REPORT OF THE MARYLAND INSURANCE ADMINISTRATION ON PROVIDER CREDENTIALING

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REPORT OF THE MARYLAND INSURANCE ADMINISTRATION ON PROVIDER CREDENTIALING PURSUANT TO CHAPTER 54, ACTS OF 2006

I. EXECUTIVE SUMMARY

In recognition of the need to examine and improve the efficiency and ease of the provider credentialing process in the State of Maryland, the Maryland General Assembly passed Senate Bill 636/House Bill 574 "Health Insurance - Credentialing and Recredentialing of Health Care Providers." (Chapter 54, Acts of 2006) The law requires, among other things, that:

> The Maryland Insurance Administration, in consultation with the Department of Health and Mental Hygiene, the Maryland Board of Physicians, and representatives of nonprofit health service plans, health insurers, health maintenance organizations, physicians, practice managers, hospitals, and other health care providers, shall:
>
> (1) compare the credentialing system for health providers used in the State to the systems used in other states;
>
> (2) compare the uniform credentialing form used in the State to the format used by the Council for Affordable Quality Healthcare;
>
> (3) identify the mechanisms used by physicians and other health care providers to complete credentialing; and
>
> (4) identify ways to improve the credentialing system used in the State.

The Maryland Insurance Administration is required to report its findings to the Senate Finance Committee and the House Health and Government Operations Committee by January 1, 2007.

In order to meet its charges, the Maryland Insurance Administration:

- gathered information on the credentialing requirements and systems within Maryland and other states;
- reviewed and made a comparison of the uniform credentialing form and the form used by the Council for Affordable Quality Healthcare;
- identified and examined how physicians and other providers complete the credentialing process;

- solicited feedback from any and all interested parties beginning September 6, 2006;
- conducted a public meeting with interested parties as an opportunity to discuss the various viewpoints on the issues on September 13, 2006; and
- consulted with the Department of Health and Mental Hygiene and the Board of Physicians.

Recommendations

As a result of the review conducted, the Maryland Insurance Administration makes the following recommendations:

- Make the Council for Affordable Quality Healthcare form the Uniform Credentialing Form accepted by all carriers, except dental plan organizations, in Maryland.

- Create a dental-specific Uniform Credentialing Form for use by dental plan organizations.

- Permit a credentialing intermediary that uses the uniform credentialing form for hospitals designed by Department of Health and Mental Hygiene (DHMH) to use the DHMH form instead of the UCF.

- Require carriers to accept the paper version of the UCF.

- Specify the date certain by which a properly credentialed physician is recognized as participating on a carrier's provider panel.

II. INTRODUCTION

During its 2006 legislative session, the Maryland General Assembly passed Senate Bill 636/House Bill 574 "Health Insurance - Credentialing and Recredentialing of Health Care Providers." (Chapter 54, Acts of 2006) This legislation was enacted in response to various concerns raised by interested parties regarding provider credentialing and recredentialing in Maryland. The bill addressed several issues regarding provider credentialing, including (1) shortening the time period within which a health insurance carrier must make a decision regarding the participation of a health care provider on the carrier's provider panel, and (2) prohibiting health insurance carriers from requiring health care providers to be recredentialed based on a change in the federal tax identification number under certain circumstances. In addition, the new law requires, among other things, that:

> The Maryland Insurance Administration, in consultation with the Department of Health and Mental Hygiene, the Maryland Board of Physicians, and representatives of nonprofit health service plans, health insurers, health maintenance organizations, physicians, practice managers, hospitals, and other health care providers, shall:
>
> (1) compare the credentialing system for health providers used in the State to the systems used in other states;
>
> (2) compare the uniform credentialing form used in the State to the format used by the Council for Affordable Quality Healthcare;
>
> (3) identify the mechanisms used by physicians and other health care providers to complete credentialing; and
>
> (4) identify ways to improve the credentialing system used in the State.

The Maryland Insurance Administration (MIA) is required to report its findings to the Senate Finance Committee and the House Health and Government Operations Committee by January 1, 2007.

In order to meet its charges, the MIA commenced work on the report over the summer of 2006. The MIA began by gathering information on the credentialing requirements and systems within Maryland and other states. Information gathered as part of that inquiry can be found at the end of this report as Appendix B. The MIA:

- reviewed and made a comparison of the uniform credentialing form and the form used by the Center for Affordable Quality Healthcare;
- identified and examined how physicians and other providers complete the credentialing process;
- solicited feedback from any and all interested parties beginning September 6, 2006;
- conducted a public meeting with interested parties as an opportunity to discuss the various viewpoints on the issues on September 13, 2006; and
- consulted with the Department of Health and Mental Hygiene and the Board of Physicians.

III. CREDENTIALING IN MARYLAND AND OTHER STATES

Credentialing is the administrative process by which a health carrier validates the qualifications of a health care provider and evaluates the health care provider's background. The process is an objective assessment of a health care provider's current licensure, training or experience, competence, and ability to provide particular services or perform particular procedures. In order to obtain the information to be reviewed, health carriers require health care providers to complete a credentialing form that solicits the necessary information.

Credentialing in Maryland

In 1999, the Maryland General Assembly passed Senate Bill 641 (Chapter 589, Acts of 1999) mandating the use of a Uniform Credentialing Form (UCF) in Maryland. This UCF, specified in regulation, is the only form to be accepted by carriers credentialing for Maryland health plans. The form gathers personal information (e.g. name, address, employer) and professional information (e.g. education, employment history, training). This information is then subject to primary source verification by the health carrier or the carrier's designated credentialing intermediary. A copy of the current Maryland UCF can be found in Appendix C.

In addition to mandating the use of the UCF, Maryland law also specifies timeframes applicable to the application and credentialing process. Maryland law requires that a health care provider who wishes to participate on a carrier's provider panel shall submit an application to the carrier. (See Insurance Article § 15-112 (d)(1)) If a carrier receives an incomplete application, the carrier must return the application to the health care provider, along with a notice identifying what information is needed to make the application complete, within 10 days of receipt of the application. (See Insurance Article § 15-112 (d)(2)) Once a carrier receives a complete application, the carrier must notify the health care provider that either the carrier intends to continue processing the application to obtain the needed credentialing information or that the application is rejected within 30

days. (See Insurance Article § 15-112(d)(3)(i)) If the carrier intends to continue to process the application in order to obtain credentialing information, the carrier must either accept or reject the health care provider for participation on the panel and send notice of that decision within 120 days. (See Insurance Article § 15-112 (d)(3)(iii)) The law does not specify the timeframe in which a health care provider shall be permitted to begin participating on a carrier's panel once they have been accepted.

Credentialing in Other States

The MIA reviewed the credentialing laws of all states. The need for provider credentialing exists in every state. Whether or not the state mandates the type or content of the form to be used or the timeframe in which the process is to occur differs from state to state. The MIA learned that 24 other states have laws or regulations that address a credentialing form. Some states mandate the use of a uniform form similar to Maryland. Other states have laws that address the minimum requirements for credentialing forms and verification. See Appendix B for a breakdown of the laws in other states.

Of the states that mandate a specific form, like Maryland, many mandate the insurance regulator to develop the form to be used. In a handful of states, the mandated form is currently the Council for Affordable Quality Healthcare Provider Application form (CAQH form). To date, the CAQH form is supported by state officials in Indiana, Kentucky, Tennessee, Louisiana, Rhode Island, Vermont and the District of Columbia. The CAQH form is also used on a voluntary basis in 26 other states where no mandated form exists. A copy of the CAQH form can be found in Appendix D.

IV. COMPARISON OF THE MARYLAND UNIFORM CREDENTIALING FORM AND THE CENTER FOR QUALITY AFFORDABLE HEALTHCARE CREDENTIALING FORM

The CAQH is a nonprofit organization that promotes industry collaboration in order to simplify the administration of health care. As part of that effort, the CAQH has created the Universal Credentialing Datasource (UCD). The UCD is the web portal that incorporates the provider application form used by CAQH and allows the information to be submitted electronically to carriers. Through the UCD, a provider can fill out the CAQH form and submit it directly to carriers of the provider's choosing.

The MIA reviewed and compared the Maryland UCF and the CAQH form. The comparison of the UCF and the CAQH form focused on the use, content and questions asked in each of the forms. A detailed breakdown of the questions that appear on the CAQH form and the UCF can be found in Appendix E. This comparison does not address the online process used by the CAQH UCD when

used as the portal through which a health care provider submits a completed form to a carrier.

After comparing both forms, the reviewers found that the UCF and the CAQH form are substantially similar. Both forms seek out the same type of information and contain many questions in common. However, the reviewers found that one of the main differences between the UCF and the CAQH form is that the CAQH form serves as both the credentialing data source and the health care provider application combined into one document. In Maryland, carriers must use a separate application form in addition to the UCF. Carriers who use the UCF as the provider application violate COMAR 31.10.16.03 because the form of application may not include questions relating to gender, race, age or national origin. This personal information is either required or requested voluntarily on the UCF.

The review process also identified various data elements that are required on the UCF but not the CAQH form. Unlike the CAQH form, the UCF requires the submission of a copy of the provider's Board Certification certificate, if held. In addition, several sections of the UCF contained questions that did not appear on the CAQH form. Specifically, the UCF asked 50 additional questions not asked on the CAQH form. A summary of these questions is in Appendix E.

The CAQH form requires submission of an Application release, a W-9 form and a Workers Compensation Certificate of Coverage. None of these documents is required for submission with the UCF. In addition, the CAQH form asks several questions that do not appear on the UCF. Specifically, the CAQH form asked a total of 76 additional questions. A summary of these questions is in Appendix E.

In comparing the UCF to the CAQH form, the MIA reviewer found the following additional differences, other than content of the questions:

- The CAQH form is designed to be used as an electronic form and submitted through the UCD, which is convenient for the provider when trying to apply in different states for different carriers. It streamlines the credentialing data submission process for physicians. It appears that the CAQH UCD has the potential to significantly reduce the time and paperwork involved compared to traditional data submission procedures. This electronic format is saved by the data source and available for future credentialing updates.

- The CAQH form allows more space for filling in responses and appears to be more detailed in the nature of the questions.

V. MECHANISMS USED BY PHYSICIANS AND OTHER HEALTH CARE PROVIDERS TO COMPLETE CREDENTIALING

Maryland's law does not require any particular mechanism for credentialing be used. A health care provider may submit a credentialing form to the carrier in any form the carrier is willing to accept; however, a carrier must accept a paper credentialing form from a health care provider seeking to be credentialed.

In order to participate on a carrier's provider panel, a health care provider must complete the credentialing process. Maryland law requires that a carrier make available the UCF for interested health care providers. Currently, carriers either have internal departments responsible for credentialing health care providers or they use a credentialing intermediary. A credentialing intermediary is defined as "a person to whom a carrier has delegated credentialing or recredentialing authority and responsibility." (See Insurance Article § 15-112.1(a)(3)) This allows carriers to contract with a third party entity to complete the review of credentialing information on behalf of the carrier. Sometimes this third party entity is a company that specializes in health care provider credentialing. Other times, carriers will contract with large provider organizations such as hospitals, other health care facilities or large provider practice groups to act as the credentialing intermediary. In these arrangements, the credentialing intermediary is an organization which would also be credentialing the provider for its own purpose. In order to obtain an administrative efficiency, the carrier substitutes the process of the credentialing intermediary for its own, preventing the duplication of effort. The credentialing intermediary stands in the shoes of the carrier and is required to comply with all laws applicable to the credentialing process as if it were the carrier. The Commissioner has the ability to impose a penalty against a carrier for its failure to comply with the law or the failure of its credentialing intermediary. (See Insurance Article § 15-112.1(c))

Through the information-gathering process for this report, it became apparent that there is some confusion about the use and role of a credentialing intermediary. A carrier is not required to use a credentialing intermediary at any time. Carriers are permitted to use credentialing intermediaries as part of their credentialing process at their discretion. The law makes no distinction in the types of credentialing intermediaries subject to the provisions of §§ 15-112 and 15-112.1 of the Insurance Article. Whether the credentialing intermediary is a private company in the business of credentialing on behalf of a carrier or a hospital system credentialing its faculty on behalf of a carrier, all provisions applicable to credentialing intermediaries apply.

In addition, carriers are permitted to use other third party vendors that do not meet the definition of a credentialing intermediary as part of their credentialing process. For instance, a carrier could contract with a third party vendor to digitize all paper credentialing forms the carrier received. That same carrier could contract with a separate third party vendor to conduct primary

source verification. There is no limit in the law to the number of vendors a carrier may use to complete its credentialing process. If the carrier retains the ultimate authority and responsibility to determine if a health care provider is appropriately credentialed for participation on the carrier's panel, the vendors do not meet the definition of a credentialing intermediary. Regardless of the number of vendors used, the carrier would be required to comply with all statutorily mandated timeframes and would be subject to penalty for failure to do so.

VI. POSSIBLE IMPROVEMENTS TO MARYLAND'S CREDENTIALING SYSTEM

The MIA received feedback from a number of interested parties regarding potential changes to the laws or regulations applicable to the credentialing process. As a result of the review conducted by the MIA and the feedback received, the MIA has five recommendations for changes to Maryland law or regulation.

Recommendations

- Make the Council for Affordable Quality Healthcare form the Uniform Credentialing Form accepted by all carriers, except dental plan organizations, in Maryland.

The majority of the interested parties that provided feedback on the CAQH form did not object to the CAQH form becoming the Maryland UCF. Because of the growing acceptance of the CAQH form and the increasing push for uniformity between state processes, the MIA believes that adoption of the CAQH form is an appropriate move at this time. In order to best effectuate this change, the MIA further recommends removing the requirement that the Commissioner adopt the UCF through regulation by amending the definition of UCF in § 15-112.1(a)(6) of the Insurance Article. This change will give the Commissioner the flexibility to make necessary changes to the UCF as needed.

- Create a dental-specific Uniform Credentialing Form for use by dental plan organizations.

The greatest concern about the adoption of the CAQH form as the Maryland UCF came from dental plan organizations. While the CAQH form was designed to be used by any health care provider, the form was not designed with dental providers as its basis. At this time, there is only one dental carrier participating with CAQH. The MIA believes that the creation of a credentialing form specific to dental plan organizations is an appropriate action at this time.

- Permit a credentialing intermediary that uses the uniform credentialing form for hospitals designed by Department of Health and Mental Hygiene (DHMH) to use the DHMH form instead of the UCF.

Many of the interested parties described to the MIA how a health care facility that acts as a credentialing intermediary completes the credentialing process. Through this investigation, it has become clear that these entities capture the needed information though the credentialing form required for the facility. These credentialing intermediaries are not requiring that health care providers complete the UCF in addition to the form required by the facility. Completing one form for the purpose of credentialing for both the facility and the carrier panel is administratively efficient for both the health care provider seeking to be credentialed and the facility serving as the credentialing intermediary. In recognition of this efficiency, the MIA, through MIA Bulletin 02-25, has permitted facilities credentialing their own providers to use a form other than the UCF. This recommendation would make it explicit in the law that this exception to the UCF is permitted in Maryland.

- Require carriers to accept the paper version of the UCF.

Current Maryland law requires carriers to accept the paper version of the UCF but permits carriers to accept an electronic copy of the UCF. The MIA supports the use of electronic submission; however, the MIA believes that the decision as to whether or not to submit credentialing information electronically should rest with the health care provider. While there are providers who like the ability to use an online submission process, many of the objections received by the MIA focused on problems or concerns related to the CAQH Universal Credentialing Datasource as the only submission process. The MIA feels that there is an important distinction between permitting online submission and requiring its use and that any change to the law should continue to require carriers to accept the paper form at the health care provider's discretion.

- Specify the date certain by which a properly credentialed physician is recognized as participating on a carrier's provider panel.

The most frequent complaint voiced by providers to the MIA through the comment process was that carriers take an inordinate amount of time to activate a provider's participation on a provider panel. Currently, § 15-112 of the Insurance Article requires that a carrier notify a provider that they have been accepted onto the carrier's panel within 120 days of receiving a completed application. The law is silent on the amount of time the carrier has to begin treating that provider as participating. Providers reported waiting upwards of three months after acceptance to be considered participating. It seems appropriate to the MIA that the General Assembly consider clarifying the timeframe for this last step in the credentialing process.

