

Kentucky Application for Provider Evaluation and Re-evaluation

March 2007

Form KAPER-l (03/2007)

Office of Insurance

Kentucky Application for Provider Evaluation and Re-evaluation - 2007

Introduction. Development of a uniform application form and guidelines for the evaluation and re-evaluation of health care providers, including psychologists, was mandated under KRS 304.17 A-545 (5). In response to the requirement, the Kentucky Office of Insurance developed the form Kentucky Application for Provider Evaluation and Re-evaluation in December 2005 (Form KAPER-1 (12/05). This form was subsequently amended in March 2007. Form KAPER-1 (03/2007) consists of two (2) parts, Part A and Part B.

The form KAPER-1 (03/2007), Part A was adopted with consent from the Council for Affordable Quality Health care form entitled "Provider Application." All health insurers offering managed care plans in Kentucky are required to use either the CAQH's provider application of this Form KAPER-1, Part A, for the evaluation (credentialing) and re-evaluation (recredentialing) of health care providers, who will be on their lists of participating providers.

The form KAPER-1 (03/2007), Part B was developed in collaboration with health care providers, insurers and the Kentucky Cabinet for Health and Family Services. This part is for use by Kentucky hospitals and health care facilities and consists of two (2) sections. Form KAPER-1 (03/2007), Part B, Section 1 is for initial evaluation (credentialing) of a physician or allied health professional and form KAPER-1 (03/2007), Part B, Section 2 is for re-evaluation (recredentialing) of a physician or allied health professional.

The form KAPER-1 (03/2007) may be accessed on the Office's Web site (http://doi.ppr.kv.gov/kentuckv/) or obtained directly from the Kentucky Office of Insurance, Division of Health Insurance Policy and Managed Care, P. O. Box 517, Frankfort, KY 40602-0517. Reproduction of the form without any changes is allowed.

Form KAPER-l (03/2007)

Part A

For Evaluation (Credentialing) and Reevaluation (Recredentialing) of Health Care Providers Desiring Participation in Kentucky Managed Care Plans and the Kentucky Medical Assistance Program.

Commonwealth of Kentucky

Instructions - Form KAPER-I (03/2007). Part A

A. Uniform Application for Evaluation (Credentialing) Form. Following is form KAPER-1 (03/2007), Part A, which was adopted with consent of the Council for Affordable Quality Health Care pursuant to KRS 304.17 A-545(5).

A complete form KAPER-I (03/2007), Part A, with required attachments, as specified in item C of this instruction, must be accepted by an insurer offering a managed care plan in Kentucky for the evaluation (credentialing) and re-evaluation (recredentialing) of a health care provider who will be on the insurer's list of participating providers. "Health care provider" is defined in Section 1(4) of 806 KAR 17:480. The form KAPER-I (03/2007), Part A, which must be accepted by the insurer in an electronic or handwritten format, is available on the Web site of the Office of Insurance http://doippr.ky.gov/kentucky/ or at a location designated by the health insurer.

Prior to completing form KAPER-1 (03/2007), it is advised that a provider contact the insurer for information regarding electronic or handwritten submission of the form with required attachments, as specified in item C of this instruction, and cover letter, if applicable.

- **B. Cover Letter.** If a complete form KAPER-1 (03/2007), Part A is submitted to an insurer, a cover letter signed and dated by the health care provider requesting consideration of evaluation or revaluation may be required by the insurer.
- **C. Required Attachments**. Unless otherwise specified in this instruction, one (1) photocopy of each of the following eight (8) supporting documents shall be on 8 ½" X 11" paper, labeled, and attached to the complete form KAPER-I (03/2007), Part A in the following order.
 - 1. Drug enforcement agency (DEA) registration certificate;
 - 2. State controlled dangerous substance (CDS) certificate, if applicable;
 - 3. W -9 of each tax identification number;
 - 4. Workers compensation certificate of coverage;
 - 5. Current professional liability insurance policy face sheet (showing expiration dates, limits and health care provider's name);
 - 6. Signed and dated authorization, attestation and release form;
 - 7. Supplemental forms, if any, in page number order; and
 - 8. Additional pages, if indicated (e.g. lists, etc.).

