Superior Dental Care®
A Medical Mutual® Company

800.762.3159 | superiordental.com |

Individual Provider Credentialing Application

Application Instructions

In order to comply with Ohio laws, the following ***Individual Provider Credentialing Application*** is required for all dentists applying for network participation. Please complete the highlighted sections on the following pages of this ***Application***.

As referenced on the ***Application***, if you should require a ***Supplemental Form*** or need to reference a ***Table***, visit the **Dentist Support Center** on our website at **superiordental.com**.

Provider Type, Specialty and Language Codes

Codes will be needed to complete portions of the application. The code lists for these sections have been printed on the back of this cover sheet for your convenience.

Required Dentist Agreement and W-9 Form

In addition to the ***Application***, please complete a ***Summary Disclosure and Dentist Participation Agreement*** and ***W-9 Form***. These forms are also available in the **Dentist Support Center** on the SDC website—they can be found below the application. Send your completed ***Application***, ***Summary Disclosure and Dentist Participation Agreement*** and ***W-9 Form*** along with any other supporting documentation to SDC by mail or fax:

Superior Dental Care
Attn: Dental Services
6683 Centerville Business Parkway
Centerville, OH 45459

FAX **(866) 788-7301**

If you have any questions, please contact Dental Services at **(937) 438-0283**.

Please be aware that SDC's minimum professional liability coverage requirements are $1 million/incident, $3 million/aggregate for Oral Surgeons and $200,000/incident, $600,000/aggregate for General Dentists and all other specialties.

Provider Type, Specialty and Language Codes

The following codes will be needed to complete the application:

Provider Type Codes (page 1, section 1)

002	Doctor of Dental Surgery (DDS)
003	Doctor of Dental Medicine (DMD)

Specialty Codes – DDS / DMD (page 5, section 3)

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

Language Codes (page 1, section 1 and page 10, section 4)

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

Provider Application

CORRECT NUMBERS AND LETTERS: A B C 1 2 3 | CORRECT MARK: X | INCORRECT MARKS: ≋ ✓ •

CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING, COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Instructions

Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays

1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1 — Personal Information and Professional IDs

Provider Type

Code list is found on page 36. Enter the associated 3-digit code in the space provided.*

YES NO

DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name

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

LAST NAME* | SUFFIX (JR, III)

FIRST NAME* | MIDDLE NAME

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

OTHER LAST NAME | SUFFIX (JR, III)

OTHER FIRST NAME | OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME (M M D D Y Y Y Y) | DATE STOPPED USING OTHER NAME (M M D D Y Y Y Y)

General Information

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

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

GENDER* MALE FEMALE

DATE OF BIRTH* (M M D D Y Y Y Y)

CITY OF BIRTH | STATE OF BIRTH | COUNTRY OF BIRTH

SSN* (- -)

FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN) | FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK

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

Home Address

NUMBER | STREET | APT NUMBER

CITY | STATE | ZIP CODE

TELEPHONE (- - -)

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

E-MAIL

FAX (- - -) | PREFERRED METHOD OF CONTACT* E-MAIL FAX

3076

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

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

Section 1 — Personal Information and Professional IDs (Continued)

Professional IDs

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

Provide all current and previous licenses/ certifications.

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

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

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

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

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

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

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

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

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

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

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

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

Other ID Numbers

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

ARE YOU A PARTICIPATING MEDICARE PROVIDER?* YES NO

MEDICARE NUMBER

UPIN

ARE YOU A PARTICIPATING MEDICAID PROVIDER?* YES NO

MEDICAID NUMBER

MEDICAID STATE

INDIVIDUAL NPI - TYPE 1

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) (M M D D Y Y Y Y)

3077

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

Section 2 — Education and Training

Undergraduate School(s)

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

Professional School(s)

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

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

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

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

UNDERGRADUATE SCHOOL

OFFICIAL NAME OF UNDERGRADUATE SCHOOL

ADDRESS

CITY | STATE | ZIP/POSTAL CODE

COUNTRY CODE | TELEPHONE | FAX

START DATE (M M Y Y Y Y) | END DATE (GRADUATION DATE) (M M Y Y Y Y) | DEGREE AWARDED

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

GRADUATE TYPE*:

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

U.S. OR CANADIAN SCHOOL

SCHOOL CODE (U.S./ CANADIAN ONLY) | NAME OF U.S./ CANADIAN SCHOOL:

START DATE* (M M Y Y Y Y) | END DATE (GRADUATION DATE)* (M M Y Y Y Y) | DEGREE AWARDED

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

NON - U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL

ADDRESS

CITY | COUNTRY CODE | POSTAL CODE

START DATE* (M M Y Y Y Y) | END DATE (GRADUATION DATE)* (M M Y Y Y Y) | DEGREE AWARDED

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

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* 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 3 — Professional / Medical Specialty Information

Primary Specialty

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

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

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

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

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

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

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

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

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

Secondary Specialty

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

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

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

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

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

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

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

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

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

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

* 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 3 — Professional / Medical Specialty Information (Continued)

Certifications

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

			EXPIRATION DATE																											
BASIC LIFE SUPPORT?*	YES	NO	M	M	D	D	Y	Y	Y	Y																				
CPR?*	YES	NO	M	M	D	D	Y	Y	Y	Y																				
ADV CARDIAC LIFE SPT?*	YES	NO	M	M	D	D	Y	Y	Y	Y																				
NEONATAL ADVANCED LIFE SPT?*	YES	NO	M	M	D	D	Y	Y	Y	Y																				

			EXPIRATION DATE																											
ADV LIFE SUPPORT IN OB?*	YES	NO	M	M	D	D	Y	Y	Y	Y																				
ADV TRAUMA LIFE SUPPORT?*	YES	NO	M	M	D	D	Y	Y	Y	Y																				
PEDIATRIC ADVANCED LIFE SPT?*	YES	NO	M	M	D	D	Y	Y	Y	Y																				

Practice Interests

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

Primary Credentialing Contact

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

LAST NAME

FIRST NAME

M.I.