Changes for further consideration

In addition to the recommendations made in this report, there are changes that the MIA believes deserve further consideration but the MIA is not prepared to make recommendations on these issues under this report, at this time.

- Is it appropriate for a credentialing intermediary who is a participating facility on the carrier's provider panel to be exempted from the statutorily-mandated timeframes related to credentialing?

Hospitals indicated that it is difficult to fit their credentialing process into the statutory timeframes. Unlike the change of the form that creates an efficiency for both the facility and the health care provider, this is a change that could negatively impact providers. At the same time, it is not in the best interest of the State to impose timeframes that prevent a hospital from doing a complete and thorough review of health care providers for both a health carrier and for the hospital's own credentialing process. We received a great deal of feedback on this issue from facilities and carriers but not from providers. This may be a worthwhile change but would require the examination of more specific data regarding how long facilities take to credential. In addition, the MIA believes it is important to allow health care providers an opportunity to comment.

- Should the state require all health care provider licensure information be made available in real time on the internet in order to speed the primary source verification process?

This change may expedite this portion of the credentialing process. This change aids the credentialing process but is not actually a part of the credentialing process. This change impacts DHMH both in terms of staff and significant financial cost. There is additional review needed before the State elects to implement access to real time licensing information for all provider licenses.

VII. CONCLUSION

This report offers findings and recommendations to improve the efficiency and ease of the provider credentialing process in the State of Maryland. The MIA hopes that this report is a useful piece in the ongoing discussion of provider credentialing issues within the State. The MIA looks forward to working with DHMH, the General Assembly and other stakeholders to implement the report's recommendations to improve the provider credentialing process.

APPENDIX A

Enabling Legislation

A copy of Senate Bill 636 may be accessed through the following link
to the Maryland General Assembly:

http://mlis.state.md.us/2006rs/bills/sb/sb0636t.pdf

APPENDIX B

Information on Other States Credentialing Process

State	Citation	Form/ Forms Used	Total Time Allowed for Review	Other Specifications
Arkansas	17-95-107	Physicians submit the requested credentialing info to the Ark. State Medical Board so they may let accrediting organizations verify it	ASMB shall provide requested info about the licensed person (which the person releases) within 15 days	
Delaware	69.401	Lists minimum requirements for credentialing forms and verification	Review time not specified but several things must be re-verified every 3 years	Provider has the right to review and correct any erroneous information
District of Columbia	31-3252	Health insurers/ credentialing intermediaries shall accept the uniform credentialing form as the sole application		
Illinois	410 ILS 517/15	Health care plans and entities may only require a uniform credentialing form for credentialing and re-credentialing. Electronic and paper form accepted, moving toward a date when only the former is accepted	Must complete the process within 60 days of submission	Health care professionals have 5 days to correct certain changes/ updates/ modifications and 45 days for all others from the date he/she knew of the change - as listed in Section (g)
Indiana	27-13-43-2	Must use the CAQH form in paper or electronic format	Give an update on the status of the application within 60 days, and update status every 30 days until completion	Must notify applicant of deficiencies on the form within 30 days
Kentucky	KRS § 304.17A-545	The executive director shall promulgate administrative regulations to establish a		

State	Citation	Form/ Forms Used	Total Time Allowed for Review	Other Specifications
		uniform application form and guidelines for the evaluation and reevaluation of health care providers, including psychologists, who will be on the plan's list of participating providers in accordance with subsection (4) of this section. In developing a uniform application and guidelines, the office shall consider industry standards and guidelines adopted by the Council for Affordable Quality Healthcare. The uniform application form and guidelines shall be used by all insurers.		
Louisiana	R.S. 22:11.1	CAQH or Louisiana Standardized Credentialing Application Form- paper or electronic	Complete the process within 90 days of receipt of all information	Must notify applicant of deficiencies on the form within 30 days
Maine	24-A s 4303	Health carriers must consult with appropriately qualified health care professionals and develop objective credentialing standards	Decisions must be made within 60 days of receipt of application, with the possibility of extending it to a 180 day maximum in certain instances	Carrier shall review application and return it to applicant with a list of all needed corrections for him/ her to update
Massachusetts	243 CMR 3.05	Lists minimum requirements for credentialing forms and verification		Must repeat the credentialing process every 2 years
Michigan	500.3528	Lists minimum requirements for	No time frame but must give the	Must keep those documents

State	Citation	Form/ Forms Used	Total Time Allowed for Review	Other Specifications
		credentialing forms and verification	professional the opportunity to review and correct info	for 2 years, re-verify certain info every 3 years
Mississippi	98-1.7	Commissioner adopted a basic uniform credentialing application and attached it to the regulation	No time frame but the professional may review and correct info on the application as he is notified and find out the source of that info. Some info must be re-credentialed every 2 years, some every 3 years	The form may be augmented for obtaining more information but not less and must be approved by the commissioner
Nebraska	44-7006	List the minimum requirements for credentialing forms and verification	No time frame but the professional may review and correct information that does not meet the standards and find out the source of that info. Some info re-verified every 3 years	Retain those documents for 5 years
Nevada	NAC 679B.0405	Must use Nevada Division of Insurance Form 901	Form 901 asks for 3 months to process the application	
New Hampshire	420-J:4	Lists the minimum requirements for credentialing forms and verification	Some info re-verified every three years	Retain those documents for 7 years
New Mexico	8-8-9.2	Superintendent of insurance shall adopt rules that include standards by a national committee on quality assurance		Re-credentialed no more than every 3 years
North Carolina	11 NCAC 20 .0404 through .0407	Lists the minimum requirements for credentialing forms and verification	Carrier shall notify a professional within 15 days of incomplete application needing changes. Within 60 days of receipt of application decision	Re-verification at least every 3 years

State	Citation	Form/ Forms Used	Total Time Allowed for Review	Other Specifications
			must be made unless certain problems occur.	
Ohio	Rule 3901-1-58	Mandatory use of Superintendent prescribed standard credentialing form		
Oklahoma	36 s 4405.1	Based on the uniform credentialing application required by Section 1-106.2 of Title 63 in Oklahoma Statutes	Notify the applicant of incomplete application within 10 days of receipt- after all is completed the decision must be made within 45 days	
Oregon	OAR 836-052-0700	Oregon Practitioner Credentialing Application, and Re-credentialing Application shall be used		
Pennsylvania	40-39-1221	Managed care plans shall establish a credentialing process to be approved by "the department" – may adopt nationally recognized accrediting standards		Managed care plan shall report to the department about its process at least every 2 years
Tennessee	56-7-1009	Health insurance entity shall accept in addition to its own credentialing applications, the CAQH application		If using CAQH- shall accept paper or electronic format
Texas	28 TAC s 21.3201	Texas Standardized Credentialing Application shall be used		Also used for re-credentialing and may be submitted electronically
Vermont	18 V.S.A. § 9408a	The department shall prescribe the credentialing application		

State	Citation	Form/ Forms Used	Total Time Allowed for Review	Other Specifications
		form used by the Council for Affordable Quality Healthcare (CAQH), or a similar, nationally recognized form prescribed by the commissioner, in electronic or paper format, which must be used beginning January 1, 2007 by an insurer or a hospital that performs credentialing.		
West Virginia	114-53-6	Lists the minimum requirements for credentialing forms and verification		Re-credentialing process shall be established and used at least every three years

Appendix C

Maryland Uniform Credentialing Form

UNIFORM CREDENTIALING FORM

Please type or print.
Incomplete Applications Will Not Be Processed.

☐ Initial Credentialing ☐ Maryland

☐ Re-credentialing ☐ Other: ____________________________

SECTION I
PERSONAL INFORMATION

Name (Last, First, Middle) ____

Professional Degree (M.D., D.D.S., R.N., etc.) ____________________________

Home Street Address ____

City/State/Zip ____

Home Phone Number (_____)__________________ Years at this Address ______________

Other Names Used ____

Previous Address if less than five (5) years at current address:

____

Date of Birth (MM/DD/YY) _______________ UPIN# _________________________

Languages Spoken ____

U.S. Citizen? ___ Yes ___ No If No, Status & Visa Number ___________________________________

SS# ___________________________ Federal Employee ID # __________________________

Gender: ☐ Male ☐ Female

VOLUNTARY INFORMATION:
Patients often express preferences for providers of a particular ethnic background or gender. Therefore, your completion of the information below will allow us to more readily meet these patients' needs when a referral is requested. If you **VOLUNTEER** to provide the following information, it will be used only when a patient indicates such information is important in selecting a provider and it will be held in strictest confidence. The information will not be released to any other party, except in aggregate form.

Ethnic background: ☐ Black/African American ☐ Hispanic/Latino

☐ Asian/Pacific Islander ☐ American Indian/Alaska Native American

☐ Caucasian ☐ Other

SECTION II
OFFICE INFORMATION

Primary Office Street Address ____

City/State/Zip ____

Office Phone(s) (_____)_____________ (_____)_____________ Office Fax (_____)_____________

Office Email ________________________ Office Manager ________________________________

Billing Address ____

City/State/Zip ____County__________________________

Type of Practice (L.L.C., Corp., etc.): ____

Group/Corporate Name _______________________________________ Fed Tax ID# ______________

Medicare # _____________________________ Medicaid # _____________________________

EPSDT Certified? ☐ Yes ☐ No If Yes, EPSDT # _____________________

Please list other licensed/certified professional members of your practice:

____

____

____

Please list health care providers who cover in your absence:

____

____

____

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Do you currently: (Circle One)

Accept new patients into your practice? Y N
Accept new patients from referral only? Y N
Accept Medicare patients? Y N
Accept new Medicare patients? Y N
Accept Medicaid patients? Y N
Accept new Medicaid patients? Y N

Does the office: (Circle One)

Have 24-hour phone coverage? Y N
Have capability for electronic billing? Y N
Does this location have TDD? Y N
Have public transportation access? Y N
Meet Americans with Disabilities Act accessibility standards? Y N

Please complete this page if you have an additional office

Office Street Address ____

City/State/Zip ____

Office Phone(s) (_____)______________ (_____)______________ Office Fax (_____)______________

Office Email ________________________ Office Manager _______________________________

Billing Address ____

City/State/Zip ______________________________________County____________________________

Type of Practice (L.L.C., Corp., etc.): ____

Group/Corporate Name ____________________________________ Fed Tax ID# ______________

Medicare # _______________________ Medicaid # _________________________

EPSDT Certified? ☐ Yes ☐ No If Yes, EPSDT # ______________________

Please list other licensed/certified professional members of your practice:

____

____

____

Please list health care providers who cover in your absence:

____

____

____

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Do you currently: (Circle One)

Accept new patients into your practice? Y N
Accept new patients from referral only? Y N
Accept Medicare patients? Y N
Accept new Medicare patients? Y N
Accept Medicaid patients? Y N
Accept new Medicaid patients? Y N

Does the office: (Circle One)

Have 24-hour phone coverage? Y N
Have capability for electronic billing? Y N
Does this location have TDD? Y N
Have public transportation access? Y N
Meet Americans with Disabilities Act accessibility standards Y N

Please complete this page if you have an additional office

Office Street Address ____

City/State/Zip ____

Office Phone(s) (_____)______________ (_____)______________ Office Fax (_____)______________

Office Email ________________________ Office Manager _______________________________

Billing Address ____

City/State/Zip ______________________________________County_____________________________

Type of Practice (L.L.C., Corp., etc.): ____

Group/Corporate Name _____________________________________ Fed Tax ID# ______________

Medicare # _______________________ Medicaid # _________________________

EPSDT Certified? ☐ Yes ☐ No If Yes, EPSDT # _____________________

Please list other licensed/certified professional members of your practice:

____

____

____

Please list health care providers who cover in your absence:

____

____

____

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Do you currently: (Circle One)

Accept new patients into your practice? Y N
Accept new patients from referral only? Y N
Accept Medicare patients? Y N

Accept new Medicare patients? Y N
Accept Medicaid patients? Y N
Accept new Medicaid patients? Y N

Does the office: (Circle One)

Have 24-hour phone coverage? Y N
Have capability for electronic billing? Y N
Does this location have TDD? Y N

Have public transportation access? Y N
Meet Americans with Disabilities Act accessibility standards Y N

SECTION III
EDUCATION

List all, including undergraduate, completed or not, beginning with the most recent. Attach separate sheet, if necessary. Psychologist, please indicate whether APA approved program.

School Name ____

Degree Awarded ____________________ Program Title ____________________

Mailing Address ____

Dates Attended (MM/YY) From __________ to __________ APA approved? ☐ Yes ☐ No

School Name ____

Degree Awarded ____________________ Program Title ____________________

Mailing Address ____

Dates Attended (MM/YY) From __________ to __________ APA approved? ☐ Yes ☐ No

School Name ____

Degree Awarded ____________________ Program Title ____________________

Mailing Address ____

Dates Attended (MM/YY) From __________ to __________ APA approved? ☐ Yes ☐ No

SECTION IV
TRAINING

Internships/Residencies/Fellowships/Preceptorships. List all, completed or not, beginning with the most recent. Attach a separate sheet if necessary. Psychologist, indicate whether APA approved program.

Institution ____

Mailing Address ____

Dates Attended (MM/YY) From __________ to __________ Program Completed? ☐ Yes ☐ No

Type of Training/Specialty ____

Program Director______________________________ APA approved? ☐ Yes ☐ No

Institution ____

Mailing Address ____

Dates Attended (MM/YY) From __________ to __________ Program Completed? ☐ Yes ☐ No

Type of Training/Specialty ____

Program Director______________________________ APA approved? ☐ Yes ☐ No

Institution ____

Mailing Address ____

Dates Attended (MM/YY) From __________ to __________ Program Completed? ☐ Yes ☐ No

Type of Training/Specialty ____

Program Director______________________________ APA approved? ☐ Yes ☐ No

SECTION V
PROFESSIONAL LICENSURE

List all Current Professional Licenses. Please attach copies.

State	Type	Number	Issue Date	Expiration Date

List all Past Professional Licenses:

State	Type	Number	Issue Date	Expiration Date

SECTION VI
CERTIFICATIONS/REGISTRATION

Please attach copies of any of the following certifications, if held. Attach a separate sheet if necessary.

Federal DEA Registration Number ____

Date Issued ___________________________ Expiration Date _______________________

State CDS Number ______________________ State ________________________________

Date Issued ___________________________ Expiration Date _______________________

CPR Certified? ☐ Yes ☐ No Expiration Date _______________________

If Yes, List Classifications: ____

International Graduates: Are you ECFMG Certified? ☐ Yes ☐ No

USMLE/ECFMG Number: ____________________ Issue Date: ___________________

Nursing Professionals: Please list any certifications held:

Certification	Received From	Expiration (MM/YY)

SECTION VII
SPECIALTY INFORMATION

Primary Specialty _______________________ ☐ Qualified ☐ Certified ☐ Not Applicable
Board Name ________________________________ Date of Initial Certification ______________

Board Certification expires? ☐ Yes ☐ No If yes, Date of Expiration? _________________

Have you been recertified? ☐ Yes ☐ No ☐ N/A If Yes, Date of Recertification ______________
If Qualified, when does status expire? (MM/YY) ______________________
If Qualified, date exam is scheduled: _________________________

Board certification results pending? ☐ Yes ☐ No

Do you wish to be listed in the organization directory under this specialty? ☐ Yes ☐ No

Would you like to be classified as a: ☐ Primary Care Provider ☐ Specialist ☐ Both
☐ Hospitalist ☐ Not Applicable

Sub-Specialty ___________________________ ☐ Qualified ☐ Certified ☐ Not Applicable
Board Name __________________________ Date of Initial Certification ______________

Board Certification expires? ☐ Yes ☐ No If yes, Date of Expiration? _________________

Have you been recertified? ☐ Yes ☐ No ☐ N/A If Yes, Date of Recertification ______________
If Qualified, when does status expire? (MM/YY) ______________________
If Qualified, date exam is scheduled: _________________________

Board certification results pending? ☐ Yes ☐ No

Do you wish to be listed in the organization directory under this specialty? ☐ Yes ☐ No

Would you like to be classified as a: ☐ Primary Care Provider ☐ Specialist ☐ Both
☐ Hospitalist ☐ Not Applicable

Sub-Specialty ___________________________ ☐ Qualified ☐ Certified ☐ Not Applicable
Board Name __________________________ Date of Initial Certification ______________

Board Certification expires? ☐ Yes ☐ No If yes, Date of Expiration? _________________

Have you been recertified? ☐ Yes ☐ No If Yes, Date of Recertification ______________
If Qualified, when does status expire? (MM/YY) ______________________
If Qualified, date exam is scheduled: _________________________

Board certification results pending? ☐ Yes ☐ No

Do you wish to be listed in the organization directory under this specialty? ☐ Yes ☐ No

Would you like to be classified as a: ☐ Primary Care Provider ☐ Specialist ☐ Both
☐ Hospitalist ☐ Not Applicable

SECTION VIII
BEHAVIORAL HEALTH PROVIDERS/PRACTITIONERS

If you practice Behavioral Health, please complete this section. Please attach copies of any certifications held.

