

* 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.

<input type="text"/>	<input type="text"/>	
FEDERAL DEA NUMBER	DEA ISSUE DATE (MM/DD/YYYY)	
<input type="text"/>	<input type="text"/>	
DEA STATE OF REGISTRATION	DEA EXPIRATION DATE (MM/DD/YYYY)	
<hr/>		
<input type="text"/>	<input type="text"/>	
CDS CERTIFICATE NUMBER	CDS ISSUE DATE (MM/DD/YYYY)	
<input type="text"/>	<input type="text"/>	
CDS STATE OF REGISTRATION	CDS EXPIRATION DATE (MM/DD/YYYY)	
<hr/>		
<input type="text"/>	<input type="text"/>	<input type="text"/>
STATE LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE ISSUE DATE (MM/DD/YYYY)
IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="text"/>
		LICENSE EXPIRATION DATE (MM/DD/YYYY)
<input type="text"/>	Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.	<input type="text"/>
LICENSE STATUS CODE	LICENSE TYPE	Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.
<hr/>		
<input type="text"/>	<input type="text"/>	<input type="text"/>
STATE LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE ISSUE DATE (MM/DD/YYYY)
IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="text"/>
		LICENSE EXPIRATION DATE (MM/DD/YYYY)
<input type="text"/>	Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.	<input type="text"/>
LICENSE STATUS CODE	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?*	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="text"/>	<input type="text"/>
		MEDICARE NUMBER	UPIN
ARE YOU A PARTICIPATING MEDICAID PROVIDER?*	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="text"/>	<input type="text"/>
		MEDICAID NUMBER	MEDICAID STATE
<input type="text"/>	<input type="text"/>		
NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER	USMLE NUMBER (WITHOUT HYPHENS)		
<input type="text"/>			
WORKERS COMPENSATION NUMBER			
<hr/>			
<input type="text"/>	<input type="text"/>		
ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)	ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY) (MM/DD/YYYY)		

* 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 (MM/YYYY)

END DATE (GRADUATION DATE)
(MM/YYYY)

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* (MM/YYYY)

END DATE (GRADUATION DATE)*
(MM/YYYY)

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* (MM/YYYY)

END DATE (GRADUATION DATE)*
(MM/YYYY)

DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?

YES

NO

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

Section 2

Education and Training (Continued)

Training

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

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

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

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

		<small>SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)</small>
<small>INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)</small>		
<small>NUMBER</small>	<small>STREET</small>	<small>SUITE/BUILDING</small>
<small>CITY</small>	<small>STATE</small>	<small>ZIP/POSTAL CODE</small>
<small>COUNTRY CODE</small>	<small>TELEPHONE</small>	<small>FAX</small>
<small>DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION?</small>		
<input type="checkbox"/> YES <input type="checkbox"/> NO		
<small>(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)</small>		

<p>List each department separately, if applicable.</p> <p>List Internship/Residency, Fellowship and Other programs separately.</p>	<input type="checkbox"/> <small>INTERNSHIP/RESIDENCY</small> <input type="checkbox"/> <small>FELLOWSHIP</small> <input type="checkbox"/> <small>OTHER</small>		
	<small>START DATE (MM/YYYY)</small> <small>END DATE (MM/YYYY)</small>		
	<small>DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</small>		
	<small>NAME OF DIRECTOR</small>		
	<input type="checkbox"/> <small>INTERNSHIP/RESIDENCY</small> <input type="checkbox"/> <small>FELLOWSHIP</small> <input type="checkbox"/> <small>OTHER</small>		
<small>START DATE (MM/YYYY)</small> <small>END DATE (MM/YYYY)</small>			
<small>DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</small>			
<small>NAME OF DIRECTOR</small>			
	<input type="checkbox"/> <small>INTERNSHIP/RESIDENCY</small> <input type="checkbox"/> <small>FELLOWSHIP</small> <input type="checkbox"/> <small>OTHER</small>		
<small>START DATE (MM/YYYY)</small> <small>END DATE (MM/YYYY)</small>			
<small>DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</small>			
<small>NAME OF DIRECTOR</small>			

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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	<input type="text"/>	INITIAL CERTIFICATION DATE (MM/DD/YYYY)	<input type="text"/>	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
BOARD CERTIFIED?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	PPO	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
CERTIFYING BOARD CODE	<input type="text"/>	EXPIRATION DATE (IF APPLICABLE) (MM/DD/YYYY)	<input type="text"/>	POS	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	

IF NOT BOARD CERTIFIED (SELECT ONE)	<input type="checkbox"/>	I HAVE TAKEN EXAM, RESULTS PENDING FOR	<input type="text"/>	<input type="checkbox"/>	I INTEND TO SIT FOR AN EXAM ON (MM/DD/YYYY)	<input type="text"/>	<input type="checkbox"/>	I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.
CERTIFYING BOARD CODE	<input type="text"/>							

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	<input type="text"/>	INITIAL CERTIFICATION DATE (MM/DD/YYYY)	<input type="text"/>	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
BOARD CERTIFIED?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	PPO	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
CERTIFYING BOARD CODE	<input type="text"/>	EXPIRATION DATE (IF APPLICABLE) (MM/DD/YYYY)	<input type="text"/>	POS	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	

IF NOT BOARD CERTIFIED (SELECT ONE)	<input type="checkbox"/>	I HAVE TAKEN EXAM, RESULTS PENDING FOR	<input type="text"/>	<input type="checkbox"/>	I INTEND TO SIT FOR AN EXAM ON (MM/DD/YYYY)	<input type="text"/>	<input type="checkbox"/>	I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.
CERTIFYING BOARD CODE	<input type="text"/>							

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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Section 3

Professional / Medical Specialty Information (Continued)

Certifications

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

			EXPIRATION DATE (MM/DD/YYYY)				EXPIRATION DATE (MM/DD/YYYY)				
BASIC LIFE SUPPORT?*	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="text"/>	ADV LIFE SUPPORT IN OB?*	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="text"/>
CPR?*	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="text"/>	ADV TRAUMA LIFE SUPPORT?*	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="text"/>
ADV CARDIAC LIFE SPT?*	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="text"/>	PEDIATRIC ADVANCED LIFE SPT?*	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="text"/>
NEONATAL ADVANCED LIFE SPT?*	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="text"/>						

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.