Provider Application

CORRECT NUMBERS AND LETTERS A	BC123 CORRECT X INCORRECT COMMON ABBREVIATIONS, AND ZIP CODE MATCHING, PLEASE MARKS CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING, COMMON ABBREVIATIONS, AND ZIP CODE MATCHING, PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.	
Instructions Read all instructions carefully prior to submitting your application.	Tips to avoid processing delays 1. Complete only this application and its supplemental forms. Do not use another provider's application. 2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen. 3. Print legibly and inside the boxes provided based upon the examples given above. 4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces. 5. Complete all sections that are applicable to you. 6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43. NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.	
SECTION 1	Personal Information and Professional IDs	
Provider Type	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 - NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blan CCTION 1 Personal Information and Professional IDS Code list is found on page 36. Enter the associated 3-digit code in the space provided.* Order Type Code list is found on page 36. Enter the associated 3-digit code in the space provided.* PRACTITIONER, RADIOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NI (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NI PRACTITIONER, RADIOLOGISTS, PHYSICIANS, NI PRACTITIONER, PARTICIONER, RADIOLOGISTS, PHYSICIANS, NI PRACTITIONER, PARTICIONER, RADIOLOGISTS, PHYSICIANS, NI PRACTITIONER, PARTICIONER, PARTICIO	
Name Do not use nicknames or initials, unless they	LAST NAME* SUFFIX (JR, III)	
are part of your legal name.		
	OTHER LAST NAME SUFFIX (JR, III)	1
	OTHER FIRST NAME OTHER MIDDLE NAME	_
General		
Information	GENDER* MALE FEMALE DATE OF BIRTH* M M D D Y Y Y Y	
Only enter a Foreign National Identification Number if you do not		
have a SSN. Do not enter National Provider Identification (NPI)	CITY OF BIRTH STATE OF COUNTRY OF BIRTH BIRTH	
Number here. Code lists are found on	SSN* FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN) FNIN COUNTRY OF ISSUE	
pages 36-43. Enter the associated 3-digit code in the space provided.	ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK	
	LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE	_
Home Address		
	NUMBER STREET APT NUMBER APT NUMBER	
	CITY STATE ZIP CODE TELEPHONE	
NOTE: CAQH will use this method for application follow-up.	E-MAIL	
	FAX PREFERRED METHOD OF CONTACT* E-MAIL FAX	
ı	3076	

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

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 1 Personal Information and Professional IDs (Continued) **Professional IDs** FEDERAL DEA NUMBER DEA ISSUE DATE Include all state licenses, DEA Registration and State Controlled Dangerous DEA STATE OF REGISTRATION DEA EXPIRATION DATE Substance (CDS) certification numbers. Provide all current and CDS CERTIFICATE NUMBER previous licenses/ certifications. CDS STATE OF REGISTRATION CDS EXPIRATION DATE Non-licensed professionals should enter certification/ LICENSE ISSUING STATE LICENSE ISSUE DATE registration number in STATE LICENSE NUMBER the space provided for IF THIS IS A STATE LICENSE, ARE YOU license number. YES NO **CURRENTLY PRACTICING IN THIS STATE?** If you have additional LICENSE EXPIRATION DATE Professional IDs to Code list is found on page 36; use license status codes. Enter Code list is found on page 36; use provider type codes. Enter report, use the Professional IDs 3-digit code in space provided. 3-digit code in space provided. Supplemental Form on LICENSE TYPE page 19. STATE LICENSE NUMBER LICENSE ISSUING STATE LICENSE ISSUE DATE IF THIS IS A STATE LICENSE, ARE YOU YES NO **CURRENTLY PRACTICING IN THIS STATE?** LICENSE EXPIRATION DATE Code list is found on page 36; Code list is found on page 36; use license status codes. Enter use provider type codes. Enter 3-digit code in space provided. 3-digit code in space provided. LICENSE TYPE LICENSE STATUS CODE Other ID ARE YOU A PART-YES NO ICIPATING MEDICARE **Numbers** PROVIDER?* MEDICARE NUMBER ARE YOU A PART-If you have additional ICIPATING MEDICAID PROVIDER?* YES Professional IDs to NO report, use the MEDICAID NUMBER Professional IDs Supplemental Form on page 19. NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER **USMLE NUMBER (WITHOUT HYPHENS)** WORKERS COMPENSATION NUMBER 0 ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY) ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY) 3077

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

	Education and Training	
ıate	UNDERGRADUATE SCHOOL	
opriate		
	OFFICIAL NAME OF UNDERGRADUATE SCHOOL	
		Г
	ADDRESS	
	ADDRESS	
	CITY STATE ZIP/POSTAL CODE	
	COUNTRY CODE TELEPHONE FAX	
	START DATE END DATE (GRADUATION DATE) DEGREE AWARDED	
	DID YOU COMPLETE YOUR	
	UNDERGRADUATE EDUCATION YES NO AT THIS SCHOOL?	
	GRADUATE TYPE*:	
	U.S. OR CANADIAN GRADUATE NON-U.S./CANADIAN GRADUATE FIFTH PATHWAY GRADUATE	
Ī	U.S. OR CANADIAN SCHOOL	
า	SCHOOL CODE (U.S./	
	CANADIAN ONLY) CANADIAN SCHOOL:	
	MMYYYYY	
	START DATE* END DATE (GRADUATION DATE)* DEGREE AWARDED	
	DID YOU COMPLETE YOUR	
	GRADUATE EDUCATION AT THIS SCHOOL?	
al	NON - U.S. OR CANADIAN SCHOOL	
	NON - 0.3. OR CANADIAN SCHOOL	
	OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL	
	ADDRESS	
	CITY CODE POSTAL CODE	
	MMYYYY	
	M M Y Y Y Y START DATE* END DATE (GRADUATION DATE)* DEGREE AWARDED	
	START DATE* END DATE (GRADUATION DATE)* DEGREE AWARDED DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS YES NO	
	START DATE* END DATE (GRADUATION DATE)* DEGREE AWARDED DID YOU COMPLETE YOUR	
	START DATE* END DATE (GRADUATION DATE)* DEGREE AWARDED DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS YES NO	

