

**CREDENTIALING APPLICATION**

Please Type or Print in Black

Under what specialty do you choose to be listed in the directory? \_\_\_\_\_

Are you a PCP? Yes  No

**A. General Information**

Last Name	First Name	Middle Initial	Professional Designation or Title
Social Security Number (REQUIRED)	Date of Birth (REQUIRED)	Sex	Maiden/Other Name
Email Address			

**B. Primary Office Information**

Practice Name			Start Date (month/year)
Practice Address Line 1		Practice Address Line 2	
City	State	Zip	Appointment Telephone
Office Manager (if applicable)			Fax Telephone

Make checks payable to (must match tax ID owner name on file with IRS for the EIN listed below)			Type of Corporation
Billing Address Line 1		Billing Address Line 2	
City	State	Zip	Telephone
Employer Identification Number (EIN)	Your UPIN Number	Your NPI Number	Your Medicare Number
Your Medicaid Number			

Hours of Operation (actual practice hours each day at this location):

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
From	To	From	To	From	To	From	To	From	To	From	To

Is this office handicapped accessible? Yes \_\_\_ No \_\_\_ Is this office accessible to public transportation? Yes \_\_\_ No \_\_\_

Identify any foreign language(s) or sign language that is spoken fluently in treating patients in this office. (select no more than 5):

<input type="checkbox"/> Arabic (AR)	<input type="checkbox"/> Chinese (CH)	<input type="checkbox"/> Farsi (FA)	<input type="checkbox"/> French (FR)	<input type="checkbox"/> German (GE)
<input type="checkbox"/> Hebrew (HE)	<input type="checkbox"/> Hindi (HI)	<input type="checkbox"/> Italian (IT)	<input type="checkbox"/> Japanese (JA)	<input type="checkbox"/> Korean (KO)
<input type="checkbox"/> Laotian (LA)	<input type="checkbox"/> Portuguese (PO)	<input type="checkbox"/> Russian (RU)	<input type="checkbox"/> Sign Language (SL)	<input type="checkbox"/> Spanish (SP)
<input type="checkbox"/> Vietnamese (VI)	<input type="checkbox"/> Tagalog (TA)	<input type="checkbox"/> Other (specify): _____		

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**C. Patient Referral Information**

Identify the percentage of your practice time dedicated to the following patient population and modality categories:

Population	% of Practice	Business Lines	% of Practice
Child (up to age 12)		Group Health (PPO)	
Adolescent (13 – 17)		Capitation (HMO)	
Adult (18 – 64)		Workers Compensation	
Geriatric (65+)		Personal Injury	

**D. Additional Office Information**

Practice Name			
Practice Address Line 1		Practice Address Line 2	
City	State	Zip	Appointment Telephone
Office Manager (if applicable)			Fax Telephone

**Make checks payable to** (must match tax ID owner name on file with IRS for the EIN listed below)

Billing Address Line 1		Billing Address Line 2	
City	State	Zip	Telephone
Employer Identification Number (EIN)	Your UPIN Number	Your NPI Number	Your Medicare Number
Your Medicaid Number			

Hours of Operation (actual practice hours each day at this location):

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
From	To	From	To	From	To	From	To	From	To	From	To

Is this office handicapped accessible? Yes \_\_\_ No \_\_\_ Is this office accessible to public transportation? Yes \_\_\_ No \_\_\_

**E. Referral Information for offices**

Identify the percentage of your practice time dedicated to the following patient population and modality categories:

Population	% of Practice	Business Lines	% of Practice
Child (up to age 12)		Group Health (PPO)	
Adolescent (13 – 17)		Capitation (HMO)	
Adult (18 – 64)		Workers Compensation	
Geriatric (65+)		Personal Injury	

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**F. License/Certification Information**

**DRUG CERTIFICATE:** If applicable, listed below is your current DEA/CDS Certificate on file with Med Advantage. If the certificate has expired, or if you have changes to report, strike out the incorrect information and make the necessary corrections.

DEA Certificate #	Exp. Date (mm/dd/yy)

(NOTE: to expedite credentialing, please enclose a copy of your DEA certificate even if it has not expired.)

CDS Certificate #	Exp. Date (mm/dd/yy)

(NOTE: to expedite credentialing, please enclose a copy of your CDS certificate even if it has not expired.)

**PROFESSIONAL LICENSE(S):** Listed below is(are) your current professional license(s) on file with Med Advantage. If a license has expired, or if you have changes to report, strike out the incorrect information and make corrections. To expedite credentialing, submit a copy of your current state license even if it is not listed as expired below. **Please list licenses you have held for the most recent five (5) year period.**

Board Name	Certificate #	Cert. Date (mm/dd/yy)	Exp. Date (mm/dd/yy)

**G. Malpractice Insurance**

Listed below is your current malpractice carrier on file with Med Advantage. Enclose a copy of your current policy certificate and/or declarations page showing the coverage limits and dates of coverage, even if the policy below has not expired.

Current Carrier (Name and Address)	Policy Number	Dates of Coverage (mm/dd/yy)	Coverage Limits

In the space provided below, list the name and address of the malpractice carrier who has provided coverage for you for the most recent five (5) year period. **If there has been more than one carrier, please indicate the dates of coverage with each carrier, and the reason for changing carriers.**

Carrier (Name and Address)	Policy Number	Dates of Coverage (mm/dd/yy)	Reason for Changing Carriers

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**H. Education Information**

Educational Institution (include name and complete address)	Degree	Specialty	From (mm/yy)	To (mm/yy)
Undergraduate				
Graduate/Medical School				
Internship				
Residency				
Fellowship				

If you are a foreign medical school graduate, ECFMG# \_\_\_\_\_  
 (Please attach copy of certificate(s))

**CONTINUING EDUCATION:** List any continuing education seminars/workshops you have attended in the past 24 months. Please attach copy of CEU certificate(s) of completion or you may attach a copy of your Accredited Continuing Education Agency's Report, if applicable.