Employee Assistance Program Affiliates Only:

Do you have a minimum of 1400 hours of experience in a direct substance related disorder treatment program, agency or facility offering in-service and clinical supervision? The 1400 hours can span no more than 2 years. ☐ Yes ☐ No

Do you have a minimum of 3 graduate level hours or 40 clock hours or 4 CEUs or a combination thereof of documented education/training in S/A related disorders? ☐ Yes ☐ No

Do you have a minimum of 1 year, clinically supervised full time work experience under a masters level or higher S/A provider? Please note part time may occur within 2 years and total experience hours must be achieved within no more than 4 years. ☐ Yes ☐ No

Do you have 4 years full time EAP experience as an EAP clinician with 10 or more EAP cases over a 1-year period? ☐ Yes ☐ No

Are you a licensed or certified addictions counselor at the state or national level? ☐ Yes ☐ No

If Yes: ☐ state level ☐ national level

Are you CEAP certified? ☐ Yes ☐ No

Psychologists Only:

Are you a Member of the National Register of Health Service providers (NHR)? ☐ Yes ☐ No

Are you a Diplomate of the American Board of Professional Neuropsychology? ☐ Yes ☐ No

Are you a Diplomate of the American Board of Professional Psychology? ☐ Yes ☐ No

All Behavioral Health Practitioners:

Do you offer emergency appointments (within 24 hours of call)? ☐ Yes ☐ No

Do you treat younger children (age 0-5)? ☐ Yes ☐ No

Do you treat older children (age 6 to 12)? ☐ Yes ☐ No

Do you treat adolescents (age 13-17)? ☐ Yes ☐ No

Do you treat adults (age 18-65)? ☐ Yes ☐ No

Do you treat geriatric patients (age 65 and older)? ☐ Yes ☐ No

Do you provide family therapy? ☐ Yes ☐ No

Do you provide group therapy? ☐ Yes ☐ No

Do you provide crisis evaluation/intervention services? ☐ Yes ☐ No

Are you available to see clients at least 4 full days a week? ☐ Yes ☐ No

What is the average waiting time to obtain an appointment? ______________________________

SECTION IX
DENTAL PROVIDERS/PRACTITIONERS

If you are a Dental Provider, please complete this section. Please attach copies of any licenses held.

Licensure Status (please check all that apply and indicate licensure information in Section V):

General dental license Limited dental license Teacher's dental license
Inactive dental license Other: ________________________

Are you recognized as a Specialist by the Dental Board? ☐ Yes ☐ No

If Yes, please specify: ____

Do you hold a permit to administer general anesthesia? ☐ Yes ☐ No

Do you hold a permit to administer conscious sedation? ☐ Yes ☐ No

Do you utilize nitrous oxide in your practice? ☐ Yes ☐ No

SECTION X
VISION PROVIDERS/PRACTITIONERS

If you are a vision provider, please complete this section. Please attach copies of any certifications held.

Which of the following are you certified to use or prescribe:

☐ Topical Ocular Diagnostic Pharmaceutical Agents

☐ Therapeutic Pharmaceutical Agents

☐ Diagnostic Pharmaceutical Agents

Does your office have an on-site lab? ☐ Yes ☐ No

SECTION XI
HEALTH CARE FACILITY AFFILIATIONS

List all health care facilities where you currently have privileges, beginning with the most recent. Please attach a separate sheet if necessary.

Facility Name ______________________________

Street Address ______________________________

City/State/Zip ______________________________

Staff Category ____________________ Status of Privileges ____________

Dates of Affiliation From __________ to ____________

Any past or present restriction of privileges? (If Yes, explain in Section XVI) ☐ Yes ☐ No

Is this your Primary Facility? ☐ Yes ☐ No

Facility Name ______________________________

Street Address ______________________________

City/State/Zip ______________________________

Staff Category ____________________ Status of Privileges ____________

Dates of Affiliation From __________ to ____________

Any past or present restriction of privileges? (If Yes, explain in Section XVI) ☐ Yes ☐ No

Is this your Primary Facility? ☐ Yes ☐ No

Facility Name ______________________________

Street Address ______________________________

City/State/Zip ______________________________

Staff Category ____________________ Status of Privileges ____________

Dates of Affiliation From __________ to ____________

Any past or present restriction of privileges? (If Yes, explain in Section XVI) ☐ Yes ☐ No

Is this your Primary Facility? ☐ Yes ☐ No

Facility Name ______________________________

Street Address ______________________________

City/State/Zip ______________________________

Staff Category ____________________ Status of Privileges ____________

Dates of Affiliation From __________ to ____________

Any past or present restriction of privileges? (If Yes, explain in Section XVI) ☐ Yes ☐ No

Is this your Primary Facility? ☐ Yes ☐ No

SECTION XII
WORK HISTORY

List professional work history for the last five (5) years, beginning with the most recent, not mentioned previously, including academic appointments. Explain any gaps of six months or more in Section XVI.

Practice/Employer ______________________________
Contact Name ______________________________ Phone ______________________________
Mailing Address ______________________________
Dates of Employment From ____________ to ____________
Reason for Leaving ______________________________

Practice/Employer ______________________________
Contact Name ______________________________ Phone ______________________________
Mailing Address ______________________________
Dates of Employment From ____________ to ____________
Reason for Leaving ______________________________

Practice/Employer ______________________________
Contact Name ______________________________ Phone ______________________________
Mailing Address ______________________________
Dates of Employment From ____________ to ____________
Reason for Leaving ______________________________

Practice/Employer ______________________________
Contact Name ______________________________ Phone ______________________________
Mailing Address ______________________________
Dates of Employment From ____________ to ____________
Reason for Leaving ______________________________

SECTION XIII
PROFESSIONAL LIABILITY INSURANCE COVERAGE

Please provide information on professional liability insurance for the past five (5) years.

Carrier Name ____

Carrier Address ____

Agent Name______________________ Policy Number ________________

Policyholder ____

Amount of Coverage ____________________ ____________________
Coverage amount per Occurrence Coverage amount per Aggregate

Dates of Coverage From __________ to ______________

Type of Coverage Claims Made Occurrence

Carrier Name ____

Carrier Address ____

Agent Name______________________ Policy Number ________________

Policyholder ____

Amount of Coverage ____________________ ____________________
Coverage amount per Occurrence Coverage amount per Aggregate

Dates of Coverage From __________ to ______________

Type of Coverage Claims Made Occurrence

Carrier Name ____

Carrier Address ____

Agent Name______________________ Policy Number ________________

Policyholder ____

Amount of Coverage ____________________ ____________________
Coverage amount per Occurrence Coverage amount per Aggregate

Dates of Coverage From __________ to ______________

Type of Coverage Claims Made Occurrence

SECTION XIV
MALPRACTICE CLAIMS HISTORY

Please provide information for all cases occurring in the past ten (10) years, beginning with the most recent. Attach additional sheets if necessary.

☐ None

Date of Occurrence ___________________________ Date Claim Filed ________________________

Professional liability carrier involved ____

You were: ☐ Primary Defendant ☐ Co-Defendant

Other Defendants (if any): ____

Describe the allegations against you: ____

Describe the alleged injury to the patient ____

____

Claimant/Plaintiff Filed Suit in Court? ☐ Yes ☐ No If Yes, Date Filed _________________

State Court Case Number ________________ State _______________ County _______________

Federal Court (U.S. District Court) Case Number ____________________ District _________________

Present status of the Claim/Case:

☐ Pending ☐ Settled ☐ Arbitrated ☐ Awarded

☐ In Appeal ☐ Adjudicated ☐ Withdrawn ☐ Other ____________________________

Please provide additional information/explanation (e.g. the condition/diagnosis of the patient at the time of the incident, treatment rendered and the condition of the patient subsequent to treatment) in Section XVI.

Date of Occurrence ___________________________ Date Claim Filed ________________________

Professional liability carrier involved ____

You were: ☐ Primary Defendant ☐ Co-Defendant

Other Defendants (if any): ____

Describe the allegations against you: ____

Describe the alleged injury to the patient ____

____

Claimant/Plaintiff Filed Suit in Court? ☐ Yes ☐ No If Yes, Date Filed _________________

State Court Case Number ________________ State _______________ County _______________

Federal Court (U.S. District Court) Case Number ____________________ District _________________

Present status of the Claim/Case:

☐ Pending ☐ Settled ☐ Arbitrated ☐ Awarded

☐ In Appeal ☐ Adjudicated ☐ Withdrawn ☐ Other ____________________________

Please provide additional information/explanation (e.g. the condition/diagnosis of the patient at the time of the incident, treatment rendered and the condition of the patient subsequent to treatment) in Section XVI.

SECTION XV
ADDITIONAL QUESTIONS

1. Have any of your board certifications ever been suspended, revoked, or voluntarily surrendered? ☐ Yes ☐ No

2. Have any of your professional licenses, in any state, ever been limited, sanctioned, voluntarily/involuntarily restricted, denied, revoked, suspended, surrendered, subjected to a consent order, placed on probation or cancelled? ☐ Yes ☐ No

3. Has your DEA license or state CDS certification ever been voluntarily or involuntarily suspended, restricted, revoked, surrendered, denied, or otherwise limited? ☐ Yes ☐ No

4. Have your privileges at any hospital, facility, HMO, or health plan been voluntarily or involuntarily surrendered, denied, suspended, revoked, restricted, limited, or placed on probation? ☐ Yes ☐ No

5. Have you ever been placed on probation or asked to resign from an internship, residency or other training program? ☐ Yes ☐ No

6. Have you ever been named a Defendant in any criminal case, other than misdemeanor traffic violation? ☐ Yes ☐ No

7. Has your malpractice insurance ever been cancelled, suspended, restricted, limited, special rated, or not renewed? ☐ Yes ☐ No

8. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified (terminated, suspended, restricted, revoked, limited, cancelled)? ☐ Yes ☐ No

9. Has information pertaining to you ever been reported to the National Practitioner Data Bank? ☐ Yes ☐ No

10. Have you ever been sanctioned or otherwise disciplined for a violation of ethical standards by a professional organization and/or a licensing board? ☐ Yes ☐ No

11. Are you engaged in the illegal use of drugs? ☐ Yes ☐ No

12. Within the last five (5) years, have you been sanctioned, reprimanded or otherwise disciplined in any manner by any state licensing authority or other professional board or peer committee for conduct related to the use of alcohol or the use of drugs? ☐ Yes ☐ No

13. Have you ever been the subject of a focused review by a peer review organization or similar agency including, but not limited to, Medicare, Medicaid, etc.? ☐ Yes ☐ No

14. Have you ever received sanctions from a regulatory agency (e.g., CLIA, OSHA, etc.)? ☐ Yes ☐ No

15. Do you, or your business entity, own, have an investment in, manage, own stock in, participate in a joint venture, or act as a partner, contract consultant or medical/dental advisor in any medical/dental enterprise or medical/dental supplier outside of your direct practice where you would financially benefit directly or indirectly? ☐ Yes ☐ No

    If so, please provide the following information:

    ______________________________________ ____________________________
    Name of Organization Type of Organization

    ____
    Mailing Address of Organization

    ____________________________________ __________________________________
    Telephone Number Tax ID Number

    ___________________________________ __________________________________
    Percent of Business Owned/Invested by You Nature of Business Investment (owner, partner, investor, etc.)

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE PROVIDE AN EXPLANATION FOR EACH AFFIRMATIVE RESPONSE IN SECTION XVI.

SECTION XVI
EXPLANATION

Please use this space to provide any necessary explanation from previous sections. Please indicate the Section and Question Number.

SECTION XVII
PROFESSIONAL REFERENCES

Please list three (3) peers who have personal knowledge of your current clinical abilities, ethical character, and ability to work cooperatively with others. The named individuals must have acquired the requisite knowledge through observation of your professional practice over a reasonable period of time. None of your references should be relatives by blood or marriage.

1. ______________________________ ______________________
Name Phone

____
Mailing Address

2. ______________________________ ______________________
Name Phone

____
Mailing Address

3. ______________________________ ______________________
Name Phone

____
Mailing Address

SECTION XVIII
ADDITIONAL DOCUMENTATION

Please attach copies of the following documents (if applicable):

1. **Current State Licenses**
2. **State Controlled Dangerous Substance Certificate**
3. **Current Federal DEA Registration**
4. **ECFMG Certificate**
5. **Board Certification Certificate**
6. **Current Professional Liability Insurance Face Sheets**
7. **Therapeutic Pharmaceutical Agents/Diagnostic Pharmaceutical Agents Licenses**
8. **Any other Certificates held**

SECTION XIX
AUTHORIZATION TO RELEASE INFORMATION AND AFFIRMATION

Please make additional copies of this page for each Carrier to whom you apply. Please insert the appropriate name in the space provided.

I authorize __________________________________ ("Carrier") and its affiliates, subsidiaries or related entities to consult with hospital administrators, members of medical staffs of hospitals, malpractice carriers, licensing boards, professional organizations**,** and other persons to obtain and verify information and I release the Carrier and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application; and,

I consent to the release by any person to the Carrier of all information that may be reasonably relevant to an evaluation of my professional competency, character, and moral and ethical qualification, including any information relating to any disciplinary action, suspension or limitation of privileges, and hereby release any such person providing such information from any and all liability for doing so.

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I further agree to notify the Carrier of any change to the information provided in this application within thirty (30) days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by the Carrier.

____ ______________________________

Applicant Signature Date

____ (____)__________________________

Applicant's Printed Name Phone

____

Mailing Address

Appendix D

Council for Affordable Quality Healthcare Form

Provider Application

CORRECT NUMBERS AND LETTERS A B C 1 2 3 CORRECT MARK X INCORRECT 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.*

YES NO DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name

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

LAST NAME*

SUFFIX (JR, III)

FIRST NAME*

MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?* YES NO IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME

SUFFIX (JR, III)

OTHER FIRST NAME

OTHER MIDDLE NAME

M M D D Y Y Y Y

DATE STARTED USING OTHER NAME

M M D D Y Y Y Y

DATE STOPPED USING OTHER NAME

General Information

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

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

GENDER* MALE FEMALE

DATE OF BIRTH* M M D D Y Y Y Y

CITY OF BIRTH

STATE OF BIRTH

COUNTRY OF BIRTH

SSN* - -

FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN)

FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK

LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Home Address

NUMBER

STREET

APT NUMBER

CITY

STATE

ZIP CODE

TELEPHONE - -

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

E-MAIL

FAX - -

PREFERRED METHOD OF CONTACT* E-MAIL FAX

3076

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

Section 1 — Personal Information and Professional IDs (Continued)

Professional IDs

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

Provide all current and previous licenses/ certifications.