 $\hbox{\tt {\tt \#}} \ {\tt REQUIRED} \ {\tt RESPONSE}. \ {\tt NO} \ {\tt RESPONSE} \ {\tt MAY} \ {\tt CAUSE} \ {\tt PROCESSING} \ {\tt DELAYS} \ {\tt AND} \ {\tt REQUIRE} \ {\tt FOLLOW-UP}.$

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 2 **Education and Training (Continued) Training** List all training SCHOOL CODE (E.G., programs you AFFILIATED MEDICAL SCHOOL) attended. Use one section per institution. INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED) If you have additional post-graduate training NUMBER SUITE/BUILDING programs, use the STREET Supplemental Training Form on page 21. CITY STATE ZIP/POSTAL CODE Please explain on the Supplemental Professional / Work History Gap Form on page 33 any training TELEPHONE COUNTRY CODE gap(s) of three (3) months or greater, or DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS YES NO any gap(s) of a shorter duration if required by (IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.) 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. INTERNSHIP/ List each **FELLOWSHIP** OTHER RESIDENCY department separately, if START DATE FND DATE applicable. List DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE) Internship/ Residency, Fellowship and Other NAME OF DIRECTOR programs separately. INTERNSHIP/ **FELLOWSHIP** OTHER RESIDENCY START DATE FND DATE DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE) NAME OF DIRECTOR INTERNSHIP/ **FELLOWSHIP** OTHER RESIDENCY END DATE START DATE DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE) NAME OF DIRECTOR

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 3 **Professional / Medical Specialty Information** INITIAL DO YOU WISH TO **Primary** SPECIALTY BE LISTED IN THE DIRECTORY HMO YES NO CODE Specialty DATE UNDER THIS RECERTIFICATION SPECIALTY? BOARD Code lists are found on NO YES DATE PPO YES NO CERTIFIED? (IF APPLICABLE) pages 36-43. Enter the associated 3-digit code CERTIFYING in the space provided. **EXPIRATION DATE** POS YES NO (IF APPLICABLE) CODE I INTEND TO SIT FOR AN I DO NOT INTEND TO TAKE BOARD **EXAM RESULTS** EXAM ON A CERTIFYING BOARD EXAM. CERTIFIED PENDING FOR (SELECT ONE) CERTIFYING BOARD CODE 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** INITIAL DO YOU WISH TO SPECIALTY BE LISTED IN THE DIRECTORY HMO YES NO CERTIFICATION CODE **Specialty** DATE RECERTIFICATION SPECIALTY? BOARD YES NO DATE (IF APPLICABLE) YES NO PPO Code lists are found on CERTIFIED? pages 36-43. Enter the associated 3-digit code CERTIFYING **EXPIRATION DATE** in the space provided. BOARD POS YES NO (IF APPLICABLE) CODE If you have additional IF NOT I HAVE TAKEN I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM. Professional / Medical I INTEND TO SIT FOR AN BOARD **EXAM. RESULTS** EXAM ON Specialties to report. CERTIFIED (SELECT PENDING FOR use the Additional ONE) Specialties Supplemental Form on page 22. CERTIFYING BOARD CODE 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.

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 3 Professional / Medical Specialty Information (Continued) Certifications Do you hold the following certifications? If yes, provide expiration dates. **EXPIRATION DATE EXPIRATION DATE** ADV LIFE BASIC LIFE YES NO SUPPORT IN OB?* YES NO SUPPORT?* ADV TRAUMA LIFE YES NO YES NO SUPPORT?* PEDIATRIC CARDIAC LIFE SPT?* YES NO ADVANCED YES NO LIFE SPT?* NEONATAL ADVANCED YES NO LIFE SPT? **Practice Interests** Provide additional areas of professional practice interest, activities, procedures, diagnoses or populations. **Primary** Credentialing LAST NAME Contact CHECK HERE TO FIRST NAME USE THE OFFICE MANAGER AND ADDRESS OF THE PRIMARY PRACTICE LOCATION AS THE NUMBER STREET SUITE/BUILDING CREDENTIALING INFORMATION. CITY STATE ZIP CODE NOTE: Even if you checked TELEPHONE the boxes above, please provide the e-mail address, if E-MAIL ADDRESS available.