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Section 4 Practice Location Information

Primary Practice Location

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

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

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

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

CURRENTLY PRACTICING AT THIS ADDRESS? YES NO PREVIOUS OR FUTURE START DATE? (MM/DD/YYYY)

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

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

INDIVIDUAL TAX ID GROUP TAX ID

Office Manager or Business Office Staff Contact

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

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

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

NOTE:

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

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

* 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 Remittance

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

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

NOTE:

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

ELECTRONIC BILLING CAPABILITIES?* YES NO
 BILLING DEPARTMENT (IF HOSPITAL-BASED)

CHECK PAYABLE TO*

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	FRIDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
TUESDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	SATURDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
WEDNESDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	SUNDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
THURSDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					

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?* IF YES YES NO ANSWERING SERVICE VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE VOICE MAIL WITH OTHER INSTRUCTIONS

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 NONE FEMALE ONLY

AGE LIMITATIONS MINIMUM AGE MAXIMUM AGE

LIST OTHER LIMITATIONS

* 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)

Mid-Level Practitioners

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

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

* 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)

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

	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE

INTERPRETERS AVAILABLE?*

YES NO

LANGUAGES INTERPRETED

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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?*	<input type="checkbox"/> YES <input type="checkbox"/> NO	TEXT TELEPHONY (TTY)*	<input type="checkbox"/> YES <input type="checkbox"/> NO	ACCESSIBLE BY PUBLIC TRANSPORTATION?*	<input type="checkbox"/> YES <input type="checkbox"/> NO
PARKING?*	<input type="checkbox"/> YES <input type="checkbox"/> NO	AMERICAN SIGN LANGUAGE*	<input type="checkbox"/> YES <input type="checkbox"/> NO	BUS*	<input type="checkbox"/> YES <input type="checkbox"/> NO
RESTROOM?*	<input type="checkbox"/> YES <input type="checkbox"/> NO	MENTAL/PHYSICAL IMPAIRMENT SERVICES*	<input type="checkbox"/> YES <input type="checkbox"/> NO	SUBWAY*	<input type="checkbox"/> YES <input type="checkbox"/> NO
				REGIONAL TRAIN*	<input type="checkbox"/> YES <input type="checkbox"/> NO

OTHER HANDICAPPED ACCESS

OTHER DISABILITY SERVICES

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

* 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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME			SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 36)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME			SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 36)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME			SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 36)	

Covering Colleagues

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

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

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

<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME		SPECIALTY CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>
FIRST NAME		M.I. PROVIDER TYPE (CODE PG 36)
<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME		SPECIALTY CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>
FIRST NAME		M.I. PROVIDER TYPE (CODE PG 36)
<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME		SPECIALTY CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>
FIRST NAME		M.I. PROVIDER TYPE (CODE PG 36)

Section 5 Hospital Affiliations

Admitting Arrangements

DO YOU HAVE HOSPITAL PRIVILEGES? * YES NO IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?

* 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 5

Hospital Affiliations (Continued)

Hospital Privileges

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

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

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

PRIMARY HOSPITAL

HOSPITAL NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP CODE

TELEPHONE

FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME

M.I.

FULL, UNRESTRICTED PRIVILEGES?

YES

NO

ARE PRIVILEGES TEMPORARY?

YES

NO

AFFILIATION START DATE (MM/YYYY)

AFFILIATION END DATE (MM/YYYY)

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

 %

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

OTHER HOSPITAL

HOSPITAL NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP CODE

TELEPHONE

FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME

M.I.

FULL, UNRESTRICTED PRIVILEGES?

YES

NO

ARE PRIVILEGES TEMPORARY?

YES

NO

AFFILIATION START DATE (MM/YYYY)

AFFILIATION END DATE (MM/YYYY)

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

 %

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

PLEASE EXPLAIN TERMINATED AFFILIATION

* 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 6

Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

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

SELF-INSURED?* YES NO

CARRIER OR SELF-INSURED NAME*

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

ORIGINAL EFFECTIVE DATE* EFFECTIVE DATE* EXPIRATION DATE

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

TYPE OF COVERAGE?* INDIVIDUAL SHARED

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.

SELF-INSURED? YES NO

CARRIER OR SELF-INSURED NAME

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

ORIGINAL EFFECTIVE DATE* (MM/DD/YYYY) EFFECTIVE DATE* (MM/YYYY) EXPIRATION DATE (MM/YYYY)

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

TYPE OF COVERAGE?* INDIVIDUAL SHARED

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

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

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.

<input type="text"/>		<input type="text"/>
TELEPHONE		FAX
<input type="text"/>	<input type="text"/>	<input type="text"/>
COUNTRY CODE	START DATE (MM/YYYY)	END DATE (MM/YYYY)
REASON FOR DEPARTURE (IF APPLICABLE)		
<input type="text"/>		
<input type="text"/>		

WORK HISTORY

<input type="text"/>			
PRACTICE / EMPLOYER NAME			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NUMBER	STREET		SUITE/BUILDING
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CITY		STATE	ZIP/POSTAL CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
TELEPHONE		FAX	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
COUNTRY CODE	START DATE (MM/YYYY)	END DATE (MM/YYYY)	
REASON FOR DEPARTURE (IF APPLICABLE)			
<input type="text"/>			
<input type="text"/>			

WORK HISTORY

<input type="text"/>			
PRACTICE / EMPLOYER NAME			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NUMBER	STREET		SUITE/BUILDING
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CITY		STATE	ZIP/POSTAL CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
TELEPHONE		FAX	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
COUNTRY CODE	START DATE (MM/YYYY)	END DATE (MM/YYYY)	
REASON FOR DEPARTURE (IF APPLICABLE)			
<input type="text"/>			
<input type="text"/>			

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

Section 7

Work History and References (Continued)

Gaps in Professional / Work History

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

GAP START DATE (MM/YYYY) GAP END DATE (MM/YYYY)

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

Professional References

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

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

NOTE:

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

Please check with credentialing entity for any special requirements.

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

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

Section 8

Disclosure Questions

Disclosure Questions

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

Allied Health Providers

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

LICENSURE

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

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

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

EDUCATION, TRAINING AND BOARD CERTIFICATION

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

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

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

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

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

OTHER SANCTIONS OR INVESTIGATIONS

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

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

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

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*

DATE SIGNED* (MM/DD/YYYY)

Name (print)*

Professional IDs Supplemental Form

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

Section 1 Personal Information and Professional IDs

Professional IDs

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

Provide all current and previous licenses/certifications.

