



PROVIDER CREDENTIALING APPLICATION

The information requested in this application is required under a Federal Program and supersedes any and all information that may be found in a centralized state credentialing database.

To meet the minimum credentialing criteria established by Humana Veterans Healthcare Services (Humana Veterans), you must:

- have graduated from a school appropriate to your profession, and completed post graduate training appropriate to your practicing specialty;
- have a current, valid, unrestricted and unprobated professional state license in the State(s) you practice within;
- have a current, valid, unrestricted and unprobated DEA, if applicable to your profession;
- have a current, valid, unrestricted and unprobated State Controlled Dangerous Substance registration, if applicable to your profession and the State you practice within;
- have current professional liability insurance or meet the State/local guidelines;
- be able to participate in Federal healthcare programs;
- not have any felony conviction;
- not have any physical or mental health condition that can not be accommodated without undue hardship or without reasonable accommodation; and
- not have any unexplained gaps in your work history during the past five years.

In addition to the minimum criteria listed, Humana Veterans may take other information into consideration when determining credentialing/network participation status. All providers are subject to the satisfaction and maintenance, in Humana Veterans' sole judgment of all credentialing standards adopted by Humana Veterans.

Please fax your completed credentialing application to 1-866-836-9548 or mail it to the following address:

Humana Veterans Healthcare Services
321 West Main Street
10 West
Louisville, KY 40202

After Humana Veterans receives your completed application, you may be contacted by a Humana Veterans Credentialing Specialist or a Humana Veterans representative, for additional information.

Upon completion of the credentialing process, you will be mailed a letter indicating the decision made by the Credentialing Committee.

If at any time during the credentialing process you have any questions regarding the status of your application, please call 1-866-458-6630 and ask for the Credentialing Department.



INITIAL CREDENTIALING APPLICATION

A. GENERAL INFORMATION			
Please Print or Type Information			
Last Name	Generation (i.e., Sr., Jr., III)	Date of Birth	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No
First Name	Middle Initial	<input type="checkbox"/> Male <input type="checkbox"/> Female	If No, list alien Registration Number _____
Social Security Number / /	Languages spoken by self: Primary _____ Secondary _____ Other _____		
AKA Name: Please list any/all other names you may be/have been known as. List any name, other than the name listed above, that your degree(s), professional license(s) has ever been issued under (e.g. maiden name, alias, nickname) etc.			
Last Name	Generation (i.e., Sr., Jr., III)	Provider Type <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> DC <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Other healthcare professional, please specify: _____	
First Name	Middle Initial	_____	
B. PRACTICING SPECIALTY - Family Practitioners, Internists, Pediatricians and General Practitioners offering primary health services are usually classified as a "Primary Care Physicians" and physicians practicing all other specialties are considered to be "Specialists." "Other Health Professionals" are non-physician practitioners licensed, certified, or registered to provide direct patient care services. In each case, please indicate the area(s) of healthcare that is/are your main patient focus.			
<input type="checkbox"/> Primary Care Physician <input type="checkbox"/> Specialist <input type="checkbox"/> Other Health Professional			
My Primary Practicing Specialty is : _____ My Secondary Practicing Specialty is: _____			
C. GENERAL INFORMATION ABOUT YOUR PRACTICE - Primary Office Practice <i>If you have additional office practices, please include them on the <u>Office Practice Form</u> located on page 10 of this application.</i>			
Legal Practice Name		Tax ID Number	
Practice Address			Suite Number
City	State	Zip Code +4	County
Office Phone Number ()	General Office Fax Number ()	Referral Fax Number ()	Office Practice Type <input type="checkbox"/> Solo/Individual <input type="checkbox"/> Multi Provider group
Date (mm/yy) you started with this practice:	E-mail Address	Are you currently accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you able to submit claims or referrals electronically? <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Phone Number ()		
Are there age limitations on your patients? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify age range. From ()years To ()years	Credentiaing Contact Name _____ E-Mail Address _____ Phone Number (_____) _____ Fax (_____) _____		