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Section 4	Practice Loc	ation Inform	ation								
Primary	NOTE: IF YOU INDICATED CONTROL OF THE PROPERTY									D TO COMPLETE	THE
Practice	CURRENTLY		PREVIOUS								
Location	PRACTICING AT THIS ADDRESS?*	YES NO	OR FUTURE START DATE	, M N	ID D	Y	YY				
If you have additional practice locations, use the Supplemental	PHYSICIAN GROUP / PF	RACTICE NAME TO A	PEAR IN DIRECTO	IRY (DO NOT A	BRREVIATE)*						
Practice Location Information Form on pages 25-29.											
h-3	GROUP / CORPORATE	NAME AS IT APPEARS	S ON W-9, IF DIFFE	RENT FROM A	BOVE (DO NO	T ABBREVIA	ATE)				
NOTE: "General Correspondence" refers to any correspondence	NUMBER*	STREET	•							SUITE/BUILDING	
that might be sent to the provider that does not solely relate to creden-											
tialing or billing information.	CITY* SEND GENERAL							STA	ATE*	ZIP CODE*	
TIP Your Individual Tax	CORRESPON- DENCE HERE?*	YES NO	TELEPHONE*				FA	x			
ID is assumed to be your Primary Tax ID unless you specify											
otherwise to the right.	OFFICE E-MAIL ADDRE	ss						PRIMARY	us	E INDIVIDUAL	USE GROU
	INDIVIDUAL TAX ID		G	ROUP TAX ID				(ONE ONLY)	TA	K ID	TAX ID
Office Manager											
or Business Office Staff	LAST NAME*										
Contact											
List each contact separately. You may use the check boxes	FIRST NAME*										M.I.
below for convenience. Do not write	TELEPHONE*			FAX							
instructions like "see above". These responses will be											
rejected and will require follow-up.	E-MAIL ADDRESS										
Billing Contact											
CHECK HERE TO	LAST NAME*										
USE OFFICE MANAGER AND OFFICE ADDRESS	FIDST NAME:										M.I.
AS BILLING INFORMATION	FIRST NAME*										1
	NUMBER*	STREET								SUITE/BUILDING	
NOTE:											
Even if you checked	CITY*							ST	ATE*	ZIP CODE*	
the box above, please provide the E-mail Address of the	TELEPHONE*			FAX							
Billing Contact.											
_	E-MAIL ADDRESS										_
	-			30	83						

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

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 4 **Practice Location Information** (Continued) Payment and ELECTRONIC YES NO BILLING Remittance CAPABILITIES? YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR CHECK PAYABLE TO CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS LAST NAME AS PAYEE INFORMATION FIRST NAME* NUMBER' STREET SUITE/BUILDING NOTE: CITY* STATE* ZIP CODE* Even if you checked the box above, please provide the E-mail Address of the TELEPHONE¹ FAX Payee Contact. E-MAIL ADDRESS **Office Hours** (USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR) A=AM A=AM A=AM P=PM START START END P=PM P=PM P=PM MONDAY FRIDAY TUESDAY SATURDAY WEDNESDAY SUNDAY NOTE: THURSDAY After hours back office telephone will be used only by the health plan 24/7 PHONE COVERAGE? IF YES AFTER HOURS BACK OFFICE TELEPHONE and will not be VOICE MAIL WITH VOICE MAIL ANSWERING INSTRUCTIONS TO CALL YES NO WITH OTHER published under any ANSWERING SERVICE INSTRUCTIONS circumstances. **Open Practice** YES NO ACCEPT ALL NEW PATIENTS?* YES NO ACCEPT NEW PATIENTS INTO THIS PRACTICE?* **Status** ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* YES NO ACCEPT NEW MEDICARE PATIENTS?* YES NO YES YES NO **ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?** NO **ACCEPT NEW MEDICAID PATIENTS?*** IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN. **EXPLAIN (USE BOTH** LINES IF REQUIRED) ARE THERE ANY GENDER LIMITATIONS AGE LIMITATIONS LIST OTHER LIMITATIONS PRACTICE LIMITATIONS? MINIMUM NONE ONLY AGE NO IF YES YES **FEMALE** MAXIMUM AGE 3084

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 4 **Practice Location Information** (Continued) DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* **Mid-Level** YES NO **Practitioners** (IF YES, PLEASE PROVIDE THE INFORMATION BELOW) PRACTITIONER LAST NAME PRACTITIONER FIRST NAME PRACTITIONER TYPE (E.G., PA, CNP, NP) PRACTITIONER STATE PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER LAST NAME PRACTITIONER TYPE (E.G., PA, CNP, NP) PRACTITIONER FIRST NAME M.I. PRACTITIONER STATE PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER LAST NAME PRACTITIONER FIRST NAME мі PRACTITIONER TYPE (E.G., PA, CNP, NP) PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE PRACTITIONER LAST NAME PRACTITIONER TYPE (E.G., PA, CNP, NP) PRACTITIONER FIRST NAME PRACTITIONER STATE PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER LAST NAME PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP) PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE