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

FEDERAL DEA NUMBER

DEA ISSUE DATE (MM/DD/YYYY)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (MM/DD/YYYY)

FEDERAL DEA NUMBER

DEA ISSUE DATE (MM/DD/YYYY)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (MM/DD/YYYY)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (MM/DD/YYYY)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (MM/DD/YYYY)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (MM/DD/YYYY)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (MM/DD/YYYY)

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (MM/DD/YYYY)

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

LICENSE EXPIRATION DATE (MM/DD/YYYY)

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 (MM/DD/YYYY)

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

LICENSE EXPIRATION DATE (MM/DD/YYYY)

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 Relevant Education Supplemental Form

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

Section 2

Education and Training

**Fifth Pathway
Education**

FIFTH PATHWAY GRADUATES ONLY

INSTITUTION/HOSPITAL WHERE U.S. CLINICAL TRAINING WAS PERFORMED (DO NOT ABBREVIATE)

ADDRESS

CITY

STATE

ZIP CODE

TELEPHONE

FAX

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

START DATE (MM/YYYY)

END DATE (GRADUATION DATE)
(MM/YYYY)

**Other Relevant
Education**

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

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

TELEPHONE

FAX

COUNTRY CODE

START DATE (MM/YYYY)

END DATE (GRADUATION DATE)
(MM/YYYY)

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 (MM/YYYY)

END DATE (GRADUATION DATE)
(MM/YYYY)

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.

Section 2

Education and Training

Training

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

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

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

	SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)	
INSTITUTION / HOSPITAL NAME (USE BOTH LINES IF REQUIRED)		
NUMBER	STREET	SUITE/BUILDING
CITY	STATE	ZIP/POSTAL CODE
COUNTRY CODE	TELEPHONE	FAX
DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? <input type="checkbox"/> YES <input type="checkbox"/> NO		
(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)		

<p>List each department separately, if applicable.</p> <p>List Internship/Residency, Fellowship and Other programs separately.</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><input type="checkbox"/> INTERNSHIP/RESIDENCY</td> <td style="width: 25%;"><input type="checkbox"/> FELLOWSHIP</td> <td style="width: 25%;"><input type="checkbox"/> OTHER</td> <td style="width: 25%;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> <tr> <td colspan="4" style="text-align: center;">START DATE (MM/YYYY) END DATE (MM/YYYY)</td> </tr> <tr> <td colspan="4" style="border: none;"></td> </tr> <tr> <td colspan="4">DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</td> </tr> <tr> <td colspan="4" style="border: none;"></td> </tr> <tr> <td colspan="4">NAME OF DIRECTOR</td> </tr> </table> <hr/> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><input type="checkbox"/> INTERNSHIP/RESIDENCY</td> <td style="width: 25%;"><input type="checkbox"/> FELLOWSHIP</td> <td style="width: 25%;"><input type="checkbox"/> OTHER</td> <td style="width: 25%;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> <tr> <td colspan="4" style="text-align: center;">START DATE (MM/YYYY) END DATE (MM/YYYY)</td> </tr> <tr> <td colspan="4" style="border: none;"></td> </tr> <tr> <td colspan="4">DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</td> </tr> <tr> <td colspan="4" style="border: none;"></td> </tr> <tr> <td colspan="4">NAME OF DIRECTOR</td> </tr> </table> <hr/> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><input type="checkbox"/> INTERNSHIP/RESIDENCY</td> <td style="width: 25%;"><input type="checkbox"/> FELLOWSHIP</td> <td style="width: 25%;"><input type="checkbox"/> OTHER</td> <td style="width: 25%;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> <tr> <td colspan="4" style="text-align: center;">START DATE (MM/YYYY) END DATE (MM/YYYY)</td> </tr> <tr> <td colspan="4" style="border: none;"></td> </tr> <tr> <td colspan="4">DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</td> </tr> <tr> <td colspan="4" style="border: none;"></td> </tr> <tr> <td colspan="4">NAME OF DIRECTOR</td> </tr> </table>	<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER										START DATE (MM/YYYY) END DATE (MM/YYYY)								DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)								NAME OF DIRECTOR				<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER										START DATE (MM/YYYY) END DATE (MM/YYYY)								DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)								NAME OF DIRECTOR				<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER										START DATE (MM/YYYY) END DATE (MM/YYYY)								DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)								NAME OF DIRECTOR			
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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Additional Specialty Supplemental Form

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

Section 3 Professional / Medical Specialty Information

Additional Specialty

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

SPECIALTY CODE <input style="width: 80px;" type="text"/>	INITIAL CERTIFICATION DATE (MM/DD/YYYY) <input style="width: 150px;" type="text"/>	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? HMO <input type="checkbox"/> YES <input type="checkbox"/> NO PPO <input type="checkbox"/> YES <input type="checkbox"/> NO POS <input type="checkbox"/> YES <input type="checkbox"/> NO
BOARD CERTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	RECERTIFICATION DATE (IF APPLICABLE) (MM/DD/YYYY) <input style="width: 150px;" type="text"/>	
CERTIFYING BOARD CODE <input style="width: 80px;" type="text"/>	EXPIRATION DATE (IF APPLICABLE) (MM/DD/YYYY) <input style="width: 150px;" type="text"/>	

IF NOT BOARD CERTIFIED (SELECT ONE) <input type="checkbox"/> I HAVE TAKEN EXAM, RESULTS PENDING FOR <input style="width: 80px;" type="text"/> CERTIFYING BOARD CODE	<input type="checkbox"/> I INTEND TO SIT FOR AN EXAM ON <input style="width: 150px;" type="text"/>	<input type="checkbox"/> I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM
--	--	--

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

Additional Specialty

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

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

SPECIALTY CODE <input style="width: 80px;" type="text"/>	INITIAL CERTIFICATION DATE (MM/DD/YYYY) <input style="width: 150px;" type="text"/>	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? HMO <input type="checkbox"/> YES <input type="checkbox"/> NO PPO <input type="checkbox"/> YES <input type="checkbox"/> NO POS <input type="checkbox"/> YES <input type="checkbox"/> NO
BOARD CERTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	RECERTIFICATION DATE (IF APPLICABLE) (MM/DD/YYYY) <input style="width: 150px;" type="text"/>	
CERTIFYING BOARD CODE <input style="width: 80px;" type="text"/>	EXPIRATION DATE (IF APPLICABLE) (MM/DD/YYYY) <input style="width: 150px;" type="text"/>	

IF NOT BOARD CERTIFIED (SELECT ONE) <input type="checkbox"/> I HAVE TAKEN EXAM, RESULTS PENDING FOR <input style="width: 80px;" type="text"/> CERTIFYING BOARD CODE	<input type="checkbox"/> I INTEND TO SIT FOR AN EXAM ON <input style="width: 150px;" type="text"/>	<input type="checkbox"/> 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 (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Partners/Associates Supplemental Form