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

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

FEDERAL DEA NUMBER

DEA ISSUE DATE (MMDDYYYY)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (MMDDYYYY)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (MMDDYYYY)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (MMDDYYYY)

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (MMDDYYYY)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE (MMDDYYYY)

LICENSE STATUS CODE

Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE

Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (MMDDYYYY)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE (MMDDYYYY)

LICENSE STATUS CODE

Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE

Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

Other ID Numbers

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

ARE YOU A PARTICIPATING MEDICARE PROVIDER?* ☐ YES ☐ NO

MEDICARE NUMBER

UPIN

ARE YOU A PARTICIPATING MEDICAID PROVIDER?* ☐ YES ☐ NO

MEDICAID NUMBER

MEDICAID STATE

NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER

USMLE NUMBER (WITHOUT HYPHENS)

WORKERS COMPENSATION NUMBER

0 — ☐☐☐ — ☐☐☐ — ☐

ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)

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

3077

Section 2	Education and Training

Undergraduate School(s)

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

Professional School(s)

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

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

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

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

UNDERGRADUATE SCHOOL

OFFICIAL NAME OF UNDERGRADUATE SCHOOL

ADDRESS

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

START DATE: M M Y Y Y Y

END DATE (GRADUATION DATE): M M Y Y Y Y

DEGREE AWARDED

DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

GRADUATE TYPE*:

☐ U.S. OR CANADIAN GRADUATE ☐ NON-U.S./CANADIAN GRADUATE ☐ FIFTH PATHWAY GRADUATE

U.S. OR CANADIAN SCHOOL

SCHOOL CODE (U.S./ CANADIAN ONLY)

NAME OF U.S./ CANADIAN SCHOOL:

START DATE*: M M Y Y Y Y

END DATE (GRADUATION DATE)*: M M Y Y Y Y

DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

NON - U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL

ADDRESS

CITY

COUNTRY CODE

POSTAL CODE

START DATE*: M M Y Y Y Y

END DATE (GRADUATION DATE)*: M M Y Y Y Y

DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

3078

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

Section 2 Education and Training (Continued)

Training

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

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

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

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

INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

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

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? YES NO

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

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

3080

Section 3 — Professional / Medical Specialty Information

Primary Specialty

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

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Secondary Specialty

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

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

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

3081

Section 3 — Professional / Medical Specialty Information (Continued)

Certifications

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

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

Practice Interests

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

Primary Credentialing Contact

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

LAST NAME

FIRST NAME — M.I.

NUMBER — STREET — SUITE/BUILDING

CITY — STATE — ZIP CODE

TELEPHONE — FAX

E-MAIL ADDRESS

NOTE:

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

3082

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

Section 4 — Practice Location Information

Primary Practice Location

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

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

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

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.

CURRENTLY PRACTICING AT THIS ADDRESS?* ☐ YES ☐ NO

PREVIOUS OR FUTURE START DATE? M M D D Y Y Y Y

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* ☐ YES ☐ NO

TELEPHONE* FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)* ☐ USE INDIVIDUAL TAX ID ☐ USE GROUP TAX ID

Office Manager or Business Office Staff Contact

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

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

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

NOTE:

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

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

3083

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

Section 4 Practice Location Information (Continued)

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* YES NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

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

CHECK PAYABLE TO*

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

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

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

Office Hours

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

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

24/7 PHONE COVERAGE?* YES NO

IF YES: ANSWERING SERVICE; VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE; VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

NOTE:

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

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* YES NO

ACCEPT ALL NEW PATIENTS?* YES NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* YES NO

ACCEPT NEW MEDICARE PATIENTS?* YES NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* YES NO

ACCEPT NEW MEDICAID PATIENTS?* YES NO

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

ARE THERE ANY PRACTICE LIMITATIONS?* YES NO

IF YES

GENDER LIMITATIONS: MALE ONLY; FEMALE ONLY; NONE

AGE LIMITATIONS: MINIMUM AGE; MAXIMUM AGE

LIST OTHER LIMITATIONS

3084

Section 4 Practice Location Information (Continued)

Mid-Level Practitioners

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

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

3085

Section 4 Practice Location Information (Continued)

Languages

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

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED

LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

BUILDING?* YES NO

PARKING?* YES NO

RESTROOM?* YES NO

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* YES NO

TEXT TELEPHONY (TTY)* YES NO

AMERICAN SIGN LANGUAGE* YES NO

MENTAL/PHYSICAL IMPAIRMENT SERVICES* YES NO

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO

BUS* YES NO

SUBWAY* YES NO

REGIONAL TRAIN* YES NO

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

LABORATORY SERVICES? YES NO

IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)

RADIOLOGY SERVICES? YES NO

IF YES, PROVIDE X-RAY CERTIFICATION TYPE

EKGS? YES NO

ALLERGY INJECTIONS? YES NO

ALLERGY SKIN TESTING? YES NO

ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? YES NO

DRAWING BLOOD? YES NO

AGE APPROPRIATE IMMUNIZATIONS? YES NO

FLEXIBLE SIGMOIDOSCOPY? YES NO

TYMPANOMETRY/ AUDIOMETRY SCREENING? YES NO

ASTHMA TREATMENT? YES NO

OSTEOPATHIC MANIPULATION? YES NO

IV HYDRATION/ TREATMENT? YES NO

CARDIAC STRESS TEST? YES NO

PULMONARY FUNCTION TESTING? YES NO

PHYSICAL THERAPY? YES NO

CARE OF MINOR LACERATIONS? YES NO

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO

IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT?

LAST NAME | FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)* SOLO PRACTICE | SINGLE SPECIALTY GROUP | MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

3086

Section 4 — Practice Location Information (Continued)

Partners/ Associates

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

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

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | 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)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

Covering Colleagues

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

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

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

LAST NAME | 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)

Section 5 — Hospital Affiliations

Admitting Arrangements

DO YOU HAVE HOSPITAL PRIVILEGES?* ☐ YES ☐ NO

IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?

3087

Section 5 — Hospital Affiliations (Continued)

Hospital Privileges

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

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

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

PRIMARY HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

M M Y Y Y Y AFFILIATION START DATE | M M Y Y Y Y AFFILIATION END DATE

FULL, UNRESTRICTED PRIVILEGES? YES NO | ARE PRIVILEGES TEMPORARY? YES NO

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

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

OTHER HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

M M Y Y Y Y AFFILIATION START DATE | M M Y Y Y Y AFFILIATION END DATE

FULL, UNRESTRICTED PRIVILEGES? YES NO | ARE PRIVILEGES TEMPORARY? YES NO

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

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

PLEASE EXPLAIN TERMINATED AFFILIATION

3088

Section 6 — Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

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

CARRIER OR SELF-INSURED NAME* — SELF-INSURED?* ☐ YES ☐ NO

NUMBER* — STREET* — SUITE/BUILDING

CITY* — STATE* — ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) — EFFECTIVE DATE* (M M Y Y Y Y) — EXPIRATION DATE (M M Y Y Y Y) — TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?* ☐ YES ☐ NO — $ AMOUNT OF COVERAGE PER OCCURRENCE — $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Professional Liability Insurance Carrier

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

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

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

CARRIER OR SELF-INSURED NAME — SELF-INSURED? ☐ YES ☐ NO

NUMBER* — STREET* — SUITE/BUILDING

CITY* — STATE* — ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) — EFFECTIVE DATE* (M M Y Y Y Y) — EXPIRATION DATE (M M Y Y Y Y) — TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? ☐ YES ☐ NO — $ AMOUNT OF COVERAGE PER OCCURRENCE — $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Section 7 — Work History and References

Military Duty

Are you currently on active military duty or military reserve?* ☐ YES ☐ NO

Work History

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity.

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

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER — STREET — SUITE/BUILDING

CITY — STATE — ZIP/POSTAL CODE

3089

Section 7 Work History and References (Continued)

Work History

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

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity

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

TELEPHONE

FAX

COUNTRY CODE

START DATE M M Y Y Y Y

END DATE M M Y Y Y Y

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 M M Y Y Y Y

END DATE M M Y Y Y Y

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 M M Y Y Y Y

END DATE M M Y Y Y Y

REASON FOR DEPARTURE (IF APPLICABLE)

3090

Section 7 — Work History and References (Continued)

Gaps in Professional / Work History

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

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

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

Professional References

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

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

NOTE:

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

Please check with credentialing entity for any special requirements.

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

3091

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

Section 8 — Disclosure Questions

Disclosure Questions

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

Allied Health Providers

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

LICENSURE

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

2. ☐ YES ☐ NO Has there been any challenge to your licensure, registration or certification?*

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. ☐ YES ☐ NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*

4. ☐ YES ☐ NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*

5. ☐ YES ☐ NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*

EDUCATION, TRAINING AND BOARD CERTIFICATION

6. ☐ YES ☐ NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*

7. ☐ YES ☐ NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*

8. ☐ YES ☐ NO Have any of your board certifications or eligibility ever been revoked?*

9. ☐ YES ☐ NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

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

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

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

OTHER SANCTIONS OR INVESTIGATIONS

12. ☐ YES ☐ NO Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*

13. ☐ YES ☐ NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*

14. ☐ YES ☐ NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*

15. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*

16. ☐ YES ☐ NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. ☐ YES ☐ NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*

18. ☐ YES ☐ NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

3092

Section 8 — Disclosure Questions (Continued)

Disclosure Questions

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

IMPORTANT
If you answered "Yes" to **question #19**, you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.

MALPRACTICE CLAIMS HISTORY

19. ☐ **YES** ☐ **NO** Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?*
If yes, provide information for each case.

CRIMINAL/CIVIL HISTORY

20. ☐ **YES** ☐ **NO** Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*

21. ☐ **YES** ☐ **NO** In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor 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?*

22. ☐ **YES** ☐ **NO** Have you ever been court-martialed for actions related to your duties as a medical professional?*

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** Are you currently engaged in the illegal use of drugs?*
("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.)

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 functions 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?*

3093

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 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 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 Y

DATE SIGNED*

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

Std. App. v.5.0
Reprinted on 10/31/06

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

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

Provide all current and previous licenses/ certifications.

If you need to report additional Professional IDs, photocopy this page as needed and submit as instructed.

FEDERAL DEA NUMBER

DEA ISSUE DATE (MMDDYYYY)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (MMDDYYYY)

FEDERAL DEA NUMBER

DEA ISSUE DATE (MMDDYYYY)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (MMDDYYYY)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (MMDDYYYY)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (MMDDYYYY)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (MMDDYYYY)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (MMDDYYYY)

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (MMDDYYYY)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE (MMDDYYYY)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (MMDDYYYY)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE (MMDDYYYY)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

3095

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

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

M M Y Y Y Y
START DATE

M M Y Y Y Y
END DATE (GRADUATION DATE)

Other Relevant Education

If you need to report additional Education, photocopy this page as needed and submit as instructed.

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

TELEPHONE

FAX

COUNTRY CODE

M M Y Y Y Y
START DATE

M M Y Y Y Y
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

M M Y Y Y Y
START DATE

M M Y Y Y Y
END DATE (GRADUATION DATE)

DEGREE AWARDED

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

3079

Other Training Supplemental Form

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

Section 2 Education and Training

Training

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

If you need to report additional Training, photocopy this page as needed and submit as instructed.

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

INSTITUTION / HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

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

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? YES NO

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

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER M M Y Y Y Y M M Y Y Y Y

START DATE END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER M M Y Y Y Y M M Y Y Y Y

START DATE END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER M M Y Y Y Y M M Y Y Y Y

START DATE END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

3096

Additional Specialty Supplemental Form

Section 3 Professional / Medical Specialty Information

Additional Specialty

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

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Additional Specialty

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

If you need to report additional Specialties, photocopy this page as needed and submit as instructed.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

3097

Partners/Associates
Supplemental Form

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

Section 4 — **Practice Location Information**

Partner/ Associates

Use this page to report additional partners/associates at the designated practice location.

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

Check "Covering Colleague?" if he/she provides coverage for you at THIS location.

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

If you need to report additional partners/associates, photocopy this page as needed and submit as instructed.

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION # ☐☐ ☐ PRIMARY PRACTICE

PRACTICE NAME

PRACTICE ADDRESS

LAST NAME — SPECIFICITY 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)

LAST NAME — 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)

LAST NAME — 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)

LAST NAME — 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)

3098

Covering Colleagues
Supplemental Form

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

Section 4 | **Practice Location Information**

Covering Colleagues

Include all colleagues providing regular coverage and his/her specialty, including if he/she is a partner in one or more of your practice locations.

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

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

If you need to report additional Covering Colleagues, photocopy this page as needed and submit as instructed.

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION # ☐☐ ☐ PRIMARY PRACTICE

PRACTICE NAME

PRACTICE ADDRESS

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)

LAST NAME | SPECIALTY CODE
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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)

3099

Practice Location Information
Supplemental Form

* 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

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

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

LOCATION* #

CURRENTLY PRACTICING AT THIS ADDRESS?* YES NO

PREVIOUS OR FUTURE START DATE? M M D D Y Y Y Y

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPON-DENCE HERE?* YES NO

TELEPHONE* FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID GROUP TAX ID

PRIMARY TAX ID (ONLY ONE)* USE INDIVIDUAL TAX ID USE GROUP TAX ID

Office Manager or Business Office Contact

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

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

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

NOTE:

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

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

3100

Practice Location Information
Supplemental Form

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

Section 4 | **Practice Location Information - Page 2 of 5**

Add'l Practice Location (Cont.)

LOCATION* #

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* YES NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

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

CHECK PAYABLE TO*

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

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

Office Hours

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

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

NOTE:

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

24/7 PHONE COVERAGE?* YES NO

IF YES: ANSWERING SERVICE / VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE / VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* YES NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* YES NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* YES NO

ACCEPT ALL NEW PATIENTS?* YES NO

ACCEPT NEW MEDICARE PATIENTS?* YES NO

ACCEPT NEW MEDICAID PATIENTS?* YES NO

IF ANY OF THE ABOVE VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?* YES NO

IF YES

GENDER LIMITATIONS: MALE ONLY / NONE / FEMALE ONLY

AGE LIMITATIONS: MINIMUM AGE / MAXIMUM AGE

LIST OTHER LIMITATIONS

3101

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

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Practice Location Information
Supplemental Form

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

Section 4 | **Practice Location Information - Page 3 of 5**

Additional Practice Location (Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

LOCATION* #

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

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

Mid-Level Practitioners

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

3102

Practice Location Information Supplemental Form

* 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 Practice Location
(Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

LOCATION* # ☐☐

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL: LANGUAGE CODE ☐ LANGUAGE CODE ☐ LANGUAGE CODE ☐ LANGUAGE CODE ☐ LANGUAGE CODE ☐

INTERPRETERS AVAILABLE?* ☐ YES ☐ NO

LANGUAGES INTERPRETED: LANGUAGE CODE ☐ LANGUAGE CODE ☐ LANGUAGE CODE ☐ LANGUAGE CODE ☐

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* ☐ YES ☐ NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING
- BUILDING?* ☐ YES ☐ NO
- PARKING?* ☐ YES ☐ NO
- RESTROOM?* ☐ YES ☐ NO

OTHER HANDICAPPED ACCESS ☐

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* ☐ YES ☐ NO
- TEXT TELEPHONY (TTY)* ☐ YES ☐ NO
- AMERICAN SIGN LANGUAGE* ☐ YES ☐ NO
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* ☐ YES ☐ NO

OTHER DISABILITY SERVICES ☐

ACCESSIBLE BY PUBLIC TRANSPORTATION?* ☐ YES ☐ NO
- BUS* ☐ YES ☐ NO
- SUBWAY* ☐ YES ☐ NO
- REGIONAL TRAIN* ☐ YES ☐ NO

OTHER TRANSPORTATION ACCESS ☐

Services

Does this location provide any of the following services?