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Section 4				nation (Contin				22 (E.)											
anguages rode lists are found on ages 37. Enter the ssociated 3-digit code the space provided.	LANGUAGES NON-ENGLISH LANG SPOKEN BY OFFICE INTERPRETERS AVAILABLE?*	UAGES		IGUAGE CODE L LANGUAGES INTERPRETED	ANGUAGE				GE CODE		ANGUA					CODE			
Accessibilities	DOES THIS OFFICE N	IEET ADA ACC	CESSIBILI	TY REQUIREMENTS?*	YE	s	NO												
	DOES THIS SITE OFF		PPED	DOES THIS SERVICES					YES	NO			SSIBLE E C TRANS		TION?)*	YES		NO
	BUILDING?*	YES	NO	TEXT	TELEPHON	IY (TTY)	*		YES	NO			BUS*				YES		NO
	PARKING?*	YES	NO	AMERI	CAN SIGN	LANGU	AGE*		YES	NO			SUBV	VAY*			YES		NO
	RESTROOM?*	YES	NO	MENTA SERVI	AL/PHYSIC CES*	AL IMPA	IRMEN	ІТ	YES	NO			REGI	ONAL T	RAIN*		YES		NO
																			ĺ
	OTHER HANDICAPP	ED ACCESS		OTHER I	DISABILIT	Y SERVI	CES					ОТНЕ	R TRANS	SPORT	ATION	ACCES	S		
Gervices	Does this location LABORATORY SERVICES?	provide any	y of the f	following services? IF YES, PROVIDE ACCERTIFYING PROGREG., CLIA, COLA, M	RAM	IG/													
	RADIOLOGY SERVICES?	YES	NO	IF YES, PROVIDE X- CERTIFICATION TYP															
	EKGS?	YES	NO	ALLERGY INJECTIONS?	YES		NO	ALLE TEST	RGY SKIN ING?		YES		NO	GYNI	TINE C ECOLO VIC/PA			YES	
	DRAWING BLOOD?	YES	NO	AGE APPROPRIATE IMMUNIZATIONS?	YES		NO	FLEXI SIGM(BLE OIDOSCOP	Y?	YES		NO	Y/ AL	PANON IDIOMI ENIN	ETRY		YES	
	ASTHMA TREATMENT?	YES	NO	OSTEOPATHIC MANIPULATION?	YES		NO		DRATION/		YES		NO	CARI	DIAC ESS TE	ST?		YES	
	PULMONARY FUNCTION TESTING?	YES	NO	PHYSICAL THERAPY?	YES		NO		OF MINOR		YES		NO						
	IS ANESTHESIA ADMINISTERED IN YOUR OFFICE?	YES	NO	IF YES, WHAT CLASS/CATEGORY DO YOU USE?															
	IF YES, WHO ADMINISTERS IT?	AST NAME									FIRST	NAME							
	TYPE OF PRACTICE (SELECT ONE ONLY)		SOLO P	PRACTICE	SIN	IGLE SP	ECIAL	TY GROU	UP		MULT	-SPEC	IALTY G	ROUP					
	ADDITIONAL OFFICE	PROCEDURE	S PROVII	DED (INCLUDING SURG	ICAL PRO	CEDURI	ES)												
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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 4 Practice Location Information (Continued) LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE Partners/ **Associates** Code lists are found on COVERING LAST NAME SPECIALTY CODE pages 36-43. Enter the COLLEAGUE associated 3-digit code (Y/N)? in the space provided. FIRST NAME M.I. PROVIDER TYPE (CODE PG 36) If you have additional partners/associates at THIS location, use the Partner/Associate COVERING LAST NAME SPECIALTY CODE Supplemental Form on COLLEAGUE page 23. Photocopy as (Y/N)? necessary. Be certain to check "Primary FIRST NAME M.I. PROVIDER TYPE (CODE PG 36) Location" at the top of the page. SPECIALTY CODE LAST NAME COVERING COLLEAGUE (Y/N)? FIRST NAME M.I. PROVIDER TYPE (CODE PG 36) LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE Covering **Colleagues** Code lists are found on SPECIALTY CODE LAST NAME pages 36-43. Enter the associated 3-digit code in the space provided. FIRST NAME PROVIDER TYPE (CODE PG 36) If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues SPECIALTY CODE LAST NAME Supplemental Form on page 24. Photocopy as necessary. Be certain FIRST NAME M.I. to check "Primary PROVIDER TYPE (CODE PG 36) Location" at the top of the page. SPECIALTY CODE LAST NAME FIRST NAME МΙ PROVIDER TYPE (CODE PG 36) Section 5 **Hospital Affiliations** DO YOU HAVE IF YOU DO NOT ADMIT PATIENTS, WHAT **Admitting** YES NO HOSPITAL TYPE OF ADMITTING ARRANGEMENTS DO PRIVILEGES? **Arrangements** YOU HAVE? 3087