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

Section 4

Practice Location Information

Partner/ Associates

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

IMPORTANT

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

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

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

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

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

LOCATION # PRIMARY PRACTICE PRACTICE NAME _____
 PRACTICE ADDRESS _____

<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

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

Covering Colleagues Supplemental Form

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

Section 4

Practice Location Information

Covering Colleagues

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

IMPORTANT

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

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

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

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

LOCATION # PRIMARY PRACTICE PRACTICE NAME _____
 PRACTICE ADDRESS _____

LAST NAME SPECIALTY CODE

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

LAST NAME SPECIALTY CODE

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

LAST NAME SPECIALTY CODE

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

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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 1 of 5

Additional Practice Location

LOCATION* #

CURRENTLY PRACTICING AT THIS ADDRESS?* YES NO PREVIOUS OR FUTURE START DATE?

IMPORTANT

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

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

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

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

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

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* YES NO TELEPHONE* FAX

OFFICE E-MAIL ADDRESS

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

Office Manager or Business Office 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

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 of the Billing Contact, if available.

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

Practice Location Information Supplemental Form

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

Section 4 Practice Location Information - Page 2 of 5

Add'l Practice Location (Cont.)

Payment and Remittance

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

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

NOTE:

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

LOCATION* #

ELECTRONIC BILLING CAPABILITIES?* YES NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

CHECK PAYABLE TO*

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	FRIDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
TUESDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	SATURDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
WEDNESDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	SUNDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
THURSDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					

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?* IF YES ANSWERING SERVICE VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* YES NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* YES NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* YES NO

ACCEPT ALL NEW PATIENTS?* YES NO

ACCEPT NEW MEDICARE PATIENTS?* YES NO

ACCEPT NEW MEDICAID PATIENTS?* YES NO

IF ANY OF THE ABOVE VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?* IF YES YES NO

GENDER LIMITATIONS MALE ONLY NONE FEMALE ONLY

AGE LIMITATIONS MINIMUM AGE MAXIMUM AGE

LIST OTHER LIMITATIONS

Practice Location Information Supplemental Form

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

Section 4 Practice Location Information - Page 3 of 5

Additional Practice Location

(Continued)

IMPORTANT

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

Mid-Level Practitioners

→ **LOCATION* #**

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

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER FIRST NAME

PRACTITIONER STATE

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER LAST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER FIRST NAME

PRACTITIONER STATE

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER LAST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER FIRST NAME

PRACTITIONER STATE

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER LAST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER FIRST NAME

PRACTITIONER STATE

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER LAST NAME

M.I.

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER FIRST NAME

PRACTITIONER STATE

PRACTITIONER LICENSE / CERTIFICATE NUMBER

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

Practice Location Information Supplemental Form

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

Section 4 Practice Location Information - Page 4 of 5

Additional Practice Location
(Continued)

IMPORTANT

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

→ **LOCATION* #**

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>
	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED

	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>
	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?* <input type="checkbox"/> YES <input type="checkbox"/> NO	TEXT TELEPHONY (TTY)* <input type="checkbox"/> YES <input type="checkbox"/> NO	ACCESSIBLE BY PUBLIC TRANSPORTATION?* <input type="checkbox"/> YES <input type="checkbox"/> NO
PARKING?* <input type="checkbox"/> YES <input type="checkbox"/> NO	AMERICAN SIGN LANGUAGE* <input type="checkbox"/> YES <input type="checkbox"/> NO	BUS* <input type="checkbox"/> YES <input type="checkbox"/> NO
RESTROOM?* <input type="checkbox"/> YES <input type="checkbox"/> NO	MENTAL/PHYSICAL IMPAIRMENT SERVICES* <input type="checkbox"/> YES <input type="checkbox"/> NO	SUBWAY* <input type="checkbox"/> YES <input type="checkbox"/> NO
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
OTHER HANDICAPPED ACCESS	OTHER DISABILITY SERVICES	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? <input type="checkbox"/> YES <input type="checkbox"/> NO	ALLERGY INJECTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO	ALLERGY SKIN TESTING? <input type="checkbox"/> YES <input type="checkbox"/> NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? <input type="checkbox"/> YES <input type="checkbox"/> NO
DRAWING BLOOD? <input type="checkbox"/> YES <input type="checkbox"/> NO	AGE APPROPRIATE IMMUNIZATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO	FLEXIBLE SIGMOIDOSCOPY? <input type="checkbox"/> YES <input type="checkbox"/> NO	TYMPANOMETRY/ AUDIOMETRY SCREENING? <input type="checkbox"/> YES <input type="checkbox"/> NO
ASTHMA TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	OSTEOPATHIC MANIPULATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	IV HYDRATION/TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	CARDIAC STRESS TEST? <input type="checkbox"/> YES <input type="checkbox"/> NO
PULMONARY FUNCTION TESTING? <input type="checkbox"/> YES <input type="checkbox"/> NO	PHYSICAL THERAPY? <input type="checkbox"/> YES <input type="checkbox"/> NO	CARE OF MINOR LACERATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO	

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

IF YES, WHO ADMINISTERS IT?

<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
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)

Practice Location Information Supplemental Form

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

Section 4 Practice Location Information - Page 5 of 5

Additional Practice Location

(Continued)

→ LOCATION* #

IMPORTANT

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

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

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

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

Covering Colleagues

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

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

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

<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	
LAST NAME		SPECIALTY CODE	
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	
LAST NAME		SPECIALTY CODE	
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	
LAST NAME		SPECIALTY CODE	
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	
LAST NAME		SPECIALTY CODE	
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	<input style="width: 80%; height: 25px;" type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

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

Hospital Privileges (Current) Supplemental Form

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

Section 5

Hospital Affiliations

Hospital Privileges

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

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

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

OTHER HOSPITAL

HOSPITAL NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP CODE

TELEPHONE

FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME

FULL, UNRESTRICTED PRIVILEGES?

YES

NO

ARE PRIVILEGES TEMPORARY?