D. CORRESPONDENCE ADDRESS (If different from Primary Office)				E. BILLING ADDRESS (If different from Primary Office)				
Name				Name				
Street Address			Suite #	Street Address			Suite #	
City				City				
State	Zip Code +4		County	State	Zip Code +4		County	
Office Phone Number () ()		Office Fax Number () ()		Office Phone Number () ()		Office Fax Number () ()		
What hours do you see patients in your office?								
	FROM	TO		FROM	TO			
Monday			Wednesday			Friday		
Tuesday			Thursday			Saturday		
						Sunday		
<i>Please list your covering practitioners</i>								
Name				Name				
Phone Number () ()		Specialty		Phone Number () ()		Specialty		
F. CREDENTIALS INFORMATION								
Medicare UPIN Number				Medicare Number(s)				
National Provider Identifier (NPI) <i>NPI is a unique 10-digit numeric identifier assigned to all HIPAA covered healthcare providers. For more information see the CMS website: www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/default.asp.</i>								
State Licenses/Certificates List all professional licenses or certificates held in the last ten years. If the license(s) is not current, please explain why. If you need additional space, attach a separate sheet.								
1.	State	License/Certificate #	Type (i.e., MD,DO)	2.	State	License/Certificate #	Type (i.e., MD,DO)	
	Date of Initial License/Certificate - -		Expiration Date of Current State License/Certificate - -		Date of Initial License/Certificate - -		Expiration Date of Current State License/Certificate - -	
	Is this license certificate active? <input type="checkbox"/> Yes <input type="checkbox"/> No If not active, why?		Do you currently practice under it? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this license certificate active? <input type="checkbox"/> Yes <input type="checkbox"/> No If not active, why?		Do you currently practice under it? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Does your license/certification level require supervision? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please explain.</i>				Does your license/certification level require supervision? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please explain.</i>			
3.	State	License/Certificate #	Type (i.e., MD,DO)	4.	State	License/Certificate #	Type (i.e., MD,DO)	
	Date of Initial License/Certificate - -		Expiration Date of Current State License/Certificate - -		Date of Initial License/Certificate - -		Expiration Date of Current State License/Certificate - -	
	Is this license certificate active? <input type="checkbox"/> Yes <input type="checkbox"/> No If not active, why?		Do you currently practice under it? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this license certificate active? <input type="checkbox"/> Yes <input type="checkbox"/> No If not active, why?		Do you currently practice under it? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Does your license/certification level require supervision? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please explain.</i>				Does your license/certification level require supervision? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please explain.</i>			
Federal DEA Certificate <i>Attach a copy of your current Federal DEA Certificate(s).</i>								
1.	State	DEA Certificate Number	Expiration Date	Limited or Restricted? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain.			
State Narcotics Registration <i>Attach a copy of all your current Controlled Dangerous Substance (CDS) Registration(s).</i>								
1.	State	CDS Certificate Number	Expiration Date	Limited or Restricted? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain.			



G. BOARD CERTIFICATION STATUS

For each certification, please indicate your specialty, the certificate number, and the dates of certification and expiration. Please include issuing board (ABMS, AOA, etc.).

1.	Specialty		2.	Specialty	
	Issuing Board (ABMS, AOA, etc.)			Issuing Board (ABMS, AOA, etc.)	
	Certificate Number	Original Effective Date		Certificate Number	Original Effective Date
	Expiration Date	Last Recertification Date		Expiration Date	Last Recertification Date

H. EDUCATION, TRAINING AND PROFESSIONAL ACTIVITY MEDICAL/PROFESSIONAL EDUCATION

Month and year must be indicated. Foreign Medical School Graduates; Please enclose a copy of your ECFMG certificate.