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

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Section 5	Hospi	tal A	\ffil	iatic	ons	(Co	ntin	ued	l)																		
Hospital	PRIMAR	ү ноз	SPITA	٩L																							
Privileges .																											
If applicable, list all hospital affiliations. List	HOSPITAL	NAME																					_				
primary hospital, then																											
other current affiliations, followed by	NUMBER					STRE	ET														-		_	SUITE	/BUILI	DING	
previous affiliations in chronological order.																											
If you have additional	CITY				_		_	_	_	_	_										ST	ATE		ZIP (CODE		
hospital privileges, use			-			-								-													
the Supplemental Hospital Privileges	TELEPHO	NE									F	AX											_				
Form on page 30.																							┸			Ш	
	DEPARTM	ENT NA	ME																				1				
	DEPARTM	ENT DI	RECTO	OR'S L	AST N	AME																					
													П														
	DEPARIM	וע ואם	KEUI	UKSF	ıkərn	IAWE																_					М.І.
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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. **Professional Liability Insurance Carrier** Section 6 **Professional** NO SELF-INSURED? YES Liability CARRIER OR SELF-INSURED NAME Insurance Carrier NUMBER IMPORTANT IF YOU DO NOT CARRY MALPRACTICE INSURANCE, CHECK CITY STATE* ZIP CODE THIS BOX AND SKIP THIS SECTION. TYPE OF INDIVIDUAL SHARED COVERAGE? ORIGINAL EFFECTIVE DATE* EFFECTIVE DATE* EXPIRATION DATE DO YOU HAVE UNLIMITED COVERAGE YES NO WITH THIS INSURANCE CARRIER?* AMOUNT OF COVERAGE PER OCCURRENCE AMOUNT OF COVERAGE AGGREGATE POLICY INCLUDES TAIL COVERAGE? YES NO POLICY NUMBER* **Professional** SELF-INSURED? Liability CARRIER OR SELF-INSURED NAME Insurance Carrier List other current, NUMBER³ STREET SUITE/BUILDING future, or previous carrier(s) if current carrier is less than ten CITY ZIP CODE* (10) years. TYPE OF NOTE: A longer period INDIVIDUAL SHARED COVERAGE? may be required by ORIGINAL EFFECTIVE DATE* **EFFECTIVE DATE*** **EXPIRATION DATE** your healthcare entity. If you have additional DO YOU HAVE UNLIMITED COVERAGE YES NO WITH THIS INSURANCE CARRIER? Insurance, use the AMOUNT OF COVERAGE PER OCCURRENCE AMOUNT OF COVERAGE AGGREGATE Supplemental Insurance Form on POLICY INCLUDES TAIL COVERAGE? NO YES page 31. POLICY NUMBER* Section 7 **Work History and References** Military Are you currently on active military YES NO duty or military reserve?* Duty **WORK HISTORY** Work History Include a chronological work history for the past 10 years. PRACTICE / EMPLOYER NAME A longer period may be required by your NUMBER SUITE/BUILDING healthcare entity. If you have additional work history, use the CITY ZIP/POSTAL CODE Supplemental Work History Form on page 32 3089

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

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

Section 8 **Disclosure Questions Disclosure** LICENSURE Questions Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, YES denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any con-Answer all questions. ditions or limitations by any state or professional licensing, registration or certification board?* For any "Yes" response, provide an YES NO Has there been any challenge to your licensure, registration or certification?* explanation on the Supplemental Disclosure Question HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS Explanation Form on Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever page 34. been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for YES reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, Allied Health or governing board?* **Providers** YES NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?* If you are an Allied Health Provider and you do not believe a Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action. YES question is applicable by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?* to you, you should answer the question **EDUCATION, TRAINING AND BOARD CERTIFICATION** "NO". Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, resi-YES dency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?* NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status YES as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?* YES NO Have any of your board certifications or eligibility ever been revoked?* 8. 9. YES NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?* DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been chal-10. YES lenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?* MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or other-YES wise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?* OTHER SANCTIONS OR INVESTIGATIONS Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, educa-12. YES tion or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?* To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare 13 YES Integrity and Protection Data Bank?* Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, YES NO OSHA, etc.)?* Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or 15. YES NO resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or 16 YES agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?* PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your 17 YES NO individual liability history?* Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance 18 YES carrier, based on your individual liability history?*

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

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

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

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

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

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

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

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)*	
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Professional IDs Supplemental Form

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

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

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

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Other Relevant Education Supplemental Form

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

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

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

Other Training Supplemental Form

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

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Additional Specialty Supplemental Form

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

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Partners/Associates Supplemental Form

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

	Practice Location Infor	<u>matio</u> n										
	SPECIFY PRACTICE LOCATION	INDICATE	HE PRAC	TICE LO	CATION TO	WHICH	OU AR	E ASSOCIA	ATING THESE	PROVIDERS.		
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es at						PRACT	ICE AD	DRESS				
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ed,	LAST NAME										SPECIALTY CODE	COVERING
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	LAST NAME										SPECIALTY CODE	COVERING COLLEAGUE
												(Y/N)?
	FIRST NAME									M.I.	PROVIDER TYPE (C	ODE PG 36)
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	LAST NAME										SPECIALTY CODE	COVERING COLLEAGUE
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Covering Colleagues Supplemental Form

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SPECIFY	PRACTIC	E LOCA	ΠΟΝ	INDICA	TE THE	PRAC	TICE L	OCAT	ION TO	wнісн	YOU A	RE AS	SOCIA	TING 1	HESE P	ROVIDER	RS.		
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Practice Location Information Supplemental Form

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

^{*} 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.