YES

NO

AFFILIATION START DATE (MM/YYYY)

AFFILIATION END DATE (MM/YYYY)

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

 %

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

PLEASE EXPLAIN TERMINATED AFFILIATION

THIS SPACE HAS BEEN PURPOSELY LEFT BLANK

Professional Liability Insurance Carrier Supplemental Form

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

Section 6 Professional Liability Insurance Carrier

Other Professional Liability Insurance Carrier

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

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

<input style="width: 100%;" type="text"/>		SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO
CARRIER OR SELF-INSURED NAME		
NUMBER*	STREET*	SUITE/BUILDING
CITY*		STATE*
		ZIP CODE*
ORIGINAL EFFECTIVE DATE* (MM/YYYY)	EFFECTIVE DATE* (MM/YYYY)	EXPIRATION DATE (MM/YYYY)
		TYPE OF COVERAGE?* <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SHARED
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
POLICY NUMBER*		

Other Professional Liability Insurance Carrier

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

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

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

<input style="width: 100%;" type="text"/>		SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO
CARRIER OR SELF-INSURED NAME		
NUMBER*	STREET*	SUITE/BUILDING
CITY*		STATE*
		ZIP CODE*
ORIGINAL EFFECTIVE DATE* (MM/YYYY)	EFFECTIVE DATE* (MM/YYYY)	EXPIRATION DATE (MM/YYYY)
		TYPE OF COVERAGE?* <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SHARED
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
POLICY NUMBER*		

Work History Supplemental Form

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

Section 7

Work History

Work History

Use this form to continue listing work history.

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

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER **STREET** **SUITE/BUILDING**

CITY **STATE** **ZIP/POSTAL CODE**

TELEPHONE **FAX**

COUNTRY CODE **START DATE (MM/YYYY)** **END DATE (MM/YYYY)**

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 (MM/YYYY)** **END DATE (MM/YYYY)**

REASON FOR DEPARTURE (IF APPLICABLE)

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

Professional Training / Work History Gaps Supplemental Form

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

Section 7	Professional Training / Work History Gaps
------------------	--

Professional Training / Work History Gaps

Please explain any time periods or gaps in training or work history that have occurred since graduation from professional school and are longer than three month in duration or of a shorter duration if required by the organization for which you are being credentialed.

GAP START DATE (MM/YYYY)		GAP END DATE (MM/YYYY)	

GAP START DATE (MM/YYYY)		GAP END DATE (MM/YYYY)	

GAP START DATE (MM/YYYY)		GAP END DATE (MM/YYYY)	

GAP START DATE (MM/YYYY)		GAP END DATE (MM/YYYY)	

GAP START DATE (MM/YYYY)		GAP END DATE (MM/YYYY)	

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

Disclosure Questions Supplemental Form

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

Section 8

Disclosure Questions

Disclosure Questions

Use this form to report any "Yes" response to one or more of the Disclosure Questions in Section 8. Your response should not exceed the spaces provided.

Record the question number in the first column, then your explanation in the second column.

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

QUESTION #	EXPLANATION
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

QUESTION #	EXPLANATION
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

QUESTION #	EXPLANATION
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
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<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

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

Malpractice Claims Explanation Supplemental Form

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

Section 8

Malpractice Claims Explanation

Malpractice Claims Explanation

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

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

DATE OF OCCURRENCE* (MM/DD/YYYY)		DATE CLAIM WAS FILED* (MM/DD/YYYY)	
STATUS OF CLAIM* (NOTE: IF CASE IS PENDING, SELECT OPEN)			
<input type="checkbox"/> OPEN		<input type="checkbox"/> CLOSED	
		IF SETTLED, ENTER DATE CLAIM WAS SETTLED (MM/DD/YYYY)	
PROFESSIONAL LIABILITY CARRIER INVOLVED* (USE BOTH LINES IF NECESSARY)			
NUMBER*	STREET*	SUITE/BUILDING	
CITY*	STATE*		ZIP CODE*
TELEPHONE	POLICY NUMBER		
\$		METHOD OF RESOLUTION?*	
AMOUNT OF AWARD OR SETTLEMENT*		<input type="checkbox"/> DISMISSED <input type="checkbox"/> SETTLED <input type="checkbox"/> MEDIATION <input type="checkbox"/> ARBITRATION	
		<input type="checkbox"/> JUDGMENT FOR DEFENDANT(S) <input type="checkbox"/> JUDGMENT FOR PLAINTIFF(S)	
DESCRIPTION OF ALLEGATIONS* (USE ALL FOUR LINES BELOW, IF NECESSARY)			
WERE YOU THE PRIMARY DEFENDANT OR CO-DEFENDANT?*		NUMBER OF OTHER CO-DEFENDANTS (IF ANY)	
<input type="checkbox"/> PRIMARY DEFENDANT <input type="checkbox"/> CO-DEFENDANT		<input type="text"/>	
YOUR INVOLVEMENT IN CASE* (ATTENDING, CONSULTING, ETC)			
DESCRIPTION OF ALLEGED INJURY TO THE PATIENT (USE ALL FOUR LINES BELOW, IF NECESSARY)			
DID THE ALLEGED INJURY RESULT IN DEATH?		TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?*	
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

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

Code Lists

Provider Type Codes

001 Medical Doctor (MD)		
002 Doctor of Dental Surgery (DDS)		
003 Doctor of Dental Medicine (DMD)		
004 Doctor of Podiatric Medicine (DPM)		
005 Doctor of Chiropractic (DC)		
007 Osteopathic Doctor (DO)		
020 Acupuncturist	030 Licensed Practical Nurse	041 Optometrist
021 Alcohol/Drug Counselor	031 Marriage/Family Therapist	042 Pharmacist
022 Audiologist	032 Massage Therapist	043 Physical Therapist
023 Biofeedback Technician	033 Naturopath	044 Physician Assistant
024 Certified Registered Nurse Anesthetist	034 Neuropsychologist	045 Professional Counselor
025 Christian Science Practitioner	035 Midwife	046 Registered Nurse
026 Clinical Nurse Specialist	036 Nurse Midwife	047 Registered Nurse First Assistant
027 Clinical Psychologist	037 Nurse Practitioner	048 Respiratory Therapist
028 Clinical Social Worker	038 Nutritionist	049 Speech Pathologist
029 Dietician	039 Occupational Therapist	
	040 Optician	

License Status Codes

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

Country Codes

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

Code Lists

Country Codes (continued)

