		
		123	NO	INJECTIONS?	YES	N		ESTING?			YES		NO		GYNE (PEL)				YES
	DRAWING BLOOD?	YES	NO	AGE APPROPRIATE	YES	N		LEXIBLE IGMOIDO		?	YES		NO		TYMP Y/ AU	DIOM	ETRY		YES
	ASTHMA	YES	NO	OSTEOPATHIC	VEO			V HYDRA			VEO				CARE		G?		VEO
	TREATMENT?	169	NO	MANIPULATION?	YES	N		REATME			YES		NO		STRE		ST?		YES
	PULMONARY FUNCTION	YES	NO	PHYSICAL THERAPY?	YES	N		CARE OF			YES		NO						
	TESTING?]]						
	IS ANESTHESIA ADMINISTERED IN	YES	NO	IF YES, WHAT CLASS/CATEGORY															
	YOUR OFFICE?			DO YOU USE?															
	IF YES, WHO ADMINISTERS IT?																		
	L	AST NAME									FIRST	NAME							
	TYPE OF PRACTICE		1																
	(SELECT ONE ONLY)*		SOLO P	RACTICE	SING	LE SPE	CIALTY	SROUP			MULT	I-SPEC	CIALTY	GRO	DUP				

tion 4	Practice Loca	ation Info	rmation	(Conti	nued)										
tners/	LIST ALL PARTNER			-											
sociates															
lists are found on															
36-43. Enter the	LAST NAME												SPECIA	LTY CODE	COVERIN COLLEA (Y/N)?
ated 3-digit code space provided.															
ave additional	FIRST NAME											M.I.	PROVID	ER TYPE ((CODE PG 36)
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Associate nental Form on	LAST NAME												SPECIA	LTY CODE	COVERIN
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3. Enter the 3-digit code	LAST NAME												SPECIA	ALIT CODE	
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	LAST NAME												SPECIA	ALTY CODE	_ ≣
	FIRST NAME											M.I.	PROVI	DER TYPE	(CODE PG 36)
5	Hospital Affilia	ations													
l	DO YOU HAVE		IF YOU DO N	IOT ADMIT P	ATIENTS, W	/HAT									
ents	HOSPITAL YE PRIVILEGES?*	ES NO	TYPE OF AD YOU HAVE?	MITTING AR											
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^{*} REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Hospit	al Aff	iliat	ion	s (Co	ontin	wed)																		
PRIMARY				3 (00	711(111	iaca	<u>/</u>																		
FRIWARI	ПОЗРІ	IAL	ī																						
HOSPITAL	NAME																								
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NUMBER				STRE																		CULT	E/BUIL	DING	
NUMBER				SIKE	I .																	30111	Z/BUIL	DING	
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History Form on page																						

* 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 TELEPHONE should be listed in Section 4. Include a chronological END DATE COUNTRY CODE START DATE work history for the REASON FOR DEPARTURE (IF APPLICABLE) past 10 years. A longer period may be required by your healthcare entity If you have additional work history, use the WORK HISTORY Supplemental Work History Form on page 32. PRACTICE / EMPLOYER NAME NUMBER CITY TELEPHONE COUNTRY CODE START DATE END DATE REASON FOR DEPARTURE (IF APPLICABLE) WORK HISTORY NUMBER SUITE/BUILDING CITY TELEPHONE START DATE COUNTRY CODE REASON FOR DEPARTURE (IF APPLICABLE) 3090

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* REQUIRED RESPONSE, NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 8 **Disclosure Questions Disclosure** LICENSURE Questions Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished. YES denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any con-Answer all questions. ditions or limitations by any state or professional licensing, registration or certification board?* For any "Yes" response, provide an YES NO Has there been any challenge to your licensure, registration or certification?* explanation on the Supplemental Disclosure Question HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS Explanation Form on Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever page 34. been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for YES 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, Allied Health or governing board?* **Providers** YES NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?* If you are an Allied Health Provider and you do not believe a Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action. YES question is applicable by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?* to you, you should answer the question **EDUCATION, TRAINING AND BOARD CERTIFICATION** "NO". Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, resi-YES dency, 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?* Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status YES as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?* YES NO Have any of your board certifications or eligibility ever been revoked?* 8. 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 Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been chal-10. YES lenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished? MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or other-YES wise 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 Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, educa-12. YES tion 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? To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare 13 YES Integrity and Protection Data Bank?* Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, 14. YES NO OSHA, etc.)?* Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or 15 YES NO resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or 16 YES 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 Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your 17 YES NO individual liability history?* Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance 18 YES carrier, based on your individual liability history?*