LABORATORY SERVICES? ☐ YES ☐ NO — IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE) ☐

RADIOLOGY SERVICES? ☐ YES ☐ NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE ☐

- EKGS? ☐ YES ☐ NO
- DRAWING BLOOD? ☐ YES ☐ NO
- ASTHMA TREATMENT? ☐ YES ☐ NO
- PULMONARY FUNCTION TESTING? ☐ YES ☐ NO
- ALLERGY INJECTIONS? ☐ YES ☐ NO
- AGE APPROPRIATE IMMUNIZATIONS? ☐ YES ☐ NO
- OSTEOPATHIC MANIPULATION? ☐ YES ☐ NO
- PHYSICAL THERAPY? ☐ YES ☐ NO
- ALLERGY SKIN TESTING? ☐ YES ☐ NO
- FLEXIBLE SIGMOIDOSCOPY? ☐ YES ☐ NO
- IV HYDRATION/ TREATMENT? ☐ YES ☐ NO
- CARE OF MINOR LACERATIONS? ☐ YES ☐ NO
- ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? ☐ YES ☐ NO
- TYMPANOMETRY/ AUDIOMETRY SCREENING? ☐ YES ☐ NO
- CARDIAC STRESS TEST? ☐ YES ☐ NO

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

IF YES, WHO ADMINISTERS IT? LAST NAME ☐ FIRST NAME ☐

TYPE OF PRACTICE (SELECT ONE ONLY)* ☐ SOLO PRACTICE ☐ SINGLE SPECIALTY GROUP ☐ MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES) ☐

3103

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

Practice Location Information Supplemental Form

* 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
(Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

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

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

LOCATION* #

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | 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)

LAST NAME | 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)

Covering Colleagues

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

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

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

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)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

3104

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

Hospital Privileges (Current)
Supplemental Form

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

Section 5 | **Hospital Affiliations**

Hospital Privileges

Use this form to continue listing hospitals where you currently have privileges.

If you need to report additional space for Hospital Privileges, photocopy this page as needed and submit as instructed.

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

OTHER HOSPITAL

HOSPITAL NAME

NUMBER STREET SUITE/BUILDING

CITY STATE ZIP CODE

TELEPHONE - - FAX - -

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME M.I.

M M Y Y Y Y AFFILIATION START DATE

M M Y Y Y Y AFFILIATION END DATE

FULL, UNRESTRICTED PRIVILEGES? YES NO

ARE PRIVILEGES TEMPORARY? YES NO

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

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

PLEASE EXPLAIN TERMINATED AFFILIATION

THIS SPACE HAS BEEN PURPOSELY LEFT BLANK

3105

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

Professional Liability Insurance Carrier Supplemental Form

Section 6 — Professional Liability Insurance Carrier

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

CARRIER OR SELF-INSURED NAME — SELF-INSURED? YES NO

NUMBER* — STREET* — SUITE/BUILDING

CITY* — STATE* — ZIP CODE*

M M Y Y Y Y ORIGINAL EFFECTIVE DATE* — M M Y Y Y Y EFFECTIVE DATE* — M M Y Y Y Y EXPIRATION DATE — TYPE OF COVERAGE?* INDIVIDUAL SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? YES NO

$ AMOUNT OF COVERAGE PER OCCURRENCE — $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? YES NO

POLICY NUMBER*

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.

CARRIER OR SELF-INSURED NAME — SELF-INSURED? YES NO

NUMBER* — STREET* — SUITE/BUILDING

CITY* — STATE* — ZIP CODE*

M M Y Y Y Y ORIGINAL EFFECTIVE DATE* — M M Y Y Y Y EFFECTIVE DATE* — M M Y Y Y Y EXPIRATION DATE — TYPE OF COVERAGE?* INDIVIDUAL SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? YES NO

$ AMOUNT OF COVERAGE PER OCCURRENCE — $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? YES NO

POLICY NUMBER*

3106

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

Use this form to continue listing work history.

If you need additional space for Work History, photocopy this page as needed and submit as instructed.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

TELEPHONE

FAX

COUNTRY CODE

START DATE M M Y Y Y Y

END DATE M M Y Y Y Y

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 M M Y Y Y Y

END DATE M M Y Y Y Y

REASON FOR DEPARTURE (IF APPLICABLE)

3107

* 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	Professional Training / Work History Gaps

Professional Training / Work History Gaps

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 organization for which you are being credentialed.

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

3108

* 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.

Section 8	Disclosure Questions

Disclosure 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.

QUESTION # EXPLANATION

QUESTION # EXPLANATION

QUESTION # EXPLANATION

3109

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

Malpractice Claims Explanation Supplemental Form

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

Section 8 — Malpractice Claims Explanation

Malpractice Claims Explanation

Use this form to report any "Yes" response to Disclosure Question #19.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

DATE OF OCCURRENCE* M M D D Y Y Y Y

DATE CLAIM WAS FILED* M M D D Y Y Y Y

STATUS OF CLAIM* (NOTE: IF CASE IS PENDING, SELECT OPEN)

☐ OPEN ☐ CLOSED

IF SETTLED, ENTER DATE CLAIM WAS SETTLED M M D D Y Y Y Y

PROFESSIONAL LIABILITY CARRIER INVOLVED* (USE BOTH LINES IF NECESSARY)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE - - POLICY NUMBER

$, , AMOUNT OF AWARD OR SETTLEMENT*

METHOD OF RESOLUTION?*

☐ DISMISSED ☐ SETTLED ☐ MEDIATION ☐ ARBITRATION

☐ JUDGMENT FOR DEFENDANT(S) ☐ JUDGMENT FOR PLAINTIFF(S)

DESCRIPTION OF ALLEGATIONS* (USE ALL FOUR LINES BELOW, IF NECESSARY)

WERE YOU THE PRIMARY DEFENDANT OR CO-DEFENDANT?* ☐ PRIMARY DEFENDANT ☐ CO-DEFENDANT

NUMBER OF OTHER CO-DEFENDANTS (IF ANY)

YOUR INVOLVEMENT IN CASE* (ATTENDING, CONSULTING, ETC)

DESCRIPTION OF ALLEGED INJURY TO THE PATIENT (USE ALL FOUR LINES BELOW, IF NECESSARY)

DID THE ALLEGED INJURY RESULT IN DEATH? ☐ YES ☐ NO

TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?* ☐ YES ☐ NO

3110

Code Lists

Provider Type Codes

001 Medical Doctor (MD)
002 Doctor of Dental Surgery (DDS)
003 Doctor of Dental Medicine (DMD)
004 Doctor of Podiatric Medicine (DPM)
005 Doctor of Chiropractic (DC)
007 Osteopathic Doctor (DO)

020 Acupuncturist
021 Alcohol/Drug Counselor
022 Audiologist
023 Biofeedback Technician
024 Certified Registered Nurse Anesthetist
025 Christian Science Practitioner
026 Clinical Nurse Specialist
027 Clinical Psychologist
028 Clinical Social Worker
029 Dietician
030 Licensed Practical Nurse
031 Marriage/Family Therapist
032 Massage Therapist
033 Naturopath
034 Neuropsychologist
035 Midwife
036 Nurse Midwife
037 Nurse Practitioner
038 Nutritionist
039 Occupational Therapist
040 Optician
041 Optometrist
042 Pharmacist
043 Physical Therapist
044 Physician Assistant
045 Professional Counselor
046 Registered Nurse
047 Registered Nurse First Assistant
048 Respiratory Therapist
049 Speech Pathologist

License Status Codes

001 Active
002 Canceled
003 Denied
004 Expired
005 Inactive
006 Lapsed
007 Limited
008 Pending
009 Probation
010 Provisional
011 Restricted
012 Revoked
013 Suspended
014 Surrendered
015 Temporary
016 Terminated
017 Time Limited
018 Unrestricted
019 Other

Country Codes

004 Afghanistan
008 Albania
012 Algeria
016 American Samoa
020 Andorra
024 Angola
660 Anguilla
010 Antarctica
028 Antigua and Barbuda
032 Argentina
051 Armenia
533 Aruba
036 Australia
040 Austria
031 Azerbaijan
044 Bahamas
048 Bahrain
050 Bangladesh
052 Barbados
112 Belarus
056 Belgium
084 Belize
204 Benin
060 Bermuda
064 Bhutan
068 Bolivia
070 Bosnia and Herzegovina
072 Botswana
074 Bouvet Island
076 Brazil
086 British Indian Ocean Territory
096 Brunei Darussalam
100 Bulgaria
854 Burkina Faso
108 Burundi
116 Cambodia
120 Cameroon
124 Canada
132 Cape Verde
136 Cayman Islands
140 Central African Republic
148 Chad
152 Chile
156 China
162 Christmas Island
166 Cocos (Keeling) Islands
170 Colombia
174 Comoros
178 Congo
180 Congo, Democratic Republic of the
184 Cook Islands
188 Costa Rica
384 Cote d'Ivoire
191 Croatia
192 Cuba
196 Cyprus
203 Czech Republic
208 Denmark
262 Djibouti
212 Dominica
214 Dominican Republic
626 East Timor (provisional)
218 Ecuador
818 Egypt
222 El Salvador
226 Equatorial Guinea
232 Eritrea
233 Estonia
231 Ethiopia
238 Falkland Islands (Malvinas)
234 Faroe Islands
242 Fiji
246 Finland
250 France
249 France, Metropolitan
254 French Guiana
258 French Polynesia
260 French Southern Territories
266 Gabon
270 Gambia
268 Georgia
276 Germany
288 Ghana
292 Gibraltar
300 Greece
304 Greenland
308 Grenada
312 Guadaloupe
316 Guam
320 Guatemala
324 Guinea
624 Guinea-Bissau
328 Guyana
332 Haiti
334 Heard Island and McDonald Islands
340 Honduras
344 Hong Kong
348 Hungary
352 Iceland
356 India
360 Indonesia
364 Iran
368 Iraq
372 Ireland
376 Israel
380 Italy
388 Jamaica
392 Japan
400 Jordan
398 Kazakhstan
404 Kenya
296 Kiribati
408 Korea, North
410 Korea, South
414 Kuwait
417 Kyrgyzstan
418 Laos
428 Latvia
422 Lebanon
426 Lesotho
430 Liberia
434 Libya
438 Liechtenstein
440 Lithuania
442 Luxembourg
446 Macau
807 Macedonia
450 Madagascar
454 Malawi
458 Malaysia
462 Maldives
466 Mali
470 Malta
584 Marshall Islands
474 Martinique
478 Mauritania
480 Mauritius
175 Mayotte
484 Mexico
583 Micronesia
498 Moldova
492 Monaco
496 Mongolia
500 Montserrat
504 Morocco
508 Mozambique
104 Myanmar
516 Namibia
520 Nauru
524 Nepal
528 Netherlands
530 Netherlands Antilles
540 New Caledonia
554 New Zealand
558 Nicaragua
562 Niger
566 Nigeria
570 Niue
574 Norfolk Island
580 Northern Mariana Islands
578 Norway
512 Oman
586 Pakistan
585 Palau
591 Panama
598 Papua New Guinea
600 Paraguay
604 Peru
608 Philippines
612 Pitcairn
616 Poland
620 Portugal
630 Puerto Rico
634 Qatar
638 Réunion
642 Romania
643 Russian Federation
646 Rwanda
654 Saint Helena
659 Saint Kitts and Nevis
662 Saint Lucia
666 Saint Pierre and Miquelon
670 Saint Vincent and the Grenadines

Code Lists

Country Codes (continued)

882 Samoa
674 San Marino
678 São Tomé and Príncipe
682 Saudi Arabia
683 Scotland
686 Senegal
690 Seychelles
694 Sierra Leone
702 Singapore
703 Slovakia
705 Slovenia
090 Solomon Islands
706 Somalia
710 South Africa
239 South Georgia and the South Sandwich Islands
724 Spain
144 Sri Lanka
736 Sudan
740 Suriname
744 Svalbard and Jan Mayen
748 Swaziland
752 Sweden
756 Switzerland
760 Syria
158 Taiwan
762 Tajikistan
834 Tanzania
764 Thailand
768 Togo
772 Tokelau
776 Tonga
780 Trinidad and Tobago
788 Tunisia
792 Turkey795 Turkmenistan
796 Turks and Caicos Islands
798 Tuvalu
800 Uganda
804 Ukraine
784 United Arab Emirates
826 United Kingdom
840 United States
581 U.S. Minor Outlying Islands
858 Uruguay
860 Uzbekistan
548 Vanuatu
336 Vatican City State (Holy See)
862 Venezuela
704 Viet Nam
092 Virgin Islands, British
850 Virgin Islands, U.S.
876 Wallis and Fortuna Islands
732 Western Sahara (provisional)
887 Yemen
891 Yugoslavia
894 Zambia
716 Zimbabwe

Language Codes

001 Abkhazian
002 Afan (Oromo)
003 Afar
004 Afrikaans
005 Albanian
006 Amharic
007 Arabic
008 Armenian
009 Assamese
010 Zerbaijani
011 Bashkir
012 Basque
013 Bengali;Bangla
014 Bhutani
015 Bihari
016 Bislama
017 Breton
018 Bulgarian
019 Burmese
020 Byelorussian
021 Cambodian
022 Catalan
023 Chinese
024 Corsican
025 Croatian
026 Czech
027 Danish
028 Dutch
140 English
030 Esperonto
031 Estonian
032 Faroese
033 Fiji
034 Finnish
035 French
036 Frisian
037 Galican
038 Georgian
039 German
040 Greek
041 Greenlandic
042 Guarani
043 Gujarati
044 Hausa
045 Hebrew
046 Hindi
047 Hungarian
048 Icelandic
049 Indonesian
050 Interlingua
051 Interlingue
052 Inuktitut
053 Inupiak
054 Irish
055 Italian
056 Japanese
057 Javanese
058 Kannada
059 Kashmiri
060 Kazakh
061 Kinyarwanda
062 Kirghiz
063 Kurundi
064 Korean
065 Kurdish
066 Laothian
067 Latin
068 Latvian;Lettish
069 Lingala
070 Lithuanian
071 Macedonian
072 Malagasy
073 Malay
074 Malayalam
075 Maltese
076 Maori
077 Marathi
078 Moldavian
079 Mongolian
080 Nauru
081 Nepali
082 Norwegian
083 Occitan
084 Oriya
085 Pashto;Pushto
086 Persian (Farsi)
087 Polish
088 Portuguese
089 Punjabi
090 Quechua
091 Rhaeto-Romance
092 Romanian
093 Russian
094 Samoan
095 Sangho
096 Sanskrit
097 Scot Gaelic
098 Serbian
099 Serbo-Croatian
100 Sesotho
101 Setswana
102 Shona
103 Sindhi
104 Singhalese
105 Siswati
106 Slovak
107 Slovenian
108 Somali
109 Spanish
110 Sundanese
111 Swahili
112 Swedish
113 Tagalog
114 Tajik
115 Tamil
116 Tatar
117 Telugu
118 Thai
119 Tibetan
120 Tigrinya
121 Tonga
122 Tsonga
123 Turkish
124 Turkmen
125 Twi
126 Uigur
127 Ukrainian
128 Urdu
129 Uzbek
130 Vietnamese
131 Volapuk
132 Welsh
133 Wolof
134 Xhosa
135 Yiddish
136 Yoruba
10 Zerbaijani
137 Zhuang
138 Zulu

Code Lists

U.S. / Canadian Professional School Codes

Alabama
300 University of Alabama School of Dentistry
001 University of Alabama School of Medicine
002 University of South Alabama College of Medicine

Arkansas
003 University of Arkansas College of Medicine

Arizona
500 Arizona College of Osteopathic Medicine
004 University of Arizona College of Medicine

California
801 California College of Podiatric Medicine
400 Cleveland Chiropractic College of Los Angele
005 Keck School of Medicine
401 Life Chiropractic College West
301 Loma Linda University School of Dentistry
006 Loma Linda University School of Medicine
402 Los Angeles College of Chiropractic
403 Palmer College of Chiropractic West
404 Quantum University/SCCC
007 Stanford University School of Medicine
501 Touro University College of Osteopathic Medicine
008 UCLA School of Medicine
009 University of California
010 University of California, Irvine, College of Medicine
302 University of California, Los Angeles School of Dentistry
011 University of California, San Diego, School of Medicine
303 University of California, San Francisco, School of Dentistry
012 University of California, San Francisco, School of Medicine
304 University of Southern California School of Dentistry
305 University of the Pacific School of Dentistry
502 Western University of Health Sciences, College of Osteopathic Medicine of the Pacific

Colorado
306 University of Colorado School of Dentistry
013 University of Colorado School of Medicine

Connecticut
405 University of Bridgeport College of Chiropractic
307 University of Connecticut School of Dental Medicine
014 University of Connecticut School of Medicine
015 Yale University School of Medicine

District of Columbia
016 George Washington University
017 Georgetown University School of Medicine
308 Howard University College of Dentistry
018 Howard University College of Medicine