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

Language Codes

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

Code Lists

U.S. / Canadian Professional School Codes

Alabama

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

Arkansas

003 University of Arkansas College of Medicine

Arizona

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

California

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

Colorado

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

Connecticut

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

District of Columbia

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

Florida

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

Georgia

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

Hawaii

026 John A. Burns School of Medicine

Iowa

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

Illinois

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

Indiana

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

Kansas

036 University of Kansas School of Medicine

Kentucky

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

Louisiana

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

Massachusetts

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

Maryland

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

Maine

507 University of New England, College of Osteopathic Medicine

Michigan

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

Minnesota

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

Missouri

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

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

Code Lists

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

Mississippi

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

North Carolina

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

North Dakota

064 University of North Dakota School of Medicine and Health Sciences

Nebraska

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

New Hampshire

067 Dartmouth Medical School

New Jersey

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

New Mexico

070 University of New Mexico School of Medicine

Nevada

071 University of Nevada School of Medicine

New York

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

Ohio

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

Oklahoma

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

Oregon

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

Pennsylvania

092 Jefferson Medical College of Thomas Jefferson University

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

Puerto Rico

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

Rhode Island

101 Brown Medical School

South Carolina

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

South Dakota

104 University of South Dakota School of Medicine

Tennessee

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

Texas

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

Utah

116 University of Utah School of Medicine

Virginia

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

Vermont

120 University of Vermont College of Medicine

Washington

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

Wisconsin

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

West Virginia

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

Code Lists

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

Canada

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

Specialty Codes - MD / DO Only

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

247	Allergy & Immunology	287	Internal Medicine, Hematology	Spine	
246	Allergy & Immunology, Allergy	288	Internal Medicine, Hematology & Oncology	416	Orthopaedic Surgery, Orthopaedic Trauma
291	Allergy & Immunology, Clinical & Laboratory Immunology	450	Internal Medicine, Hepatology	803	Orthopaedic Surgery, Pediatric Orthopaedic Surgery
249	Anesthesiology	299	Internal Medicine, Infectious Disease	457	Orthopaedic Surgery, Sports Medicine
235	Anesthesiology, Addiction Medicine	451	Internal Medicine, Interventional Cardiology	119	Orthopedic
258	Anesthesiology, Critical Care Medicine	453	Internal Medicine, Magnetic Resonance Imaging (MRI)	331	Otolaryngology
126	Anesthesiology, Pain Medicine	325	Internal Medicine, Medical Oncology	458	Otolaryngology, Otolaryngic Allergy
363	Clinical Pharmacology	309	Internal Medicine, Nephrology	459	Otolaryngology, Otolaryngology/ Facial Plastic Surgery
367	Colon & Rectal Surgery	378	Internal Medicine, Pulmonary Disease	332	Otolaryngology, Otolology & Neurotology
263	Dermatology	390	Internal Medicine, Rheumatology	357	Otolaryngology, Pediatric Otolaryngology
292	Dermatology, Clinical & Laboratory Dermatological Immunology	802	Internal Medicine, Sleep Medicine	417	Otolaryngology, Plastic Surgery within the Head & Neck
444	Dermatology, Dermatological Surgery	397	Internal Medicine, Sports Medicine	804	Otolaryngology, Sleep Medicine
266	Dermatology, Dermatopathology	433	Laboratories, Clinical Medical Laboratory	480	Pain Medicine, Interventional Pain Medicine
264	Dermatology, MOHS-Micrographic Surgery	481	Legal Medicine	337	Pain Medicine
443	Dermatology, Pediatric Dermatology	278	Medical Genetics, Clinical Biochemical Genetics	338	Pathology, Anatomic Pathology
268	Emergency Medicine	261	Medical Genetics, Clinical Cytogenetic	340	Pathology, Anatomic Pathology & Clinical Pathology
445	Emergency Medicine, Emergency Medical Services	277	Medical Genetics, Clinical Genetics (M.D.)	250	Pathology, Blood Banking & Transfusion Medicine
427	Emergency Medicine, Medical Toxicology	280	Medical Genetics, Clinical Molecular Genetics	344	Pathology, Chemical Pathology
348	Emergency Medicine, Pediatric Emergency Medicine	455	Medical Genetics, Molecular Genetic Pathology	302	Pathology, Clinical Pathology/Laboratory Medicine
395	Emergency Medicine, Sports Medicine	454	Medical Genetics, Ph.D. Medical Genetics	262	Pathology, Cytopathology
446	Emergency Medicine, Undersea and Hyperbaric Medicine	306	Neonatal-Perinatal Medicine	265	Pathology, Dermatopathology
391	Facial Plastic Surgery	308	Neopathology	273	Pathology, Forensic Pathology
272	Family Practice	409	Neurological Surgery	290	Pathology, Hematology
447	Family Practice, Addiction Medicine	330	Neuromusculoskeletal Medicine & OMM	298	Pathology, Immunopathology
237	Family Practice, Adolescent Medicine	440	Neuromusculoskeletal Medicine, Sports Medicine	305	Pathology, Medical Microbiology
448	Family Practice, Adult Medicine	317	Nuclear Medicine	461	Pathology, Molecular Genetic Pathology
282	Family Practice, Geriatric Medicine	318	Nuclear Medicine, In Vivo & In Vitro Nuclear Medicine	312	Pathology, Neuropathology
396	Family Practice, Sports Medicine	315	Nuclear Medicine, Nuclear Cardiology	358	Pathology, Pediatric Pathology
225	General Practice	316	Nuclear Medicine, Nuclear Imaging & Therapy	244	Pediatrics
479	Hospitalist	321	Obstetrics & Gynecology	805	Pediatric Anesthesiology
301	Internal Medicine	260	Obstetrics & Gynecology, Critical Care Medicine	239	Pediatrics, Adolescent Medicine
449	Internal Medicine, Addiction Medicine	326	Obstetrics & Gynecology, Gynecologic Oncology	295	Pediatrics, Clinical & Laboratory Immunology
236	Internal Medicine, Adolescent Medicine	286	Obstetrics & Gynecology, Gynecology	462	Pediatrics, Developmental – Behavioral Pediatrics
248	Internal Medicine, Allergy & Immunology	303	Obstetrics & Gynecology, Maternal & Fetal Medicine	354	Pediatrics, Medical Toxicology
255	Internal Medicine, Cardiovascular Disease	320	Obstetrics & Gynecology, Obstetrics	356	Pediatrics, Neurodevelopmental Disabilities
294	Internal Medicine, Clinical & Laboratory Immunology	271	Obstetrics & Gynecology, Reproductive Endocrinology	345	Pediatrics, Pediatric Allergy & Immunology
253	Internal Medicine, Clinical Cardiac Electrophysiology	328	Ophthalmology		
257	Internal Medicine, Critical Care Medicine	441	Oral & Maxillofacial Surgery		
267	Internal Medicine, Endocrinology, Diabetes & Metabolism	411	Orthopaedic Surgery		
275	Internal Medicine, Gastroenterology	412	Orthopaedic Surgery, Adult Reconstructive Orthopaedic Surgery		
285	Internal Medicine, Geriatric Medicine	456	Orthopaedic Surgery, Foot and Ankle Orthopaedics		
		406	Orthopaedic Surgery, Hand Surgery		
		415	Orthopaedic Surgery, Orthopaedic Surgery of the		