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

Section 8 **Disclosure Questions** (Continued) **Disclosure** MALPRACTICE CLAIMS HISTORY Questions Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?* YES 19 Answer all questions. If yes, provide information for each case. For any "Yes" response, provide an **CRIMINAL/CIVIL HISTORY** explanation on the Supplemental Disclosure Question NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?* 20. YES Explanation Form on page 34. In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor YES NO traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, compe-21. **IMPORTANT** If you answered "Yes" tence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual to question #19, you must complete the YES NO Have you ever been court-martialed for actions related to your duties as a medical professional?* Supplemental Malpractice Claims Explanation Form on Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or page 35 for each credentialing organization based upon all the relevant circumstances, including the nature of the crime. malpractice claim. ABILITY TO PERFORM JOB Are you currently engaged in the illegal use of drugs?* YES ("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 application, 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 authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.) NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the func-YES 24. tions of your job with reasonable skill and safety?*

NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*

Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable

3093

25.

26.

YES

YES

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, employees, 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 designated 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

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 or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings 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 in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

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 information 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 Participation; 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 that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*	Name (print)*	
M M D D Y Y Y		
DATE SIGNED*		

Professional IDs Supplemental Form

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

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

Other Relevant Education Supplemental Form

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

Section 2	Education and Training
Fifth Pathway Education	FIFTH PATHWAY GRADUATES ONLY
	INSTITUTION/HOSPITAL WHERE U.S. CLINICAL TRAINING WAS PERFORMED (DO NOT ABBREVIATE)
	ADDRESS
	CITY STATE ZIP CODE
	TELEPHONE FAX
	DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO START DATE END DATE (GRADUATION DATE)
Other Relevant	
Education	INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)
If you need to report additional Education, photocopy this page as needed and submit as	NUMBER STREET SUITE/BUILDING
instructed.	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
	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

Other Training Supplemental Form

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

Section 2	Ed	uca	tior	ı a	ınd	Tr	ain	ing	J																														
Training					T				П	T			Т	٦						T						T							1			Ī	1		
List all postgraduate training programs you attended. Use one																																		1	AFFII	DOL (LIATI DOL)	ED M	E (E.	G., CAL
section per institution.	INSTIT	TUTION	N / HO	SPI	TAL N	IAME	(US	E BO	TH L	INES	IF R	EQU	JIREC))																				— r					
If you need to report additional Training,	NUME	BER						STRE	ET																								SU	JITE/	BUIL	DING	L		
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Code lists are found on pages 36-43. Enter the associated 3-digit code														-					-]-[
in the space provided.	COU	NTRY	CODE							TEL	EPH	ION	E													FAX													
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Additional Specialty Supplemental Form

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

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Partners/Associates **Supplemental Form**

4	Practice Location Infor	mation							
tes	SPECIFY PRACTICE LOCATION	INDICATE TH	E PRACTICE I	LOCATION TO	wнісн You	J ARE ASSOCIATI	NG THESE PROVIDERS.		
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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Covering Colleagues Supplemental Form