Complete School Name	From (month/year)	To (month/year)
Mailing Address	City	State
	Zip Code	Country
Degree Granted		

INTERNSHIP

Complete School Name	From (month/year)	To (month/year)	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address	City	State	Zip Code
		Country	Program Specialty

RESIDENCY

Complete School Name	From (month/year)	To (month/year)	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address	City	State	Zip Code
		Country	Program Specialty

SECOND RESIDENCY

Complete School Name	From (month/year)	To (month/year)	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address	City	State	Zip Code
		Country	Program Specialty

FELLOWSHIP

Complete School Name	From (month/year)	To (month/year)	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address	City	State	Zip Code
		Country	Program Specialty

OTHER POST GRADUATE TRAINING

Complete School Name	From (month/year)	To (month/year)	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address	City	State	Zip Code
		Country	Program Specialty



I. PROFESSIONAL WORK HISTORY

Please account for your professional history during the past 5 years. You must include both month and year for each position.

<p>1. From (Month/Year)</p> <p>To (Month/Year)</p> <p>Organization or Office Practice Name</p> <p>Mailing Address</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">City</td> <td style="width:10%;">State</td> <td style="width:60%;">Zip Code</td> </tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">County</td> <td style="width:70%;">Phone Number ()</td> </tr> </table> <p>Position</p>	City	State	Zip Code	County	Phone Number ()	<p>2. From (Month/Year)</p> <p>To (Month/Year)</p> <p>Organization or Office Practice Name</p> <p>Mailing Address</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">City</td> <td style="width:10%;">State</td> <td style="width:60%;">Zip Code</td> </tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">County</td> <td style="width:70%;">Phone Number ()</td> </tr> </table> <p>Position</p>	City	State	Zip Code	County	Phone Number ()
City	State	Zip Code									
County	Phone Number ()										
City	State	Zip Code									
County	Phone Number ()										
<p>3. From (Month/Year)</p> <p>To (Month/Year)</p> <p>Organization or Office Practice Name</p> <p>Mailing Address</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">City</td> <td style="width:10%;">State</td> <td style="width:60%;">Zip Code</td> </tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">County</td> <td style="width:70%;">Phone Number ()</td> </tr> </table> <p>Position</p>	City	State	Zip Code	County	Phone Number ()	<p>4. From (Month/Year)</p> <p>To (Month/Year)</p> <p>Organization or Office Practice Name</p> <p>Mailing Address</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">City</td> <td style="width:10%;">State</td> <td style="width:60%;">Zip Code</td> </tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">County</td> <td style="width:70%;">Phone Number ()</td> </tr> </table> <p>Position</p>	City	State	Zip Code	County	Phone Number ()
City	State	Zip Code									
County	Phone Number ()										
City	State	Zip Code									
County	Phone Number ()										

J. WORK HISTORY ATTESTATION Please explain any work history gap of 6 months or greater in the space provided below. Please attach a separate sheet if additional space is needed.

During the most recent five year period:

- I have had no periods of six months or greater where I was not actively engaged in patient care.
- I have had a period(s) of six months or greater wherein I was not actively engaged in patient care. During this period(s) I was:

K. PROFESSIONAL LIABILITY INSURANCE

Attach a copy of your current Professional Liability Insurance Certificate or declaration page (usually the first page of your policy) showing the name of the insured, the dates of coverage, and the amounts of coverage. Your name must appear on the page as a covered provider.

CURRENT INSURANCE CARRIER		STATE INSURANCE FUND											
<p>1. Name of Carrier</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">State</td> <td style="width:70%;">Zip Code</td> </tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">Years with Carrier</td> <td style="width:70%;">Amounts of Coverage</td> </tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">Effective Date</td> <td style="width:70%;">Expiration Date</td> </tr> </table>	State	Zip Code	Years with Carrier	Amounts of Coverage	Effective Date	Expiration Date	<p>2. Name of Carrier</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">State</td> <td style="width:70%;">Zip Code</td> </tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">Years with Carrier</td> <td style="width:70%;">Amounts of Coverage</td> </tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">Effective Date</td> <td style="width:70%;">Expiration Date</td> </tr> </table>	State	Zip Code	Years with Carrier	Amounts of Coverage	Effective Date	Expiration Date
State	Zip Code												
Years with Carrier	Amounts of Coverage												
Effective Date	Expiration Date												
State	Zip Code												
Years with Carrier	Amounts of Coverage												
Effective Date	Expiration Date												