Code Lists

Specialty Codes - MD/DO Only

346 Pediatrics, Pediatric Cardiology	Hand	Neurology	413 Surgery, Surgical Oncology
347 Pediatrics, Pediatric Critical Care Medicine	242 Preventive Medicine, Aerospace Medicine	474 Psychiatry & Neurology, Pain Medicine	423 Surgery, Trauma Surgery
463 Pediatrics, Pediatric Emergency Medicine	429 Preventive Medicine, Medical Toxicology	368 Psychiatry & Neurology, Psychiatry	400 Surgery, Vascular Surgery
349 Pediatrics, Pediatric Endocrinology	112 Preventive Medicine, Occupational Medicine	809 Psychiatry & Neurology, Sleep Medicine	421 Thoracic Surgery (Cardiothoracic Vascular Surgery)
350 Pediatrics, Pediatric Gastroenterology	471 Preventive Medicine, Sports Medicine	475 Psychiatry & Neurology, Sports Medicine	442 Transplant Surgery
351 Pediatrics, Pediatric Hematology-Oncology	431 Preventive Medicine, Undersea and Hyperbaric Medicine	476 Psychiatry & Neurology, Vascular Neurology	424 Urology
352 Pediatrics, Pediatric Infectious Diseases	114 Preventive Medicine/Occupational Environmental Medicine	366 Public Health & General Preventive Medicine	811 Urology, Pediatric Urology
355 Pediatrics, Pediatric Nephrology	370 Psychiatry & Neurology, Addiction Medicine	252 Radiology, Body Imaging	
359 Pediatrics, Pediatric Pulmonology	473 Psychiatry & Neurology, Addiction Psychiatry	173 Radiology, Diagnostic Radiology	
361 Pediatrics, Pediatric Rheumatology	371 Psychiatry & Neurology, Child & Adolescent Psychiatry	430 Radiology, Diagnostic Ultrasound	
806 Pediatrics, Sleep Medicine	313 Psychiatry & Neurology, Clinical Neurophysiology	314 Radiology, Neuroradiology	
398 Pediatrics, Sports Medicine	274 Psychiatry & Neurology, Forensic Psychiatry	319 Radiology, Nuclear Radiology	
365 Physical Medicine & Rehabilitation	373 Psychiatry & Neurology, Geriatric Psychiatry	360 Radiology, Pediatric Radiology	
468 Physical Medicine & Rehabilitation, Pain Medicine	472 Psychiatry & Neurology, Neurodevelopmental Disabilities	380 Radiology, Radiation Oncology	
389 Physical Medicine & Rehabilitation, Pediatric Rehabilitation Medicine	100 Psychiatry & Neurology, Neurology	477 Radiology, Radiological Physics	
466 Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine	311 Psychiatry & Neurology, Neurology with Special Qualifications in Child	381 Radiology, Therapeutic Radiology	
469 Physical Medicine & Rehabilitation, Sports Medicine		384 Radiology, Vascular & Interventional Radiology	
419 Plastic Surgery		434 Supplier	
470 Plastic Surgery, Plastic Surgery Within the Head and Neck		399 Surgery	
407 Plastic Surgery, Surgery of the		418 Surgery, Pediatric Surgery	
		420 Surgery, Plastic and Reconstructive Surgery	
		405 Surgery, Surgery of the Hand	
		425 Surgery, Surgical Critical Care	

Specialty Codes - DDS / DMD / DPM / DC

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

DDS / DMD	DPM	DC
2 Dentist	3 Podiatrist	1 Chiropractor
13 Dentist, Dental Public Health	231 Podiatrist, Foot & Ankle Surgery	5 Chiropractor, Internist
14 Dentist, Endodontics	230 Podiatrist, Foot Surgery	6 Chiropractor, Neurology
438 Dentist, General Practice	227 Podiatrist, Primary Podiatric Medicine	7 Chiropractor, Nutrition
16 Dentist, Oral and Maxillofacial Pathology	226 Podiatrist, Public Medicine	8 Chiropractor, Occupational Medicine
439 Dentist, Oral and Maxillofacial Radiology	228 Podiatrist, Radiology	9 Chiropractor, Orthopedic
20 Dentist, Oral and Maxillofacial Surgery	229 Podiatrist, Sports Medicine	10 Chiropractor, Radiology
15 Dentist, Orthodontics and Dentofacial Orthopedics		801 Chiropractor, Rehabilitation Specialization
17 Dentist, Pediatric Dentistry		11 Chiropractor, Sports Physician
18 Dentist, Periodontics		12 Chiropractor, Thermography
19 Dentist, Prosthodontics		

Specialty Codes - Allied Providers

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

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

Code Lists

Specialty Codes - Allied Providers (continued)