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

Section 4	Practice Location Information - Page 1 of 5
Additional Practice Location	► LOCATION* #
Location	CURRENTLY PRACTICING AT THIS ADDRESS?* YES NO PREVIOUS OR FUTURE START DATE? M M D D Y Y Y Y Y
IMPORTANT ———————————————————————————————————	
indicate to which practice location this page belongs.	PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*
For example, if you practice at three locations, the primary	GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)
location is reported in the main application and remaining locations would be	NUMBER* STREET* SUITE/BUILDING
reported on Supplemental Forms as Location 2 and Location 3.	CITY* SEND GENERAL CORRESPON- DENCE HERE?* TELEPHONE* STATE* ZIP CODE* TELEPHONE* FAX
TIP Your Individual Tax ID is assumed to be	OFFICE E-MAIL ADDRESS PRIMARY USE INDIVIDUAL USE CROI
your Primary Tax ID unless you specify otherwise to the right.	INDIVIDUAL TAX ID GROUP TAX ID
Office Manager or Business Office Contact	LAST NAME*
List each contact separately. You may use the check boxes	FIRST NAME*
below for convenience. Do not write instructions like "see above". These	TELEPHONE* FAX
responses will be rejected and will require follow-up.	E-MAIL ADDRESS
Billing Contact	
CHECK HERE TO USE OFFICE MANAGER AND	LAST NAME*
OFFICE ADDRESS AS BILLING INFORMATION	FIRST NAME* M.I.
	NUMBER* STREET* SUITE/BUILDING
NOTE: Even if you checked	CITY* STATE* ZIP CODE*
the boxes above, please provide the e-mail address of the	TELEPHONE* FAX
Billing Contact, if available.	E-MAIL ADDRESS
I	3100

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

Section 4	Practice	Location	Inform	ation	- Page	2 of 5	5											
Add'l Practice Location (Cont.)	LOCA.	TION* #																
Payment and Remittance	ELECTRONIC BILLING CAPABILITIES?*	YES	NO	BILL	NG DEPART	TMENT (IF	HOSPITAL	BASED)										
YOUR "CHECK PAYABLE TO" NFORMATION SHOULD BE CONSISTENT WITH YOUR N-9.	CHECK PAYABL	E TO*																
CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING	LAST NAME*																	
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the boxes above, please provide the E-mail Address, Department Name,	TELEPHONE*	-	-			FAX			_									
Electronic Billing and Check Payable To, if applicable.	E-MAIL ADDRES	38																
Office Hours	(USE HHMM	FORMAT AND		TO THE			IOUR)					A=AM					A=AM	_
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telephone will be used only by the health plan and will not be	24/7 PHONE COV	VED A GEOT	YES							4.53	TER HOU		V 055101					_
published under any circumstances.	YES YES	NO NO		ERING CE	INSTRU	MAIL WITH JCTIONS T ERING SER	O CALL	VOICE M WITH OT INSTRUC	HER	AFI	IEK HOOF	-	K OFFICE	LIELEF	- I			
Open Practice Status	ACCEPT NEW P	PATIENTS INTO TI	HIS PRACTIO	CE?*		YES	NO	ACCE	PT ALL N	EW PATI	ENTS?*					YES		NO
	ACCEPT EXISTI	ING PATIENTS W	ITH CHANGI	E OF PAYO	R?*	YES	NO	ACCE	PT NEW I	MEDICAR	E PATIEN	ITS?*				YES		NO
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	ARE THERE AN		F YES		R LIMITATIO	ons	AGE LI	MITATIONS		OTHER L	IMITATIO	NS						
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Page 26 Std. App. v.5.0
Reprinted on 10/31/06