L. ALLIED HEALTH ASSOCIATES

Do you employ Allied Health Practitioners (e.g. nurse midwives, nurse practitioners, physician assistant, etc...?) Yes No

1. Allied Practitioner Name Correspondence Address City State Zip Code County State License/Certification Number Specialty	2. Allied Practitioner Name Correspondence Address City State Zip Code County State License/Certification Number Specialty
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3. I attest that the Allied Practitioner employed and/or utilized by me or the group in which I am affiliated, has registered and holds a current valid license with the State Medical/Professional Board in which he/she practices.
 Signature: _____ Date: _____

M. SPONSORING HUMANA VETERANS PHYSICIAN(S) – to be completed by ALLIED HEALTH PROVIDERS only

Name of Sponsoring Physician (must be an Humana Veterans networked provider)

Phone Number	Sponsoring Physician's Social Security Number / /
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Sponsoring Physician's Signature - I attest that the Allied Health Provider employed and/or utilized by me or the group in which I am affiliated, has registered and holds a current valid license with the State Medical/Professional Board in which they practice.

Signature: _____ Date: _____

N. CONFLICT OF INTEREST STATEMENT

Do you or any member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgery center, or other business dealing with the provision of ancillary health services, equipment or supplies? Yes No **If yes, please provide the following information:**

Name of Organization	Percent of Investment/Ownership
Address	
City	State Zip Code
Phone Number ()	Tax ID Number Nature of business interest (i.e., Partner, owner, investor)
Type of Organization	Size of Organization

O. HOSPITAL AFFILIATIONS – list hospitals in the order of use

Name of Hospital	Location of Hospital (City/State)	Do you have the right to admit patients to this hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Hospital	Location of Hospital (City/State)	Do you have the right to admit patients to this hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Hospital	Location of Hospital (City/State)	Do you have the right to admit patients to this hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Hospital	Location of Hospital (City/State)	Do you have the right to admit patients to this hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No



P. MANDATORY QUESTIONNAIRE

IMPORTANT: If the answer to any question listed below is "Yes", attach a detailed explanation. If any question does not apply to you, please answer "No". Failure to check an answer or provide an explanation may result in delay of application processing. **DO NOT** use whiteout to correct/change answers; if you need to correct/change an answer, cross-out the incorrect answer, initial it and then mark the correct answer.

Provider's Name	Social Security Number
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Disciplinary Actions

1. Have any of the following been, or are currently in the process of being investigated, suspended, reduced, limited, placed on probation, not renewed, revoked, cancelled, denied, reprimanded, granted with limitation (either temporarily or permanently) or voluntarily relinquished:

a. Medical License in any State or Commonwealth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. DEA Registration?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. State CDS (Controlled Dangerous Substance) or other Professional Registration?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Board Certification?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Education, Internship, Residency, Fellowship or other Academic Positions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. Clinical Privileges?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g. Membership on any Hospital or other Medical Staff?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h. Participation in any Managed Care Organization or Federal or State Health Program? (including the Medicare and/or Medicaid Programs)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i. Military Agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been convicted of a felony or are you presently under investigation or have you been indicted for a felony? Yes No

Malpractice Claims and Professional Negligence History – During the past five years

3. Have you had any malpractice or professional negligence claims, suits, or actions settled, arbitrated, mediated or litigated? Yes No
4. Have any malpractice or professional negligence claims, suits, or actions been filed against you that are presently pending? Yes No
5. Have you ever been denied professional liability insurance coverage, ever been terminated or modified by action of an insurance carrier or rated in a higher-than-average risk class for your specialty? Yes No
6. Are you currently uninsured for professional liability (malpractice insurance) coverage? Yes No