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP CODE

TELEPHONE

FAX

E-MAIL ADDRESS

NOTE:

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

* 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

Primary Practice Location

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

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

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

NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT QUESTION ABOVE. SECTION 4 MAY BE LEFT BLANK. YOU MAY PROCEED TO SECTION 5 ON PAGE 11.

CURRENTLY PRACTICING AT THIS ADDRESS?* ☐ YES ☐ NO

IF NO, WHAT IS YOUR EXPECTED START DATE? M M D D Y Y Y Y

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

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

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* ☐ YES ☐ NO

TELEPHONE* FAX

OFFICE E-MAIL ADDRESS

TAX ID ORGANIZATION NPI - TYPE 2

Office Manager or Business Office Staff Contact

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

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

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

NOTE:

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

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

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

Section 4 — Practice Location Information (Continued)

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* ☐ YES ☐ NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

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

CHECK PAYABLE TO*

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

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

NOTE:

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

TELEPHONE* FAX

E-MAIL ADDRESS

Office Hours

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

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

NOTE:

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

24/7 PHONE COVERAGE?* ☐ YES ☐ NO

IF YES ☐ ANSWERING SERVICE ☐ VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE ☐ VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* ☐ YES ☐ NO

ACCEPT ALL NEW PATIENTS?* ☐ YES ☐ NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* ☐ YES ☐ NO

ACCEPT NEW MEDICARE PATIENTS?* ☐ YES ☐ NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* ☐ YES ☐ NO

ACCEPT NEW MEDICAID PATIENTS?* ☐ YES ☐ NO

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

ARE THERE ANY PRACTICE LIMITATIONS?* ☐ YES ☐ NO

IF YES

GENDER LIMITATIONS: ☐ MALE ONLY ☐ FEMALE ONLY ☐ NONE

AGE LIMITATIONS: ☐☐ MINIMUM AGE ☐☐ MAXIMUM AGE

LIST OTHER LIMITATIONS

3084

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

Section 4 — Practice Location Information (Continued)

Languages

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

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO — LANGUAGES INTERPRETED — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

- BUILDING?* YES NO
- PARKING?* YES NO
- RESTROOM?* YES NO

OTHER HANDICAPPED ACCESS

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

- TEXT TELEPHONY (TTY)* YES NO
- AMERICAN SIGN LANGUAGE* YES NO
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* YES NO

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO

- BUS* YES NO
- SUBWAY* YES NO
- REGIONAL TRAIN* YES NO

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

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

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

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

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

IF YES, WHO ADMINISTERS IT? LAST NAME FIRST NAME

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

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

3086

* 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)

Partners/ Associates

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

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

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)? | PROVIDER TYPE (CODE PG 36)

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)? | PROVIDER TYPE (CODE PG 36)

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)? | PROVIDER TYPE (CODE PG 36)

Covering Colleagues

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

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

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

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

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

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

Section 5 — Hospital Affiliations

Admitting Arrangements

DO YOU HAVE HOSPITAL PRIVILEGES?* YES NO

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

3087

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

Section 6 — Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

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

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

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

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

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

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Professional Liability Insurance Carrier

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

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

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

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

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

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

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

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Section 7 — Work History and References

Military Duty

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

Work History

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity.

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

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

3089

Section 7 — Work History and References (Continued)

Work History

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

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity

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

TELEPHONE — FAX

COUNTRY CODE — START DATE (M M Y Y Y Y) — END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER — STREET — SUITE/BUILDING

CITY — STATE — ZIP/POSTAL CODE

TELEPHONE — FAX

COUNTRY CODE — START DATE (M M Y Y Y Y) — END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER — STREET — SUITE/BUILDING

CITY — STATE — ZIP/POSTAL CODE

TELEPHONE — FAX

COUNTRY CODE — START DATE (M M Y Y Y Y) — END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

Section 8 — Disclosure Questions

Disclosure Questions

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

Allied Health Providers

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

LICENSURE

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

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. ☐ YES ☐ NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*
4. ☐ YES ☐ NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*
5. ☐ YES ☐ NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*

EDUCATION, TRAINING AND BOARD CERTIFICATION

6. ☐ YES ☐ NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*
7. ☐ YES ☐ NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*
8. ☐ YES ☐ NO Have any of your board certifications or eligibility ever been revoked?*
9. ☐ YES ☐ NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

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

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

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

OTHER SANCTIONS OR INVESTIGATIONS

12. ☐ YES ☐ NO Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
13. ☐ YES ☐ NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*
14. ☐ YES ☐ NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*
15. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*
16. ☐ YES ☐ NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. ☐ YES ☐ NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*
18. ☐ YES ☐ NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

Section 8 — Disclosure Questions (Continued)

Disclosure Questions

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

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

MALPRACTICE CLAIMS HISTORY

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

CRIMINAL/CIVIL HISTORY

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

21. ☐ YES ☐ NO In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*

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

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.

ABILITY TO PERFORM JOB

23. ☐ YES ☐ NO Are you currently engaged in the illegal use of drugs?*
("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

24. ☐ YES ☐ NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*

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

26. ☐ YES ☐ NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

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

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

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

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*