Florida
800 Barry University School of Graduate Medical Sciences
309 Nova Southeastern University College of Dentistry
503 Nova Southeastern University College of Osteopathic Medicine
310 University of Florida College of Dentistry
019 University of Florida College of Medicine
020 University of Miami School of Medicine
021 University of South Florida College of Medicine

Georgia
022 Emory University School of Medicine
406 Life Chiropractic College
311 Medical College of Georgia School of Dentistry
023 Medical College of Georgia School of Medicine
024 Mercer University School of Medicine
025 Morehouse School of Medicine

Hawaii
026 John A. Burns School of Medicine

Iowa
802 College of Podiatric Medicine and Surgery Des Moines University
504 Des Moines University, Osteopathic Medical Center, College of Osteopathic Medicine and Surgery
407 Palmer College of Chiropractic
312 University of Iowa College of Dentistry
027 University of Iowa College of Medicine

Illinois
028 Chicago Medical School, Finch University of Health Sciences
029 Loyola University Chicago, Stritch School of Medicine
505 Midwestern University, Chicago College of Osteopathic Medicine
408 National College of Chiropractic
313 Northwestern University Dental School
030 Northwestern University Medical School
031 Rush Medical College of Rush University
804 Scholl College of Podiatric Medicine at Finch University
314 Southern Illinois University School of Dental Medicine
032 Southern Illinois University School of Medicine
033 University of Chicago, The Pritzker School of Medicine
315 University of Illinois at Chicago College of Dentistry
034 University of Illinois College of Medicine

Indiana
316 Indiana University School of Dentistry
035 Indiana University School of Medicine

Kansas
036 University of Kansas School of Medicine

Kentucky
506 Pikeville College, School of Osteopathic Medicine
317 University of Kentucky College of Dentistry
037 University of Kentucky College of Medicine
318 University of Louisville School of Dentistry
038 University of Louisville School of Medicine

Louisiana
319 Louisiana State University School of Dentistry
039 Louisiana State University School of Medicine in New Orleans
040 Louisiana State University School of Medicine in Shreveport
041 Tulane University School of Medicine

Massachusetts
042 Boston University School of Medicine
320 Boston University, Goldman School of Dental Medicine
043 Harvard Medical School
321 Harvard School of Dental Medicine
322 Tufts University School of Dental Medicine
044 Tufts University School of Medicine
045 University of Massachusetts Medical School

Maryland
046 Johns Hopkins University School of Medicine
047 Uniformed Services University of the Health Sciences
048 University of Maryland School of Medicine
323 University of Maryland, Baltimore, College of Dental Surgery

Maine
507 University of New England, College of Osteopathic Medicine

Michigan
049 Michigan State University College of Human Medicine
508 Michigan State University, College of Osteopathic Medicine
324 University of Detroit Mercy School of Dentistry
050 University of Michigan Medical School
325 University of Michigan School of Dentistry
051 Wayne State University School of Medicine

Minnesota
052 Mayo Medical School
409 Northwestern College of Chiropractic
053 University of Minnesota, Duluth School of Medicine
054 University of Minnesota Medical School, Twin Cities
326 University of Minnesota School of Dentistry

Missouri
410 Cleveland Chiropractic College of Kansas City
509 Kirksville College of Osteopathic Medicine
411 Logan Chiropractic College
055 Saint Louis University School of Medicine
510 University of Health Sciences, College of Osteopathic Medicine

056 University of Missouri, Columbia School of Medicine
327 University of Missouri Kansas City School of Dentistry
057 University of Missouri Kansas City School of Medicine
058 Washington University in St. Louis School of Medicine

Code Lists

U.S. / Canadian Professional School Codes (continued)

Mississippi
328 University of Mississippi School of Dentistry
059 University of Mississippi School of Medicine

North Carolina
060 Duke University School of Medicine
061 The Brody School of Medicine at East Carolina University
329 University of North Carolina at Chapel Hill School of Dentistry
062 University of North Carolina at Chapel Hill School of Medicine
063 Wake Forest University School of Medicine

North Dakota
064 University of North Dakota School of Medicine and Health Sciences

Nebraska
330 Creighton University School of Dentistry
065 Creighton University School of Medicine
066 University of Nebraska College of Medicine
331 University of Nebraska Medical Center, College of Dentistry

New Hampshire
067 Dartmouth Medical School

New Jersey
068 Robert Wood Johnson Medical School
069 University of Medicine and Dentistry of New Jersey (UMDNJ)
332 UMDNJ, New Jersey Dental School
511 UMDNJ, School of Osteopathic Medicine

New Mexico
070 University of New Mexico School of Medicine

Nevada
071 University of Nevada School of Medicine

New York
072 Albany Medical College
073 Albert Einstein College of Medicine
074 Columbia University College of Physicians and Surgeons
333 Columbia University School of Dental and Oral Surgery
075 Joan & Sanford I. Weill Medical College of Cornell University
076 Mount Sinai School of Medicine of New York University
412 New York Chiropractic College
512 NY College of Osteopathic Medicine of the NY Institute of Technology
077 New York Medical College
334 New York University Kriser Dental Center
078 New York University School of Medicine
335 State University of New York at Buffalo School of Dental Medicine
082 State University of New York at Buffalo School of Medicine
336 State University of New York at Stony Brook School of Dental Medicine
081 State University of New York at Stony Brook School of Medicine
079 State University of New York College of Medicine
080 State University of New York Upstate Medical University
083 University of Rochester School of Medicine and Dentistry

Ohio
337 Case Western Reserve University School of Dentistry
084 Case Western Reserve University School of Medicine
085 Medical College of Ohio
086 Northeastern Ohio Universities College of Medicine
803 Ohio College of Podiatric Medicine
338 Ohio State University College of Dentistry
087 Ohio State University College of Medicine and Public Health
513 Ohio University College of Osteopathic Medicine
088 University of Cincinnati College of Medicine
089 Wright State University School of Medicine

Oklahoma
514 Oklahoma State University, College of Osteopathic Medicine
339 University of Oklahoma College of Dentistry
090 University of Oklahoma College of Medicine

Oregon
091 Oregon Health & Science University School of Medicine
340 Oregon Health Sciences University School of Dentistry
413 Western States Chiropractic College

Pennsylvania
092 Jefferson Medical College of Thomas Jefferson University
515 Lake Erie College of Osteopathic Medicine
093 MCP Hahnemann University School of Medicine
094 Pennsylvania State University College of Medicine
516 Philadelphia College of Osteopathic Medicine
341 Temple University School of Dentistry
095 Temple University School of Medicine
805 Temple University School of Podiatric Medicine
342 University of Pennsylvania School of Dental Medicine
096 University of Pennsylvania School of Medicine
343 University of Pittsburgh School of Dental Medicine
097 University of Pittsburgh School of Medicine

Puerto Rico
098 Ponce School of Medicine
099 Universidad Central del Caribe School of Medicine
100 University of Puerto Rico School of Medicine
344 University of Puerto Rico School of Dentistry

Rhode Island
101 Brown Medical School

South Carolina
345 Medical University of South Carolina College of Dental Medicine
102 Medical University of South Carolina College of Medicine
414 Sherman College of Chiropractic
103 University of South Carolina School of Medicine

South Dakota
104 University of South Dakota School of Medicine

Tennessee
105 East Tennessee State University
346 Meharry Medical College School of Dentistry
106 Meharry Medical College School of Medicine
347 University of Tennessee College of Dentistry
107 University of Tennessee College of Medicine
108 Vanderbilt University School of Medicine

Texas
348 Baylor College of Dentistry
109 Baylor College of Medicine
415 Parker College of Chiropractic
416 Texas Chiropractic College
110 Texas Tech University Health Sciences Center School of Medicine
111 The Texas A & M University System College of Medicine
517 UNT Health Sciences Center, Texas College of Osteopathic Medicine
349 University of Texas Health Science Center at Houston Dental School
350 University of Texas Health Science Center at San Antonio Dental School
112 University of Texas Medical Branch at Galveston
113 University of Texas Medical School at Houston
114 University of Texas Medical School at San Antonio
115 UT Southwestern Medical Center at Dallas Southwestern Medical School

Utah
116 University of Utah School of Medicine

Virginia
117 Eastern VA Medical School of the Medical College of Hampton Roads
118 University of Virginia School of Medicine Health System
351 Virginia Commonwealth University School of Dentistry
119 Virginia Commonwealth University School of Medicine

Vermont
120 University of Vermont College of Medicine

Washington
352 University of Washington School of Dentistry
121 University of Washington School of Medicine

Wisconsin
353 Marquette University School of Dentistry
122 Medical College of Wisconsin
123 University of Wisconsin Medical School

West Virginia
124 Joan C. Edwards School of Medicine at Marshall University
518 West Virginia School of Osteopathic Medicine
354 West Virginia University School of Dentistry
125 West Virginia University School of Medicine

U.S. / Canadian Professional School Codes (continued)

Canada

355 Dalhousie University Faculty of Dentistry
126 Dalhousie University Faculty of Medicine
357 Laval University Faculty of Dentistry
127 Laval University Faculty of Medicine
356 McGill University Faculty of Dentistry
128 McGill University Faculty of Medicine
129 McMaster University School of Medicine
130 Memorial University of Newfoundland Faculty of Medicine
131 Queen's University Faculty of Health Sciences
132 The University of Western Ontario Faculty of Medicine & Dentistry
133 Universite de Montreal Faculty of Medicine
134 Universite de Sherbrooke Faculty of Medicine
358 University of Alberta Faculty of Dentistry
135 University of Alberta Faculty of Medicine
359 University of British Columbia Faculty of Dentistry
136 University of British Columbia Faculty of Medicine
137 University of Calgary Faculty of Medicine
360 University of Manitoba Faculty of Dentistry
138 University of Manitoba Faculty of Medicine
361 University of Montreal Faculty of Dentistry
139 University of Ottawa Faculty of Medicine
362 University of Saskatchewan College of Dentistry
140 University of Saskatchewan College of Medicine
363 University of Toronto Faculty of Dentistry
141 University of Toronto Faculty of Medicine
364 University of Western Ontario Faculty of Dentistry

Specialty Codes - MD / DO Only

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

247 Allergy & Immunology
246 Allergy & Immunology, Allergy
291 Allergy & Immunology, Clinical & Laboratory Immunology
249 Anesthesiology
235 Anesthesiology, Addiction Medicine
258 Anesthesiology, Critical Care Medicine
126 Anesthesiology, Pain Medicine
363 Clinical Pharmacology
367 Colon & Rectal Surgery
263 Dermatology
292 Dermatology, Clinical & Laboratory Dermatological Immunology
444 Dermatology, Dermatological Surgery
266 Dermatology, Dermatopathology
264 Dermatology, MOHS-Micrographic Surgery
443 Dermatology, Pediatric Dermatology
268 Emergency Medicine
445 Emergency Medicine, Emergency Medical Services
427 Emergency Medicine, Medical Toxicology
348 Emergency Medicine, Pediatric Emergency Medicine
395 Emergency Medicine, Sports Medicine
446 Emergency Medicine, Undersea and Hyperbaric Medicine
391 Facial Plastic Surgery
272 Family Practice
447 Family Practice, Addiction Medicine
237 Family Practice, Adolescent Medicine
448 Family Practice, Adult Medicine
282 Family Practice, Geriatric Medicine
396 Family Practice, Sports Medicine
225 General Practice
479 Hospitalist
301 Internal Medicine
449 Internal Medicine, Addiction Medicine
236 Internal Medicine, Adolescent Medicine
248 Internal Medicine, Allergy & Immunology
255 Internal Medicine, Cardiovascular Disease
294 Internal Medicine, Clinical & Laboratory Immunology
253 Internal Medicine, Clinical Cardiac Electrophysiology
257 Internal Medicine, Critical Care Medicine
267 Internal Medicine, Endocrinology, Diabetes & Metabolism
275 Internal Medicine, Gastroenterology
285 Internal Medicine, Geriatric Medicine
287 Internal Medicine, Hematology
288 Internal Medicine, Hematology & Oncology
450 Internal Medicine, Hepatology
299 Internal Medicine, Infectious Disease
451 Internal Medicine, Interventional Cardiology
453 Internal Medicine, Magnetic Resonance Imaging (MRI)
325 Internal Medicine, Medical Oncology
309 Internal Medicine, Nephrology
378 Internal Medicine, Pulmonary Disease
390 Internal Medicine, Rheumatology
397 Internal Medicine, Sports Medicine
433 Laboratories, Clinical Medical Laboratory
481 Legal Medicine
278 Medical Genetics, Clinical Biochemical Genetics
261 Medical Genetics, Clinical Cytogenetic
277 Medical Genetics, Clinical Genetics (M.D.)
280 Medical Genetics, Clinical Molecular Genetics
455 Medical Genetics, Molecular Genetic Pathology
454 Medical Genetics, Ph.D. Medical Genetics
306 Neonatal-Perinatal Medicine
308 Neopathology
409 Neurological Surgery
330 Neuromusculoskeletal Medicine & OMM
440 Neuromusculoskeletal Medicine, Sports Medicine
317 Nuclear Medicine
318 Nuclear Medicine, In Vivo & In Vitro Nuclear Medicine
315 Nuclear Medicine, Nuclear Cardiology
316 Nuclear Medicine, Nuclear Imaging & Therapy
321 Obstetrics & Gynecology
260 Obstetrics & Gynecology, Critical Care Medicine
326 Obstetrics & Gynecology, Gynecologic Oncology
286 Obstetrics & Gynecology, Gynecology
303 Obstetrics & Gynecology, Maternal & Fetal Medicine
320 Obstetrics & Gynecology, Obstetrics
271 Obstetrics & Gynecology, Reproductive Endocrinology
328 Ophthalmology
441 Oral & Maxillofacial Surgery
411 Orthopaedic Surgery
412 Orthopaedic Surgery, Adult Reconstructive Orthopaedic Surgery
456 Orthopaedic Surgery, Foot and Ankle Orthopaedics
406 Orthopaedic Surgery, Hand Surgery
415 Orthopaedic Surgery, Orthopaedic Surgery of the Spine
416 Orthopaedic Surgery, Orthopaedic Trauma
457 Orthopaedic Surgery, Sports Medicine
119 Orthopedic
331 Otolaryngology
458 Otolaryngology, Otolaryngic Allergy
459 Otolaryngology, Otolaryngology/ Facial Plastic Surgery
332 Otolaryngology, Otology & Neurotology
357 Otolaryngology, Pediatric Otolaryngology
417 Otolaryngology, Plastic Surgery within the Head & Neck
480 Pain Medicine, Interventional Pain Medicine
337 Pain Medicine
338 Pathology, Anatomic Pathology
340 Pathology, Anatomic Pathology & Clinical Pathology
250 Pathology, Blood Banking & Transfusion Medicine
344 Pathology, Chemical Pathology
302 Pathology, Clinical Pathology/Laboratory Medicine
262 Pathology, Cytopathology
265 Pathology, Dermatopathology
273 Pathology, Forensic Pathology
290 Pathology, Hematology
298 Pathology, Immunopathology
305 Pathology, Medical Microbiology
461 Pathology, Molecular Genetic Pathology
312 Pathology, Neuropathology
358 Pathology, Pediatric Pathology
244 Pediatrics
239 Pediatrics, Adolescent Medicine
295 Pediatrics, Clinical & Laboratory Immunology
462 Pediatrics, Developmental – Behavioral Pediatrics
354 Pediatrics, Medical Toxicology
356 Pediatrics, Neurodevelopmental Disabilities
345 Pediatrics, Pediatric Allergy & Immunology
346 Pediatrics, Pediatric Cardiology
347 Pediatrics, Pediatric Critical Care Medicine
463 Pediatrics, Pediatric Emergency Medicine
349 Pediatrics, Pediatric Endocrinology