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Section 4	Practice	Location I	Infor	matio	on - F	Page 2	2 of	5																
Add'l Practice Location (Cont.)	LOCA	TION* #																						
Payment and Remittance	ELECTRONIC BILLING CAPABILITIES?*	YES	NO		BII I ING	DEPARTM	IENT (IE	F HO	SPITA	I-BASE	D)													
YOUR "CHECK PAYABLE TO" NFORMATION SHOULD BE CONSISTENT WITH YOUR N-9.	CHECK PAYABL	E TO*									-,													
CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING NFORMATION	LAST NAME*																							W.I.
	FIRST NAME*		STRE	EET*																SUIT	E/BUIL	DING		
NOTE:															ī				1					
Even if you checked the boxes above, please provide the E-mail Address,	CITY*						FAX			-			-				STA	ATE*		ZIP	CODE*			
Department Name, Electronic Billing and Check Payable To, if applicable.	E-MAIL ADDRES	is a second																						
Office Hours	(USE HHMM	FORMAT AND	ROUN		HE NE	AREST	HALF-																	
		START		A=AM P=PM		END			A=AM P=PM					ST	ART		A=A P=F			EN	D		A=AM P=PM	_
	MONDAY									SA	FRIDA													
NOTE:	WEDNESDAY									;	SUNDA	AY												
After hours back office telephone will be used only by the health plan	THURSDAY																							
and will not be published under any	24/7 PHONE COV	/ERAGE?* IF	YES			VOICE M	A 11 . 14/17				VOICE	- 14 41			AFTE	R HOU	RS BA	CK O	FICE	TELEP	HONE			_
circumstances.	YES	NO		RVICE	3	VOICE M. INSTRUC ANSWER	TIONS	то			WITH INSTR	OTHE	R											
Open Practice Status	ACCEPT NEW P	ATIENTS INTO TH	IS PRAC	TICE?*		Y	'ES		NO		AC	CEPT	ALL N	IEW P	ATIEN	ITS?*						YES		NO
	ACCEPT EXISTI	NG PATIENTS WIT	TH CHAN	IGE OF P	AYOR?*	Y	ES		NO		AC	CEPT	NEW	MEDIO	CARE	PATIEN	NTS?*					YES		NO
	ACCEPT NEW P	ATIENTS WITH PH	HYSICIAN	N REFER	RAL?*	Y	ES		NO		AC	CEPT	NEW	MEDIO	CAID P	ATIEN	TS?*					YES		NO
	IF ANY OF THE ABOVE VARIES PLAN, EXPLAIN																							
	ARE THERE AN		YES	GEI		MITATION	s		AGE L	IMITATI			LIST	ОТНЕ	R LIM	ITATIO	NS							
	YES	NO			ONLY		NON	E			IINIMU GE	JM												
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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	LOCATION* #
Continued)	DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* YES NO
mPORTANT In the box provided, Indicate to which	(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)
practice location this page belongs.	PRACTITIONER LAST NAME
	PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA,
Mid-Level Practitioners	PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE
	PRACTITIONER LAST NAME
	PRACTITIONER 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 (F. G. PA.
	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

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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 4 of 5 Additional**