Health Status

7. Is there any reason that you are not able to perform the essential functions of your position, with or without reasonable accommodation? Yes No
8. Are you currently engaged in the illegal use of drugs? Yes No

NPDB - HIPDB

9. To your knowledge, has information pertaining to you regarding malpractice claims, licensure issues, privileges, criminal records, etc. been reported to the National Practitioner Data Bank or Healthcare Integrity Protection Data Bank? Yes No

Hospital Affiliations

10. Are you a physician without admitting privileges/rights to a JCAHO accredited hospital? If "Yes" print the name, specialty and telephone number of the Humana Veterans network provider who admits on your behalf. Yes No
- NOTE:** Not applicable if your practicing specialty is: Allergy & Immunology, Anesthesiology, Dermatology, Emergency Medicine, Pathology, Radiology or Urgent Care

Admitting Provider: _____

Specialty: _____ Phone #: _____



Q. CONSENT and RELEASE / ATTESTATION FORM

Provider Authorization and Attestation - *Any alteration or failure to sign and date this form will delay the processing of your application.*

I hereby give permission to Humana Veterans Healthcare Services (Humana Veterans), its parent company, Humana Military Healthcare Services (Humana Military) and/or its designee(s) to request information regarding my professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certificate boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, present and past employers, and any other entity needed to obtain information necessary to complete the credentialing process, which may include a criminal history background check.

The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and or professional competence, character, ethics, or any other matter applicable to the credentialing procedure. I release and agree to hold harmless Humana Veterans, Humana Military and its designee(s) and their respective authorized representatives, from any and all liability for any damages, costs and expenses which may result from the gathering of and good faith use of the information gathered during the credentialing process.

I hereby authorize the education facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, present and past employers to submit information requested by Humana Veterans, Humana Military, directly and/or through its designee(s) including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and lawsuit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I hereby further release and agree to hold harmless any such entity referenced in the previous sentence, their representatives, employees, and agents from any damages which may result from providing this information as long as such release of information is done in good faith and without malice.

I agree that a photocopy or facsimile of this document with my signature may be accepted by any person or entity from which information is needed to complete the credentialing process. The photocopy or facsimile is sought with the same authority as the original, and I specifically waive written notice from any such entity or individual who may provide information based upon this authorized request.

I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application by Humana Veterans and/or Humana Military may result in denial of my application or termination of my participation in the Humana Veterans/Humana Military network. I further understand that any misrepresentation, misstatement, or omission from this application, if discovered after network participation has been awarded to me, may lead to immediate suspension or termination of my network status. I agree to use my best efforts to inform Humana Veterans in writing, within 15 days, if there is any change in the information contained in this application as a result of developments subsequent to my signing this application.

If I am accepted for participation, I consent to the inspection of my patient records as necessary for peer, utilization, and quality review purposes and agree to be bound by the participation agreement, credentialing plan and provider manual.

I understand that if my application is rejected for reasons related to my professional conduct or competence, Humana Veterans may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank.

I understand that I have the right to review and correct erroneous information obtained by Humana Veterans to evaluate my credentialing application. This includes information obtained from any outside primary source (e.g., malpractice insurance carriers, state licensing boards, Criminal History Background Checks, etc). The review must take place within 6 months of this application. Any corrections must be made in writing within 30 days of the review. This does not require Humana Veterans to allow a provider to review references, recommendations or other information that is peer-review protected.

I represent that the information provided in or attached to this application is complete, accurate and true to the best of my knowledge and that I have current malpractice protection through a commercial carrier. Prior to review of this application by the Humana Veterans or Humana Military Credentialing Committee, additional information will be accepted to correct incomplete, inaccurate or conflicting credentialing information.