660	Nurse Practitioner, Gerontology	679	Registered Nurse, Continuing Education/Staff Development
661	Nurse Practitioner, Neonatal	675	Registered Nurse, Critical Care Medicine
662	Nurse Practitioner, Neonatal, Critical Care	682	Registered Nurse, Diabetes Educator
670	Nurse Practitioner, Obstetrics & Gynecology	683	Registered Nurse, Dialysis, Peritoneal
671	Nurse Practitioner, Occupational Health	684	Registered Nurse, Emergency
663	Nurse Practitioner, Pediatrics	685	Registered Nurse, Enterostomal Therapy
664	Nurse Practitioner, Pediatrics, Critical Care	686	Registered Nurse, Flight
666	Nurse Practitioner, Perinatal	688	Registered Nurse, Gastroenterology
667	Nurse Practitioner, Primary Care	687	Registered Nurse, General Practice
665	Nurse Practitioner, Psych/Mental Health	689	Registered Nurse, Gerontology
668	Nurse Practitioner, School	691	Registered Nurse, Hemodialysis
669	Nurse Practitioner, Women's Health	690	Registered Nurse, Home Health
537	Nutritionist	692	Registered Nurse, Hospice
538	Nutritionist, Nutrition, Education	694	Registered Nurse, Infection Control
555	Occupational Therapist	693	Registered Nurse, Infusion Therapy
556	Occupational Therapist, Ergonomics	695	Registered Nurse, Lactation Consultant
557	Occupational Therapist, Hand	696	Registered Nurse, Maternal Newborn
558	Occupational Therapist, Human Factors	697	Registered Nurse, Medical-Surgical
559	Occupational Therapist, Neurorehabilitation	699	Registered Nurse, Neonatal Intensive Care
560	Occupational Therapist, Pediatrics	700	Registered Nurse, Neonatal, Low-Risk
561	Occupational Therapist, Rehabilitation, Driver	701	Registered Nurse, Nephrology
563	Optician	702	Registered Nurse, Neuroscience
565	Optometrist	698	Registered Nurse, Nurse Massage Therapist (NMT)
566	Optometrist, Corneal and Contact Management	703	Registered Nurse, Nutrition Support
567	Optometrist, Low Vision Rehabilitation	719	Registered Nurse, Obstetric, High-Risk
571	Optometrist, Occupational Vision	720	Registered Nurse, Obstetric, Inpatient
568	Optometrist, Pediatrics	721	Registered Nurse, Occupational Health
569	Optometrist, Sports Vision	722	Registered Nurse, Oncology
570	Optometrist, Vision Therapy	725	Registered Nurse, Ophthalmic
573	Pharmacist	724	Registered Nurse, Orthopedic
574	Pharmacist, General Practice	726	Registered Nurse, Ostomy Care
807	Pharmacist, Geriatric	723	Registered Nurse, Otorhinolaryngology & Head-Neck
575	Pharmacist, Nuclear	704	Registered Nurse, Pain Management
576	Pharmacist, Nutrition Support	706	Registered Nurse, Pediatric Oncology
808	Pharmacist, Oncology	705	Registered Nurse, Pediatrics
577	Pharmacist, Pharmacotherapy	710	Registered Nurse, Perinatal
578	Pharmacist, Psychiatric	714	Registered Nurse, Plastic Surgery
580	Physical Therapist	708	Registered Nurse, Psych/Mental Health
581	Physical Therapist, Cardiopulmonary	709	Registered Nurse, Psych/Mental Health, Adult
583	Physical Therapist, Electrophysiology, Clinical	707	Registered Nurse, Psych/Mental Health, Child & Adolescent
582	Physical Therapist, Ergonomics	810	Registered Nurse, Registered Nurse First Assistant
584	Physical Therapist, Geriatrics	712	Registered Nurse, Rehabilitation
585	Physical Therapist, Hand	713	Registered Nurse, Reproductive Endocrinology/Infertility
586	Physical Therapist, Human Factors	715	Registered Nurse, School
587	Physical Therapist, Neurology	716	Registered Nurse, Urology
590	Physical Therapist, Orthopedic	718	Registered Nurse, Women's Health Care, Ambulatory
588	Physical Therapist, Pediatrics	717	Registered Nurse, Wound Care
589	Physical Therapist, Sports	617	Respiratory Therapist, Certified
592	Physician Assistant	618	Respiratory Therapist, Certified, Critical Care
593	Physician Assistant, Medical	620	Respiratory Therapist, Certified, Educational
594	Physician Assistant, Surgical	619	Respiratory Therapist, Certified, Emergency Care
596	Psychologist	622	Respiratory Therapist, Certified, General Care
597	Psychologist, Addiction (Substance Use Disorder)	621	Respiratory Therapist, Certified, Geriatric Care
598	Psychologist, Adult Development & Aging	623	Respiratory Therapist, Certified, Home Health
599	Psychologist, Behavioral	628	Respiratory Therapist, Certified, Neonatal/Pediatrics
602	Psychologist, Child, Youth & Family	627	Respiratory Therapist, Certified, Palliative/Hospice
600	Psychologist, Clinical	629	Respiratory Therapist, Certified, Patient Transport
601	Psychologist, Counseling	624	Respiratory Therapist, Certified, Pulmonary Diagnostics
603	Psychologist, Educational	626	Respiratory Therapist, Certified, Pulmonary Function Technologist
604	Psychologist, Exercise & Sports	625	Respiratory Therapist, Certified, Pulmonary Rehabilitation
605	Psychologist, Family	630	Respiratory Therapist, Certified, SNF/Subacute Care
606	Psychologist, Forensic	631	Respiratory Therapist, Registered
607	Psychologist, HealthService	632	Respiratory Therapist, Registered, Critical Care
608	Psychologist, Men & Masculinity	634	Respiratory Therapist, Registered, Educational
609	Psychologist, Mental Retardation & Developmental Disabilities	633	Respiratory Therapist, Registered, Emergency Care
610	Psychologist, Psychoanalysis	636	Respiratory Therapist, Registered, General Care
611	Psychologist, Psychotherapy	635	Respiratory Therapist, Registered, Geriatric Care
612	Psychologist, Psychotherapy, Group	637	Respiratory Therapist, Registered, Home Health
613	Psychologist, Rehabilitation	642	Respiratory Therapist, Registered, Neonatal/Pediatrics
614	Psychologist, School	641	Respiratory Therapist, Registered, Palliative/Hospice
615	Psychologist, Women	643	Respiratory Therapist, Registered, Patient Transport
672	Registered Nurse	638	Respiratory Therapist, Registered, Pulmonary Diagnostics
673	Registered Nurse, Addiction (Substance Use Disorder)	640	Respiratory Therapist, Registered, Pulmonary Function Technologist
674	Registered Nurse, Administrator	639	Respiratory Therapist, Registered, Pulmonary Rehabilitation
711	Registered Nurse, Ambulatory Care	644	Respiratory Therapist, Registered, SNF/Subacute Care
681	Registered Nurse, Cardiac Rehabilitation	646	Social Worker, Clinical
676	Registered Nurse, Case Management	648	Specialist/Technologist, Other, Biomedical Engineering
677	Registered Nurse, College Health	506	Speech-Language Pathologist
678	Registered Nurse, Community Health	649	Technician, Other, Biomedical Engineering
680	Registered Nurse, Continence Care	502	Other, Not Listed

Code Lists

Specialty Boards - Allied Providers

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

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

MD Boards

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

Dental Boards

113 American Board of Endodontics
114 American Board of Oral & Maxillofacial Pathology
117 American Board of Oral & Maxillofacial Radiology
109 American Board of Oral & Maxillofacial Surgeons

108 American Board of Orthodontics
112 American Board of Pediatric Dentistry
111 American Board of Periodontology
115 American Board of Prosthodontics
106 American Board of Public Health Dentistry
120 Boards other than ABMS/AOA

DO Boards

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

DPM Boards

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