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Section 4	Practice Location Information - Page 3 of 5
Additional Practice Location	LOCATION* #
(Continued)	DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?*
IMPORTANTIn the box provided, indicate to which	(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)
practice location this page belongs.	PRACTITIONER LAST NAME
	PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA,
Mid-Level Practitioners	PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE
	PRACTITIONER LAST NAME
	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)
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	PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE
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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 4 Practice Location Information - Page 4 of 5 **Additional** ► LOCATION* # **Practice** Location **LANGUAGES** (Continued) NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL **IMPORTANT** LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE In the box provided. INTERPRETERS LANGUAGES indicate to which YES NO AVAILABLE?* INTERPRETED practice location this page belongs. LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE **Accessibilities** DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO DOES THIS SITE OFFER HANDICAPPED DOES THIS SITE OFFER OTHER ACCESSIBLE BY YES NO YES NO ACCESS FOR THE FOLLOWING SERVICES FOR THE DISABLED? **PUBLIC TRANSPORTATION?*** YES **BUILDING?*** YES NO **TEXT TELEPHONY (TTY)*** YES NO BUS* NO PARKING?* YES NO AMERICAN SIGN LANGUAGE* YES NO SUBWAY* YES NO MENTAL/PHYSICAL IMPAIRMENT REGIONAL TRAIN YES NO RESTROOM?* YES NO YES NO OTHER HANDICAPPED ACCESS OTHER TRANSPORTATION ACCESS OTHER DISABILITY SERVICES Services Does this location provide any of the following services? IF YES, PROVIDE ACCREDITING/ LABORATORY YES NO CERTIFYING PROGRAM SERVICES? (E.G., CLIA, COLA, MLE) RADIOLOGY IF YES, PROVIDE X-RAY YES SERVICES? **CERTIFICATION TYPE** ALLERGY INJECTIONS? ALLERGY SKIN TESTING? EKGS? YES NO YES NO NO YES NO GYNECOLOGY YES (PELVIC/PAP)? AGE TYMPANOMETR Y/ AUDIOMETRY DRAWING YES NO APPROPRIATE **FLEXIBLE** YES NO YES NO YES BLOOD? SIGMOIDOSCOPY? IMMUNIZATIONS? SCREENING? ASTHMA OSTEOPATHIC MANIPULATION? IV HYDRATION/ TREATMENT? CARDIAC STRESS TEST? YES NO YES NO YES YES NO TREATMENT? PULMONARY PHYSICAL YES NO CARE OF MINOR **FUNCTION** YES NO YES NΩ THERAPY? LACERATIONS? TESTING? IS ANESTHESIA ADMINISTERED IN IF YES. WHAT YES CLASS/CATEGORY YOUR OFFICE? DO YOU USE? IF YES, WHO ADMINISTERS IT? LAST NAME FIRST NAME TYPE OF PRACTICE SINGLE SPECIALTY GROUP MULTI-SPECIALTY GROUP SOLO PRACTICE (SELECT ONE ONLY) ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

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

Section 4	Practice Location Information - Page 5 of 5		
Additional Practice	→ LOCATION* #		
_ocation	LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE		
Continued)			
MPORTANT —			
n the box provided, ndicate to which	LAST NAME		SPECIALTY CODE COVERING COLLEAGU
oractice location this bage belongs.			(Y/N)?
0	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
f you have additional partners/associates at			
THIS location, use the Partner/Associate	LAST NAME		SPECIALTY CODE COVERING
Supplemental Form on			COLLEAGU (Y/N)?
page 23. Photocopy as necessary. Be certain	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
o indicate the Practice ocation Number at the			
op of the page.			
Code lists are found on pages 36-43. Enter the	LAST NAME		SPECIALTY CODE COVERING COLLEAGU
associated 3-digit code n the space provided.			(Y/N)?
in the space provided.	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
	LAST NAME		SPECIALTY CODE COVERING COLLEAGU
			(Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
Covering	LIST ALL COVERING COLLEAGUES THAT ARE <u>NOT</u> PARTNERS/ASSOCIATES AT THIS PRACTICE		
Colleagues			
Code lists are found on	LAST NAME		SPECIALTY CODE
pages 36-43. Enter the associated 3-digit code			
in the space provided.	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
If you have additional			
covering colleagues that are not partners at			
THIS location, use the Covering Colleagues	LAST NAME		SPECIALTY CODE
Supplemental Form on page 24. Photocopy as			
necessary. Be certain to indicate the Practice	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
Location Number at the			
top of the page.	LAST NAME		SPECIALTY CODE
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Hospital Privileges (Current) Supplemental Form

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

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Professional Liability Insurance Carrier Supplemental Form

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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.

Section 7	Work History
Work History	WORK HISTORY
Use this form to continue listing work history.	PRACTICE / EMPLOYER NAME
If you need additional space for Work History,	NUMBER STREET SUITE/BUILDING
photocopy this page as needed and submit as instructed.	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)
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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Professional Training / Work History Gaps Supplemental Form

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

Section 7	Professio	onal Training / Work Histo	tory Gaps
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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Disclosure Questions Supplemental Form

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

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Malpractice Claims Explanation Supplemental Form

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

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