Code Lists

Specialty Codes - MD/DO Only

350 Pediatrics, Pediatric Gastroenterology
351 Pediatrics, Pediatric Hematology-Oncology
352 Pediatrics, Pediatric Infectious Diseases
355 Pediatrics, Pediatric Nephrology
359 Pediatrics, Pediatric Pulmonology
361 Pediatrics, Pediatric Rheumatology
398 Pediatrics, Sports Medicine
365 Physical Medicine & Rehabilitation
468 Physical Medicine & Rehabilitation, Pain Medicine
389 Physical Medicine & Rehabilitation, Pediatric Rehabilitation Medicine
466 Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine
469 Physical Medicine & Rehabilitation, Sports Medicine
419 Plastic Surgery
470 Plastic Surgery, Plastic Surgery Within the Head and Neck
407 Plastic Surgery, Surgery of the Hand
242 Preventive Medicine, Aerospace Medicine
429 Preventive Medicine, Medical Toxicology
112 Preventive Medicine, Occupational Medicine
471 Preventive Medicine, Sports Medicine
431 Preventive Medicine, Undersea and Hyperbaric Medicine
114 Preventive Medicine/Occupational Environmental Medicine
370 Psychiatry & Neurology, Addiction Medicine
473 Psychiatry & Neurology, Addiction Psychiatry
371 Psychiatry & Neurology, Child & Adolescent Psychiatry
313 Psychiatry & Neurology, Clinical Neurophysiology
274 Psychiatry & Neurology, Forensic Psychiatry
373 Psychiatry & Neurology, Geriatric Psychiatry
472 Psychiatry & Neurology, Neurodevelopmental Disabilities
100 Psychiatry & Neurology, Neurology
311 Psychiatry & Neurology, Neurology with Special Qualifications in Child Neurology
474 Psychiatry & Neurology, Pain Medicine
368 Psychiatry & Neurology, Psychiatry
475 Psychiatry & Neurology, Sports Medicine
476 Psychiatry & Neurology, Vascular Neurology
366 Public Health & General Preventive Medicine
252 Radiology, Body Imaging
173 Radiology, Diagnostic Radiology
430 Radiology, Diagnostic Ultrasound
314 Radiology, Neuroradiology
319 Radiology, Nuclear Radiology
360 Radiology, Pediatric Radiology
380 Radiology, Radiation Oncology
477 Radiology, Radiological Physics
381 Radiology, Therapeutic Radiology
384 Radiology, Vascular & Interventional Radiology
434 Supplier
399 Surgery
418 Surgery, Pediatric Surgery
420 Surgery, Plastic and Reconstructive Surgery
405 Surgery, Surgery of the Hand
425 Surgery, Surgical Critical Care
413 Surgery, Surgical Oncology
423 Surgery, Trauma Surgery
400 Surgery, Vascular Surgery
421 Thoracic Surgery (Cardiothoracic Vascular Surgery)
442 Transplant Surgery
424 Urology

Specialty Codes - DDS / DMD / DPM / DC

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

DDS / DMD

2 Dentist
13 Dentist, Dental Public Health
14 Dentist, Endodontics
438 Dentist, General Practice
16 Dentist, Oral and Maxillofacial Pathology
439 Dentist, Oral and Maxillofacial Radiology
20 Dentist, Oral and Maxillofacial Surgery
15 Dentist, Orthodontics and Dentofacial Orthopedics
17 Dentist, Pediatric Dentistry
18 Dentist, Periodontics
19 Dentist, Prosthodontics

DPM

3 Podiatrist
231 Podiatrist, Foot & Ankle Surgery
230 Podiatrist, Foot Surgery
225 Podiatrist, General Practice
227 Podiatrist, Primary Podiatric Medicine
226 Podiatrist, Public Medicine
228 Podiatrist, Radiology
229 Podiatrist, Sports Medicine

DC

1 Chiropractor
5 Chiropractor, Internist
6 Chiropractor, Neurology
7 Chiropractor, Nutrition
8 Chiropractor, Occupational Medicine
9 Chiropractor, Orthopedic
10 Chiropractor, Radiology
11 Chiropractor, Sports Physician
12 Chiropractor, Thermography

Specialty Codes - Allied Providers

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

501 Acupuncturist
503 Audiologist
504 Audiologist, Assistive Technology Practitioner
505 Audiologist, Assistive Technology Supplier
531 Christian Science Practitioner
727 Clinical Nurse Specialist
728 Clinical Nurse Specialist, Acute Care
729 Clinical Nurse Specialist, Adult Health
730 Clinical Nurse Specialist, Chronic Care
731 Clinical Nurse Specialist, Community Health/Public Health
732 Clinical Nurse Specialist, Critical Care Medicine
733 Clinical Nurse Specialist, Emergency
734 Clinical Nurse Specialist, Ethics
735 Clinical Nurse Specialist, Family Health
736 Clinical Nurse Specialist, Gerontology
737 Clinical Nurse Specialist, Holistic
738 Clinical Nurse Specialist, Home Health
739 Clinical Nurse Specialist, Informatics
740 Clinical Nurse Specialist, Long-Term Care
741 Clinical Nurse Specialist, Medical-Surgical
742 Clinical Nurse Specialist, Neonatal
743 Clinical Nurse Specialist, Neuroscience
744 Clinical Nurse Specialist, Occupational Health
745 Clinical Nurse Specialist, Oncology
746 Clinical Nurse Specialist, Oncology, Pediatrics
747 Clinical Nurse Specialist, Pediatrics
748 Clinical Nurse Specialist, Perinatal
749 Clinical Nurse Specialist, Perioperative
750 Clinical Nurse Specialist, Psychiatric/Mental Health
751 Clinical Nurse Specialist, Psychiatric/Mental Health, Adult
752 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent
753 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family
754 Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill
755 Clinical Nurse Specialist, Psychiatric/Mental Health, Community
756 Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric
757 Clinical Nurse Specialist, Rehabilitation
759 Clinical Nurse Specialist, School
758 Clinical Nurse Specialist, Transplantation
760 Clinical Nurse Specialist, Women's Health
513 Counselor
514 Counselor, Addiction (Substance Use Disorder)
515 Counselor, Mental Health
516 Counselor, Professional
533 Dietitian, Registered
536 Dietitian, Registered, Nutrition, Metabolic
534 Dietitian, Registered, Nutrition, Pediatric
535 Dietitian, Registered, Nutrition, Renal
651 Licensed Practical Nurse
517 Marriage & Family Therapist
547 Massage Therapist
549 Midwife, Certified
652 Midwife, Certified Nurse
551 Naturopath
553 Neuropsychologist
653 Nurse Anesthetist, Certified Registered
654 Nurse Practitioner
655 Nurse Practitioner, Acute Care
656 Nurse Practitioner, Adult Health
658 Nurse Practitioner, Community Health
657 Nurse Practitioner, Critical Care Medicine
659 Nurse Practitioner, Family

Specialty Codes - Allied Providers (continued)

660 Nurse Practitioner, Gerontology
661 Nurse Practitioner, Neonatal
662 Nurse Practitioner, Neonatal, Critical Care
670 Nurse Practitioner, Obstetrics & Gynecology
671 Nurse Practitioner, Occupational Health
663 Nurse Practitioner, Pediatrics
664 Nurse Practitioner, Pediatrics, Critical Care
666 Nurse Practitioner, Perinatal
667 Nurse Practitioner, Primary Care
665 Nurse Practitioner, Psych/Mental Health
668 Nurse Practitioner, School
669 Nurse Practitioner, Women's Health
537 Nutritionist
538 Nutritionist, Nutrition, Education
555 Occupational Therapist
556 Occupational Therapist, Ergonomics
557 Occupational Therapist, Hand
558 Occupational Therapist, Human Factors
559 Occupational Therapist, Neurorehabilitation
560 Occupational Therapist, Pediatrics
561 Occupational Therapist, Rehabilitation, Driver
563 Optician
565 Optometrist
566 Optometrist, Corneal and Contact Management
567 Optometrist, Low Vision Rehabilitation
571 Optometrist, Occupational Vision
568 Optometrist, Pediatrics
569 Optometrist, Sports Vision
570 Optometrist, Vision Therapy
573 Pharmacist
574 Pharmacist, General Practice
575 Pharmacist, Nuclear Pharmacy
576 Pharmacist, Nutrition Support
577 Pharmacist, Pharmacotherapy
578 Pharmacist, Psychopharmacy
580 Physical Therapist
581 Physical Therapist, Cardiopulmonary
583 Physical Therapist, Electrophysiology, Clinical
582 Physical Therapist, Ergonomics
584 Physical Therapist, Geriatrics
585 Physical Therapist, Hand
586 Physical Therapist, Human Factors
587 Physical Therapist, Neurology
590 Physical Therapist, Orthopedic
588 Physical Therapist, Pediatrics
589 Physical Therapist, Sports
592 Physician Assistant
593 Physician Assistant, Medical
594 Physician Assistant, Surgical
596 Psychologist
597 Psychologist, Addiction (Substance Use Disorder)
598 Psychologist, Adult Development & Aging
599 Psychologist, Behavioral
602 Psychologist, Child, Youth & Family
600 Psychologist, Clinical
601 Psychologist, Counseling
603 Psychologist, Educational
604 Psychologist, Exercise & Sports
605 Psychologist, Family
606 Psychologist, Forensic
607 Psychologist, Health
608 Psychologist, Men & Masculinity
609 Psychologist, Mental Retardation & Developmental Disabilities
610 Psychologist, Psychoanalysis
611 Psychologist, Psychotherapy
612 Psychologist, Psychotherapy, Group
613 Psychologist, Rehabilitation
614 Psychologist, School
615 Psychologist, Women
672 Registered Nurse
673 Registered Nurse, Addiction (Substance Use Disorder)
674 Registered Nurse, Administrator
711 Registered Nurse, Ambulatory Care
681 Registered Nurse, Cardiac Rehabilitation
676 Registered Nurse, Case Management
677 Registered Nurse, College Health
678 Registered Nurse, Community Health
680 Registered Nurse, Continence Care
679 Registered Nurse, Continuing Education/Staff Development
675 Registered Nurse, Critical Care Medicine
682 Registered Nurse, Diabetes Educator
683 Registered Nurse, Dialysis, Peritoneal
684 Registered Nurse, Emergency
685 Registered Nurse, Enterostomal Therapy
686 Registered Nurse, Flight
688 Registered Nurse, Gastroenterology
687 Registered Nurse, General Practice
689 Registered Nurse, Gerontology
691 Registered Nurse, Hemodialysis
690 Registered Nurse, Home Health
692 Registered Nurse, Hospice
694 Registered Nurse, Infection Control
693 Registered Nurse, Infusion Therapy
695 Registered Nurse, Lactation Consultant
696 Registered Nurse, Maternal Newborn
697 Registered Nurse, Medical-Surgical
699 Registered Nurse, Neonatal Intensive Care
700 Registered Nurse, Neonatal, Low-Risk
701 Registered Nurse, Nephrology
702 Registered Nurse, Neuroscience
698 Registered Nurse, Nurse Massage Therapist (NMT)
703 Registered Nurse, Nutrition Support
719 Registered Nurse, Obstetric, High-Risk
720 Registered Nurse, Obstetric, Inpatient
721 Registered Nurse, Occupational Health
722 Registered Nurse, Oncology
725 Registered Nurse, Ophthalmic
724 Registered Nurse, Orthopedic
726 Registered Nurse, Ostomy Care
723 Registered Nurse, Otorhinolaryngology & Head-Neck
704 Registered Nurse, Pain Management
706 Registered Nurse, Pediatric Oncology
705 Registered Nurse, Pediatrics
710 Registered Nurse, Perinatal
714 Registered Nurse, Plastic Surgery
708 Registered Nurse, Psych/Mental Health
709 Registered Nurse, Psych/Mental Health, Adult
707 Registered Nurse, Psych/Mental Health, Child & Adolescent
712 Registered Nurse, Rehabilitation
713 Registered Nurse, Reproductive Endocrinology/Infertility
715 Registered Nurse, School
716 Registered Nurse, Urology
718 Registered Nurse, Women's Health Care, Ambulatory
717 Registered Nurse, Wound Care
617 Respiratory Therapist, Certified
618 Respiratory Therapist, Certified, Critical Care
620 Respiratory Therapist, Certified, Educational
619 Respiratory Therapist, Certified, Emergency Care
622 Respiratory Therapist, Certified, General Care
621 Respiratory Therapist, Certified, Geriatric Care
623 Respiratory Therapist, Certified, Home Health
628 Respiratory Therapist, Certified, Neonatal/Pediatrics
627 Respiratory Therapist, Certified, Palliative/Hospice
629 Respiratory Therapist, Certified, Patient Transport
624 Respiratory Therapist, Certified, Pulmonary Diagnostics
626 Respiratory Therapist, Certified, Pulmonary Function Technologist
625 Respiratory Therapist, Certified, Pulmonary Rehabilitation
630 Respiratory Therapist, Certified, SNF/Subacute Care
631 Respiratory Therapist, Registered
632 Respiratory Therapist, Registered, Critical Care
634 Respiratory Therapist, Registered, Educational
633 Respiratory Therapist, Registered, Emergency Care
636 Respiratory Therapist, Registered, General Care
635 Respiratory Therapist, Registered, Geriatric Care
637 Respiratory Therapist, Registered, Home Health
642 Respiratory Therapist, Registered, Neonatal/Pediatrics
641 Respiratory Therapist, Registered, Palliative/Hospice
643 Respiratory Therapist, Registered, Patient Transport
638 Respiratory Therapist, Registered, Pulmonary Diagnostics
640 Respiratory Therapist, Registered, Pulmonary Function Technologist
639 Respiratory Therapist, Registered, Pulmonary Rehabilitation
644 Respiratory Therapist, Registered, SNF/Subacute Care
646 Social Worker, Clinical
648 Specialist/Technologist, Other, Biomedical Engineering
506 Speech-Language Pathologist
649 Technician, Other, Biomedical Engineering
502 Other, Not Listed

Code Lists

Specialty Boards - Allied Providers

940 Academy of Certified Social Workers
1150 ACNM Certification Council
360 American Academy of Ambulatory Care Nursing
1550 American Academy of Anesthesiologist Assistants
230 American Academy of Audiology
370 American Academy of Experts in Traumatic Stress
270 American Academy of Health Providers in the Addictive Disorders
200 American Academy of Medical Acupuncture
405 American Academy of Nurse Practitioners
380 American Academy of Nursing
1330 American Academy of Optometry
1480 American Academy of Physician Assistants
1110 American Association for Marriage and Family Therapy
390 American Association of Critical Care Nurses
1590 American Association of Nurse Anesthetists
330 American Association of Pastoral Counselors
1010 American Association of Sex Educators, Counselors and Therapists
710 American Board Medical Psychotherapists
280 American Board of Addiction Medicine
950 American Board of Examiners in Clinical Social Work
720 American Board of Medical Psyhotherapists & Psychodiagnosticians
400 American Board of Nursing Specialties
1240 American Board of Nutrition
1300 American Board of Occupational Medicine
1360 American Board of Ophthalmology
1510 American Board of Physical Therapy Specialties
700 American Board of Professional Psychology
1130 American Naturopath Certification Board
350 American Nurses Credentialing Center
740 American Psychological Association
750 American Psychological Society
760 American Psychotherapy Association
290 American Society of Addiction Medicine
1650 American Speech-Language-Hearing Association
250 Biofeedback Certification Institute of America
1430 Board of Pharmaceutical Specialties
1250 Commission on Dietetic Registration
960 Employee Assistance Professionals Association
780 National Association for the Advancement of Psychoanalysis
1450 National Association of Boards of Pharmacy
1600 National Association of Nurse Anesthetists
770 National Association of School Psychologists
980 National Association of Social Workers
1310 National Board for Certification in Occupational Therapy
1490 National Board for Certification of Orthopaedic Physician Assistants
790 National Board for Certified Clinical Hypnotherapists
310 National Board for Certified Counselors
1630 National Board for Respiratory Care
300 National Board of Addiction Examiners
800 National Board of Cognitive Behavioral Therapists
1350 National Board of Examiners in Optometry
1090 National Certification Board for Therapeutic Massage and Bodywork
210 National Certification Commission for Acupuncture and Oriental Medicine
1440 National Institute for Standards in Pharmacist Credentialing
220 Other - Not Listed