Practice	→ LOCATIO	N* #												
MPORTANT In the box provided, indicate to which ractice location this age belongs. Accessibilities	LANGUAGES													
	NON-ENGLISH LANG SPOKEN BY OFFICE													
	STOKEN BY OFFICE	LICOUNT		NGUAGE CODE LA	ANGUAGE C	CODE LA	NGUAGE CODE	LANG	UAGE CO	DE	LANGUAGE	CODE		
In the box provided, indicate to which practice location this page belongs.	INTERPRETERS AVAILABLE?*	YES	NO	LANGUAGES INTERPRETED	ANGUAGE (CODE LA	ANGUAGE CODE	LANG	UAGE COI)E	LANGUAGE (CODE		
Accessibilities	DOES THIS OFFICE N	IEET ADA A	CCESSIBIL	ITY REQUIREMENTS?*	YES	NO								
	DOES THIS SITE OFF ACCESS FOR THE FO		APPED	DOES THIS SERVICES I			YES	NO		SIBLE B	Y PORTATION?*		ES	NO
	BUILDING?*	YES	NO	техт т	ELEPHONY	(TTY)*	YES	NO		BUS*		YE	:s	NO
	PARKING?*	YES	NO	AMERIC	CAN SIGN L	.ANGUAGE*	YES	NO		SUBW	AY*	YE	ES	NO
	RESTROOM?*	YES	NO	MENTA SERVIO	L/PHYSICAL CES*	_ IMPAIRMENT	YES	NO		REGIO	NAL TRAIN*	YE	is	NO
														1
	OTHER HANDICAPP	ED ACCESS		OTHER D	ISABILITY S	SERVICES			OTHE	R TRANS	PORTATION A	ACCESS		4
Services	Does this location	nrovide a	ny of the	following services?										
00111000		provide a	iny of the	IF YES, PROVIDE AC	CREDITING	,								
	LABORATORY SERVICES?	YES	NO	CERTIFYING PROGR (E.G., CLIA, COLA, N										
	RADIOLOGY SERVICES?	YES	NO	IF YES, PROVIDE X-F CERTIFICATION TYP										
	EKGS?	YES	NO	ALLERGY INJECTIONS?	YES	NO	ALLERGY SKIN TESTING?	Y	ES	NO	ROUTINE OF GYNECOLOG (PELVIC/PAR	GY	YES	N
	DRAWING BLOOD?	YES	NO	AGE APPROPRIATE IMMUNIZATIONS?	YES	NO	FLEXIBLE SIGMOIDOSCOR	PY?	ES	NO	TYMPANOM Y/ AUDIOME SCREENING	TRY	YES	N
	ASTHMA TREATMENT?	YES	NO	OSTEOPATHIC MANIPULATION?	YES	NO	IV HYDRATION/ TREATMENT?	Y	ES	NO	CARDIAC STRESS TES	ST?	YES	N
	PULMONARY FUNCTION TESTING?	YES	NO	PHYSICAL THERAPY?	YES	NO	CARE OF MINO LACERATIONS		ES	NO				
	IS ANESTHESIA ADMINISTERED IN YOUR OFFICE?	YES	NO	IF YES, WHAT CLASS/CATEGORY DO YOU USE?										
	IF YES, WHO ADMINISTERS IT?													
		LAST NAME						FIR	ST NAME					l
	TYPE OF PRACTICE													
	(SELECT ONE ONLY)	•	SOLO	PRACTICE	SING	LE SPECIALT	Y GROUP	MU	JLTI-SPECI	ALTY GE	ROUP			
	ADDITIONAL OFFICE	PROCEDU	RES PROVI	DED (INCLUDING SURG	ICAL PROCI	EDURES)								
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Page 28 Std. App. v.5.0 Reprinted on 10/31/06 KAPER-1 (03/2007)

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

Practice Location Information Supplemental Form

Section 4		-11	
	→ LOCATION* #		
	LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE		
IMPORTANT			
	LAST NAME		SPECIALTY CODE COVERING
			COLLEAGU (Y/N)?
diditional ractice pocation interests by the provided carbon location interests and the provided interests and the prov	PROVIDER TYPE (CODE PG 36)		
If you have additional			
partners/associates at			
Partner/Associate	LAST NAME		SPECIALTY CODE COVERING COLLEAGU
page 23. Photocopy as			(Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
	LAST NAME		SPECIALTY CODE COVERING
pages 36-43. Enter the	LAST NAME		COLLEAGU (Y/N)?
Additional Practice Location Information - Page 5 of 5 Additional Practice Location (Continues) Location (Continues) In the box provided, indicate to which practice location this practice location the space provided in the space provided i			
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
	LAST NAME		SPECIALTY CODE COVERING
			COLLEAGU (Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
Covering	LIST ALL COVEDING COLLEAGUES THAT ARE NOT DARTNERS/ASSOCIATES AT THIS REACTICE		
	EIST ALE GOVERNING COLLEGES THAT ARE NOT I ARTNERGRASSOCIATES AT THIS TRACTICE		
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	LAST NAME		SPECIALTY CODE
associated 3-digit code			
	FIRST NAME	М.І.	PROVIDER TYPE (CODE PG 36)
covering colleagues			
THIS location, use the	LAST NAME		SPECIALTY CODE
Additional Practice Location Information - Page 5 of 5 - LOCATION* # - LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE - LAST NAME - LAST NA	PROVIDER TYPE (CODE PG 36)		
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	FIRST NAME	WI.I.	PROVIDER TIPE (CODE PG 30)
	LAST NAME		SPECIALTY CODE
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
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	3104		

Hospital Privileges (Current) Supplemental Form

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Professional Liability Insurance Carrier Supplemental Form

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

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Other Professional					Ī	ī		Ī																		SELI	F-INS	URED1	?	YE	s	NO
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Carrier																																
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Work History Supplemental Form

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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** GAP START DATE GAP END DATE 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 GAP START DATE GAP END DATE or of a shorter duration if required by the organization for which you are being credentialed. **GAP START DATE** GAP END DATE GAP START DATE GAP END DATE **GAP START DATE** GAP END DATE

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

Disclosure Questions Supplemental Form

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Malpractice Claims Explanation Supplemental Form

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