Course Subject	Sponsoring Organization (Name and Address)	Date Started (mm/dd/yy)	Date Completed (mm/dd/yy)	# of CEUs Awarded

**BOARD CERTIFICATION/SPECIALTY:** Listed below are any board certifications currently on file with Med Advantage.

Board Name	Certificate #	Cert. Date (mm/dd/yy)	Exp. Date (mm/dd/yy)

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**I. Work History/Military Experience**

This section may be used for work history and military experience. Please indicate any changes below. **Please explain fully any gaps of six months or more on a separate sheet of paper.** A current Curriculum Vitae (must specify month and year) may be submitted.

From (mm/yy)	To (mm/yy)	Name & Address of Employer	Description of Activities

**J. HOSPITAL PRIVILEGES**

List below, if applicable, are the current hospital privileges we have on file for you. Please update these if necessary.

Primary Admitting Facility	Address	Type of Privilege

Other Hospital Privileges	Address	Type of Privilege

**K. Professional References**

Listed below are the professional (peer) references we have on file for you. Please update this information if necessary.

Name	Address1		Address2
City	State	Zip	Telephone

Name	Address1		Address2
City	State	Zip	Telephone

Name	Address1		Address2
City	State	Zip	Telephone

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L. Attestation

NOTE: If "YES" is checked (except if marked \*), please explain fully on a separate sheet. Documentation is required if you have malpractice claims pending or settled in the past five (5) years (include any settlements/adjudication's, original complaint and final disposition). Your signed statement regarding the alleged incident will suffice for pending cases.

Yes or No must be checked for each question.

- 1. Health Status: Do you currently have any physical, mental, or emotional condition which may impair your ability to render the professional services which are the subject of this application?
a. Do you currently use illegal drugs or abuse drugs or alcohol?
2. Insurance Coverage: Do you currently have malpractice insurance coverage?
a. Has your professional liability insurance coverage ever been denied, canceled, or non-renewed or initially refused upon application?
3. License: Has your medical or professional license in any state ever been revoked, suspended, placed on probation, conditional status, or limited?
a. Have you ever voluntarily surrendered your license?
b. Are formal charges pending against you at this time?
4. DEA: Has your DEA Registration Certificate ever been suspended, revoked, subjected to probation, placed on conditional status, or limited?
5. Hospital Privileges: Do you currently have admitting privileges at any hospital or healthcare facility?
IF YOU ANSWER NO TO QUESTION 5, PLEASE SKIP TO QUESTION 6
a. Are any of your admitting privileges not in good standing?
b. Has any hospital ever dismissed you from its staff?
c. Has any hospital ever revoked, suspended, or limited your privileges?
d. Has any hospital initiated either type of aforementioned action by formal notice to you?
e. Has any hospital refused or denied you privileges?
f. Have you ever voluntarily surrendered your hospital privileges?
6. Hospital Sanctions: Have you ever surrendered your clinical privileges upon threat of censure, restriction, suspension or revocation of such privileges?
7. Professional Membership(s): Has your membership in any professional society or association ever been canceled, revoked, or censured?
8. Medicare/Medicaid: Have you ever been fined, had an arrangement suspended, been expelled from participation or had criminal charges brought against you by Medicare or Medicaid?
9. Criminal Offenses: Have you ever been convicted of a felony or involved in charges relating to moral or ethical turpitude?
a. Have you ever been named as a defendant in any criminal proceeding?
10. Board Discipline: Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board; county; state or national professional society hospital medical or clinical staff)?
11. Malpractice Action: Has any malpractice action against you been brought or settled in the last 5 years or has there been any unfavorable judgment(s) against you in a malpractice action?
a. To your knowledge, is any malpractice action against you currently pending?

I hereby attest that all the information in this application is warranted to be true, correct and complete.

Name (Please Print)

Signature

Date (mm/dd/yy)

**AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION**

I hereby specifically authorize and consent for the following organizations to release to Med Advantage any and all records and information in your possession, which relates to my credentials as a physician and/or healthcare provider. The purpose of this authorization and consent to release is to permit Med Advantage to properly gather and verify my credentials to engage in the delivery healthcare or practice medicine.

**State Licensing Organizations**

License, Sanctions, State Requirements for Licensing, Education

**Universities/Colleges/Graduate**

Education and Training

**Hospitals/Medical Facilities**

Appointment Date/Privileges/Restrictions/Residency – Fellowship – Internship

**Professional Liability Carrier**

Certificate of Insurance that includes my professional liability insurance coverage history, which includes policy number, effective dates, limits of liability, and retroactive date.

**Additional**

The National Practitioner Data Bank, Federation of State Medical Boards, and Medicare/Medicaid for sanctions.

The purpose of this authorization and consent to release is to permit Med Advantage to properly gather and verify my credentials in accordance with the guidelines established by the National Committee on Quality Assurance (NCQA) and the Joint Commission Accreditation for Hospital Organizations (JCAHO). I hereby authorize and consent to Med Advantage providing any and all such information concerning my credentials to the healthcare organization, i.e., HMO, PPO, Hospital, etc., seeking to credential me for healthcare privileges. I hereby release any and all individuals, organizations and entities from any and all liability which might arise from their furnishing such information and records to a third-party if such release is done at my request.

I agree to notify Med Advantage of any change in information.

I agree that this authorization and consent shall remain valid and in full force and effect until specifically withdrawn by me in writing.

I agree that a photocopy of this document will serve as a duplicate original.

\_\_\_\_\_  
Please print name clearly

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date signed (mm/dd/yy)

\_\_\_\_\_  
State License number