Specialty Boards - MD / DDS / DMD / DO / DPM

MD Boards

044 American Board of Allergy & Immunology
045 American Board of Anesthesiology
046 American Board of Colon & Rectal Surgery
047 American Board of Dermatology
048 American Board of Emergency Medicine
049 American Board of Family Medicine
050 American Board of Internal Medicine
051 American Board of Medical Genetics
052 American Board of Neurological Surgery
053 American Board of Nuclear Medicine
054 American Board of Obstetrics & Gynecology
055 American Board of Ophthalmology
109 American Board of Oral & Maxillofacial Surgeons
056 American Board of Orthopaedic Surgery
057 American Board of Otolaryngology
058 American Board of Pathology
059 American Board of Pediatrics
060 American Board of Physical Medicine & Rehabilitation
061 American Board of Plastic Surgery
062 American Board of Preventive Medicine
063 American Board of Psychiatry & Neurology
064 American Board of Radiology
065 American Board of Surgery
066 American Board of Thoracic Surgery
067 American Board of Urology
142 Boards other than ABMS/AOA

Dental Boards

113 American Board of Endodontics
114 American Board of Oral & Maxillofacial Pathology
117 American Board of Oral & Maxillofacial Radiology
109 American Board of Oral & Maxillofacial Surgeons
108 American Board of Orthodontics
112 American Board of Pediatric Dentistry
111 American Board of Periodontology
115 American Board of Prosthodontics
106 American Board of Public Health Dentistry
120 Boards other than ABMS/AOA

DO Boards

118 American Osteopathic Board of Anesthesiology
119 American Osteopathic Board of Dermatology
120 American Osteopathic Board of Emergency Medicine
121 American Osteopathic Board of Family Practice
123 American Osteopathic Board of Internal Medicine
124 American Osteopathic Board of Neurology and Psychiatry
125 American Osteopathic Board of Neuromuskuloskeletal Medicine
126 American Osteopathic Board of Nuclear Medicine
127 American Osteopathic Board of Obstetrics and Gynecology
128 American Osteopathic Board of Ophthalmology and Otolaryngology
129 American Osteopathic Board of Orthopedic Surgery
130 American Osteopathic Board of Pathology
131 American Osteopathic Board of Pediatrics
132 American Osteopathic Board of Preventive Medicine
133 American Osteopathic Board of Proctology
134 American Osteopathic Board of Radiology
135 American Osteopathic Board of Rehabilitation Medicine
136 American Osteopathic Board of Surgery

DPM Boards

140 American Board of Medical Specialists in Podiatry
137 American Board of Podiatric Orthopedics and Primary Podiatric Medicine
138 American Board of Podiatric Surgery
139 American Council of Certified Podiatric Surgeons and Physicians

Appendix E

Breakdown of the Questions on the CAQH form and the Maryland UCF

Comparison of the Uniform Credentialing Form Used in the State to the Format Used By the Council for Affordable Quality Healthcare

In reviewing the differences in the Maryland Uniform Credentialing Form ("UCF") and the Universal Credentialing Datasource by the Council for Affordable Quality Healthcare ("CAQH") the examiners found the following:

One of the main differences between the UCF and the CAQH form is that the CAQH form is the credentialing data source and the provider application combined into one document. Whereas, the Uniform Credentialing form is only the credentialing form although during market conduct exams the examiners have found many carriers to also use the UCF as the provider application. This current process of using the UCF as the application causes the carrier to be in violation of COMAR.

Additional elements found on the UCF and not on the CAQH form:

Additional Documentation to be attached to the credentialing application – the UCF requests the following additional documentation to be attached to the credentialing application, (other than what the CAQH requests):

a. A copy of your Board Certification Certificate, if held

Additional Questions or Sections to the Uniform Credential Form:

Personal Information

1. "Years at this address" – form request the number of years at the provider's home address.

2. "Previous address if less than five (5) years at current address"

3. "Federal Employee ID#"

4. As voluntary information the UCF request providers to indicate their "ethnic background".

Office Information

5. "Type of practice" – provider is requested to provide the practice type such as, L.L.C., Corp., or etc.

6. "EPSDT Certified" Yes ___ No ___ If yes, EPSDT number – EPSDT stands for Medicaid Early & Periodic Screening & Diagnostic Treatment.

Education and Training

7. "Program Title" – under the name of the undergraduate school or graduate degrees the form requests the program title of the degree awarded.

8. "APA approved?" Yes__ No __ – is the educational degree awarded approved by the American Psychological Association ("APA").

9. "APA approved?" Yes __ No __ – is the training provided by the institution approved by the American Psychological Association.

10. "Nursing professionals: Please list any certifications held:" – to include the:
    a. Certification received
    b. Received from date
    c. Expiration date.

Professional Licensure

11. "List all past professional licenses." – form has a section for the provider to identify all past licenses. The CAQH for request the provider to list all licenses and has a question box under the license number to identify if the provider is practicing in the state under the license.

Specialty Information

12. "If qualified, when does status expire?" – If the provider is qualified they are still pending board certification and the above question is to find out when the certification must be obtained.

13. "Would you like to be classified as a: Primary Care Provider __ Specialist __ Both __ Hospitalist __ Not Applicable __" - under the sub section "Primary Specialty" the question above is requesting the provider to chose how they would like to be classified.

14. "Would you like to be classified as a: Primary Care Provider __ Specialist __ Both __ Hospitalist __ Not Applicable __" - under the sub section "Sub-Specialty" the question above is requesting the provider to chose how they would like to be classified.

Behavioral Health Providers/Practitioners

15. The UCF has a section identified as Behavioral Health. This section contains 21 questions relating to certifications, appointments, and who you treat. The CAQH does not contain this section or any of the related questions. Please see attached for specific section and questions. Attachment 1.

Dental Providers/Practitioners

16. The UCF has a section identified as Dental Providers. This section contains 6 questions relating to licensure information, specialties, and administration of

anesthesia. The CAQH does not contain this section or any of the related questions. Please see attached for specific section and questions. Attachment 2.

Vision Providers/Practitioners

17. The UCF has a section identified as Vision Providers. This section contains 2 questions relating to certifications, and on site labs. The CAQH does not contain this section or any of the related questions. Please see attached for specific section and questions. Attachment 3.

Work History

18. "Contact Name" – requesting name of person to contact for past work history for the specific employer.

Professional Liability Insurance

19. "Agent Name" – requesting agent who sold policy to provider

Malpractice Claims History

20. "Other Defendants (if any)" –requesting other defendants related to malpractice occurrences.

21. "Claimant/Plaintiff filed suit in court?
    a. "If yes, sate filed" – State the malpractice case was filed.
    b. "State Court Case Number"
    c. "State" – State case was filed in.
    d. "County" – County case was filed in.

22. "Federal Court (U.S. District Court) Case Number"
    a. "District" – district case was filed.

Additional/Disclosure Questions

23. "Have you ever been the subject of a focused review by a peer review organization or similar agency including, but not limited to, Medicare, Medicaid, etc.?"

24. "Do you, or your business entity, own, have an investment in, manage, own stock in, participate in a joint venture, or act as a partner, contract consult or medical/dental advisor in any medical/dental enterprise or medical/dental supplier outside of your direct practice where you would financially benefit directly or indirectly?"

Additional elements found on the CAQH and not on the UCF form:

Additional Documentation to be attached to the credentialing application – the CAQH form requests the following additional documentation to be attached to the credentialing application, other than what the UCF requests:

a. Application release
b. W-9
c. Workers Compensation Certificate of Coverage

Additional Questions or Sections to the CAQH form:

Personal Information

1. "Do you practice exclusively within the inpatient setting?" Yes __ No __

2. "Date started using other name" – related to the provider having used another name.

3. "Date stopped using other name" – related to the provider having used another name.

4. "City of birth"

5. "Foreign National Identification Number ________________ FNIN County of Issue _______" – if the provider does not have a Social Security Number.

6. "CAQH will use this method for application follow-up – CAQH has a separate section to identify application follow up methods.
   "E-mail"
   "Fax"
   "Preferred Method of Contact" E-mail ___ Fax ___

7. "DEA state of registration" – specific state in which the provider obtained their DEA license.

8. "National provider identification number (NPI)" – health care provider identification system adopted by the U.S. Department of Health and Human Services (HHS) as part of the implementation of the Health Insurance Portability and Accountability Act.

9. "USMLE Number" – United States Medical License examination number

10. "Workers Compensation Number"

11. "Medicaid state" – specific state in which the provider obtained their Medicaid number.

Education and Training – training section is broken down differently than the UCF. At the top of the page the form identifies the institution and all of its contact information. Below this section has the provider list each internship, residency, fellowship separately. Within the education section, the form has a separate section to identify non U.S. or Canadian schools. The information requested is the same except

the layout of the request is different. The questions that are different are outlined below:

12. "Telephone" – requesting the phone number of the undergraduate school that the provider attended.

13. "Fax" – requesting the fax number of the undergraduate school that the provider attended.

14. "Did you complete your undergraduate education at this school?" Yes __ No __

15. "School code (E.G., affiliated medical school)" – the training section is requesting the affiliated school.

16. "Country Code" – Country in which the training took place.

17. "Telephone" – requesting the phone number of the training institution.

18. "Fax" – requesting the fax number of the training institution.

19. "Department/Specialty" – specific department in which the residency or fellowship was preformed in.

<u>Specialty Information</u>

20. "Do you wish to be listed in the directory under this specialty" – the primary specialty section then directs the provider to select the plans in which he would like to be listed in the directory under, HMO, POS, and/or PPO.

21. "If you indicated that you did not intend to take a certifying board exam, please use the following space to explain, otherwise leave the space blank." – primary specialty question asks for more detailed information about the board exam.

22. "Do you wish to be listed in the directory under this specialty" – the secondary specialty section then directs the provider to select the plans in which he would like to be listed in the directory under, HMO, POS, and/or PPO.

23. "If you indicated that you did not intend to take a certifying board exam, please use the following space to explain, otherwise leave the space blank." – secondary specialty question asks for more detailed information about the board exam.

24. "Do you hold the following certifications?"
    a. "Basic life support?" Yes __ No __ Expiration Date ______
    b. "Adv cardiac life spt.?" Yes __ No __ Expiration Date ______
    c. "Neonatal advanced life spt.?"Yes __ No __ Expiration Date ______
    d. "Adv life support in OB?" Yes __ No __ Expiration Date ______
    e. "Adv trauma life support?" Yes __ No __ Expiration Date ______

f. “Pediatric advanced life spt? Yes __ No __ Expiration Date ______

25. “Primary credentialing contact” – this is an additional section added for contact information as it relates to the credentialing form.
    a. “Last name”
    b. “First name”
    c. Address
    d. “City”
    e. “State”
    f. “Zip Code”
    g. “Telephone”
    h. “fax”
    i. “E-mail address”

Office Information

26. “Are you currently practicing at this address?” – primary practice location

27. “If no, what is your expected state date?” – requesting start date of practice location.

28. “Send general correspondence here?” – is the practice location the location the provider wishes to have correspondence sent to.

29. “Office manager or business office staff contact” – requesting contact person for the practice.
    a. “Last name”
    b. “First name”
    c. “Telephone”
    d. “Fax”
    e. “E-mail address”

30. “Billing contact” – additional section to the CAQH requesting a contact person for billing:
    a. “Last name”
    b. “First name”
    c. “Telephone”
    d. “Fax”

31. “Payment and remittance” – additional section to the CAQH requesting the following information:
    a. “Billing department (if hospital-based)”
    b. “Check payable to”
    c. “Last name”
    d. “First name”
    e. Address
    f. “City”

g. “State”
h. “Zip”
i. “Telephone”
j. “Fax”
k. “E-mail address”

32. “Accept existing patients with change of payor?” Yes __ No __

33. “If any of the above information varies by plan, explain (use both lines if required)” – added question to explain the practice status of the plans. For example, if the plan is accepting all new patients.

34. “Are there any practice limitations” – Yes __ No __ – if this question is answered yes, the following questions proceed:
    a. “Gender limitations” – Male only __ Female only __ None __
    b. “Age limitations” Minimum age __ Maximum age__
    c. “List other limitations”

35. “Mid level practitioners” – addition section to the CAQH that request the following additional information:
    a. “Practitioners license/certificate number”
    b. “Practitioners state”

36. “Languages” – addition section to the CAQH that request the following additional information:
    a. “Non-English languages spoken by office personnel”
    b. “Interpreters available” – Yes __ No __

37. “Accessibilities” – additional section to the CAQH that request the following additional information:
    a. “Does this site offer handicapped access for the following”
       Building Yes __ No __
       Parking Yes __ No __
       Restroom Yes __ No __
    b. “Does this site offer other services for the disabled” Yes __ No __
    c. “American sign language” Yes __ No __
    d. “Mental/physical impairment” Yes __ No __
    e. “Other handicapped access”

38. “Services - Does this location provide any of the following services?”– additional section to the CAQH that request the following additional information:
    a. Laboratory services Yes __ No __, “If yes, provide accrediting/certifying program.
    b. Radiology services Yes __ No __, “If yes, provide x-ray certification type.
    c. EKGS?
    d. Drawing blood?

e. Asthma treatment?
f. Pulmonary function testing?
g. Allergy injections?
h. Age appropriate immunization?
i. Osteopathic manipulation?
j. Physical therapy?
k. Allergy skin testing?
l. Flexible sigmoidoscopy?
m. IV hydration/treatment?
n. Care of minor lacerations?
o. Routine office gynecology?
p. Tympanometry/audiometry screening?
q. Cardiac stress test?

39. "Is anesthesia administered in your office?"
    a. "If yes, what class/category do you use?"
    b. "If yes, who administers it?"

40. "Type of practice (select one only)" __ Solo practice __Single specialty group __Multi-specialty group

Hospital Affiliations

41. "Telephone" – phone number of primary hospital provider is affiliated.

42. "Fax" – fax number of primary hospital provider is affiliated.

43. Department director's first name – name of director of primary affiliated hospital.

44. "Of your total annual admissions what percentage is to this hospital?" – number of admissions to primary hospital.

45. "Telephone" – phone number of other hospital provider is affiliated.

46. "Fax" – fax number of other hospital provider is affiliated.

47. "Department director's first name" – name of director of other affiliated hospital

48. "Of your total annual admissions what percentage is to this hospital?" – number of admissions to other hospital.

Professional Liability Insurance – CAQH form request providers to provide previous, current or future carriers, if current carrier is less than 10 years. UCF request providers to provide last 5 years of professional liability insurance.

49. "Self-Insured?" Yes __ No __

50. "Type of coverage?" Individual __ Shared __

51. "Do you have unlimited coverage with this insurance carrier?" Yes __ No __

52. "Policy includes tail coverage?" Yes __ No __

Malpractice Claims History

53. "If settled, enter date claim was settled?" – requesting date malpractice claim was settled.

54. Address – address of personal liability carrier involved.

55. "Telephone" – phone number of personal liability carrier involved.

56. "Policy number" – policy number of personal liability carrier involved.

57. "Amount of award or settlement" – resulting from malpractice claim.

58. "Method of resolution" – requesting the method that the case was resolved/closed. Dismissed __, Settled __, Mediation __, Arbitration __, Judgment for defendant __, Judgment for plaintiff __

59. "Your involvement in the case (Attending, consulting, etc.)"

Work History – CAQH form request providers to include work history for the last 10 years. UCF only request the last 5 years of work history.

CAQH form request providers to explain any gaps in training or work history longer than three months. UCF only request an explanation for gaps greater than 6 months.

60. "Are you currently on active military duty or military reserve?" Yes __ No __

61. "Fax" – fax number of previous work history.

62. "Country" – county of previous work history.

References

63. "Provider type" – requesting the type of provider for whom you are referencing.

64. "Fax" – fax number for the provider for whom you are referencing.

Additional/Disclosure Questions

65. "Have you voluntarily of involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?"

66. “Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organization?”

67. “Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?”

68. “Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?”

69. “Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorization entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualification, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual misconduct?”

70. “Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?”

71. “Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual history?”

72. “Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?”

73. “Have you ever been court-martialed for actions related to your duties as a medical professional?”

74. “Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?”

75. “Do you have reason to believe that you would pose a risk to the safety or well being of your patients?”

76. “Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?