I agree that the submission of the application does not constitute approval or acceptance as a participating provider.

This health care organization does not discriminate on the basis of race, color, national origin, age, or disability.

If at any time during the credentialing process you have any questions regarding the status of your application, please call 1-866-458-6630 and ask for the Credentialing Department.

This attestation statement must be signed no more than 180 days prior to the credentialing decision. If the credentialing review and decision takes place more than 180 days after the signature below, the provider must re-sign and date this application page attesting that all application information remains current, complete, and correct.

Your signature is required to complete this application. STAMPED SIGNATURES ARE NOT ACCEPTABLE.

Name (Please Print or Type)

Signature

Date



MALPRACTICE CLAIM INFORMATION WORKSHEET			
Please provide the following information for each malpractice claim in which you have been named.			
Date of Occurrence (mm/dd/yy)			
Insurance company defending your claim:			
Insurance company address	City	State	Zip Code
Procedure(s) performed:			
Co-defendant(s):			
Court Trial? <input type="checkbox"/> Yes <input type="checkbox"/> No	Settlement out of court? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Settlement?(mm/dd/yy)	
Is the claim pending? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ Amount in reserve by insurance company?		
\$ Total amount paid to claimant on your behalf/settlement amount?	\$ Total amount paid to claimant for all defendants:		
Please provide a clinical, detailed description of the events leading up to each malpractice case . Please add additional sheets if necessary, or a copy of the court documentation.			



OFFICE PRACTICE FORM

Please complete a separate form for each additional office practice. If additional sheets are needed, please photocopy this page prior to completing.

ADDITIONAL OFFICE PRACTICE

Legal Practice Name				Tax ID Number			
Practice Address					Suite #		
City		State		Zip Code		County	
Office phone number ()		Office Fax Number ()		Referral Fax Number ()			
E-mail address				Date (mm/yy) you started with this practice:			
Correspondence Address				Billing Address (If different from Primary Office)			
Name				Name			
Street Address			Suite #	Street Address			Suite #
City				City			
State	Zip Code	County		State	Zip Code	County	
Office phone number ()				Office phone number ()			
Office Fax Number ()				Office Fax Number ()			
E-mail address				E-mail address			
What hours do you see patients in this office				FROM		TO	
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Sunday							
Please list your covering practitioners							
Name				Name			
Phone Number ()				Phone Number ()			
Emergency Number ()				Emergency Number ()			
Specialty				Specialty			



CONGRATULATIONS! YOU HAVE REACHED THE FINAL PAGE OF THIS APPLICATION. To ensure the credentialing process is quickly expedited, please make sure you have completed the following:

- YES NO Have you marked all of the sections of the application that do not apply to you as "N/A"?
- YES NO Have you included your work history, with all information for the past five years? Month and year **must** be indicated on each work item.
- YES NO Have you included a current professional liability insurance/malpractice insurance declaration sheet, including name of insured, amounts and dates of coverage?
 NOTE: Invoices or documentation that states, "upon receipt of premium your coverage will be..." will not be accepted as proof of current professional liability insurance/malpractice insurance.
- YES NO Have you included your **entire** malpractice claims history? Each claim must include the clinical details of the events leading up to the issue, the current status, and the financial outcome of each case.
- YES NO Have you included a copy of your current Drug Enforcement Administration (DEA) certificate, if applicable?
- YES NO Have you included a copy of your current Controlled Dangerous Substance (CDS) registration, if applicable?
- YES NO Have you provided a detailed explanation to every "YES" response on the Mandatory Questionnaire section of the application?

IF YOU SAID "NO" TO ANY OF THESE QUESTIONS OR IF ANY ITEM IS MISSING FROM THE APPLICATION, THE CREDENTIALING PROCESS WILL BE DELAYED.

If you have any questions regarding how to complete this application, please call your Network Service Representative at 1-866-458-6630.

THANK YOU.