

Pennsylvania Standard Application

This form should be typed or legibly printed in black or blue ink. Please answer all questions completely and fully. If more space is needed than provided on this application, attach additional sheets and reference the question being answered. If a question is not applicable to you, please respond with N/A. Incomplete applications cannot be processed and this will delay the credentialing process. Refer to instructions from each managed care insurance company for copies of documents that must be submitted with this application.

I. PERSONAL INFORMATION

Last Name _____ First _____ Middle _____

Degree and/or Title _____ SS# _____ Email _____

Any other name under which you have been known _____

Birth Date _____ Gender (Optional) Male _____ Female _____ Ethnicity (Optional) _____

If you are not a US Citizen, do you have authorization to work in the US? Yes _____ No _____ N/A _____

Primary Office Address

Name of Practice _____ Street Address _____

Suite/Bldg# _____ City _____ County _____ State _____ Zip _____

Phone _____ Fax _____ Federal Tax ID of Group _____

Are you applying for affiliation as

Primary Care Physician _____ Specialist _____ Both _____

Non-physician Practitioner _____ (Please specify _____)

If you are applying as a **PRIMARY CARE PHYSICIAN**, please mark which specialty

Family Practice _____ General Practice _____ Internal Medicine _____ Pediatrics _____ IM/Pediatrics _____ Other _____

If you have a subspecialty, please identify _____

If you are applying as a **SPECIALIST**, please indicate which specialty _____

If you have one or more subspecialties, please identify _____

Medical Licensure/Registration

Medical License Number	Issue Date	Expiration Date
CDS/BNDD Number (If Applicable)		Expiration Date
Federal DEA Reg. Number (s)		Expiration Date
Medicare Provider Number		
Medicaid Provider Number		
UPIN	Taxonomy Code(s)	
Individual NPI	Group NPI(s)	

Additional State Licenses and Numbers

State	License Number	Expiration Date
State	License Number	Expiration Date
State	License Number	Expiration Date

II. EDUCATION / TRAINING / HOSPITAL PRIVILEGES

Undergraduate/Professional Training (Must include month and year)

Institution _____ Degree _____ Date of Entry _____
City _____ State _____ Country _____ Graduation Date _____

Medical School

Institution _____ Degree _____ Date of Entry _____
City _____ State _____ Country _____ Graduation Date _____

International Medical Graduates

ECFMG Number _____ Issue Date _____

Internship/Residency

Institution _____ Type of Training _____
City _____ State _____ Country _____ Date of Entry _____
Program Completed Yes _____ Date _____ Specialty _____
No _____ Explain _____

Residency/Fellowship

Institution _____ Type of Training _____
City _____ State _____ Country _____ Date of Entry _____
Program Completed Yes _____ Date _____ Specialty _____
No _____ Explain _____

Residency/Fellowship

Institution _____ Type of Training _____
City _____ State _____ Country _____ Date of Entry _____
Program Completed Yes _____ Date _____ Specialty _____
No _____ Explain _____

Other Experience or Training (i.e., allied health, public service, or military)

Institution _____ Type of Training Program _____

City _____ State _____ Country _____ Dates of Attendance _____

Program Completed Yes _____ No _____ Supervised Clinical Hours _____

Additional Information _____

Work History

Starting with your current practice, list all employment since completion of post-graduate training. Explain any gaps in the chronology.

Employer/Practice	Location City and State	Dates (inclusive) Month <u>and</u> Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Hospital Affiliation

Note If you have no hospital privileges, please provide your arrangements for admitting and treatment of patient while hospitalized.

Primary Hospital _____ Street Address _____

Department _____ City _____ State _____ Zip _____

Staff Category _____ % of Admissions _____ Dates of Affiliation From _____ To _____

Do you currently admit and care for patients on your own hospital service? Yes _____ No _____

If yes Adult ___ Child ___ Infant ___ If no, please provide coverage arrangements for admitting and treatment of patients

Additional Hospital Affiliation

Hospital _____ Street Address _____

Department _____ City _____ State _____ Zip _____

Staff Category _____ % of Admissions _____ Dates of Affiliation From _____ To _____

Additional Hospital Affiliation

Hospital _____ Street Address _____

Department _____ City _____ State _____ Zip _____

Staff Category _____ % of Admissions _____ Dates of Affiliation From _____ To _____

Previous Hospital Affiliations (within the last 10 years)

Hospital _____
City, State _____
Hospital _____
City, State _____
Hospital _____
City, State _____

Dates of Affiliation
From _____ To _____
Dates of Affiliation
From _____ To _____
Dates of Affiliation
From _____ To _____

Board Certification

Board Certified Yes _____ No _____ Certifying Board _____
Are you pursuing Board Certification? Yes _____ No _____
If yes, give details of plans to take Board exam _____
If no, please explain _____

Certificate Number _____ Original Certification Date _____
Most Recent Recertification Date _____ Certification Expiration Date _____

Additional Board Certifications / Other Certifications

Board Certified Yes _____ No _____ Certifying Board _____
Certificate Number _____ Original Certification Date _____
Most Recent Recertification Date _____ Certification Expiration Date _____

III. OFFICE PRACTICE INFORMATION

Type of Practice

Corporation _____ Partnership _____ Solo _____ Institution _____ FQHC _____

Give a narrative description of your practice, including the type of medicine that comprises the majority of your practice, special interests, and procedures performed in your office _____

Do you receive vaccines purchased by the city/county through public funding? Yes _____ No _____ N/A _____

Individual Tax ID Number of Applicant _____

Define age restrictions or other practice limitations _____

Please list HMOs, POs, PHOs and other managed care programs in which you are participating _____

Primary Office Site

List Associates (If more space required, attach roster)

Specialties

Office Hours

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

Saturday _____

Sunday _____

Office Manager's Name _____

Handicap Access? Yes _____ No _____

Email _____

List all languages (other than English) including sign, in which you are fluent.

Provider _____

Staff _____

Other arrangements for translating _____

TDD No. _____

Billing Information for Primary Office

(Check here _____ if billing address is the same as the Primary Office Address listed on page 1)

Street _____ City _____ State _____ Zip _____

Suite/Bldg# _____ Phone _____ Fax _____

Billing Manager _____

Claims payable to _____

Submit electronic claims? Yes _____ No _____

Electronic Mail Code _____

Credentialing Contact Information

Contact Person _____ Tel No. _____ Email _____

Same as Primary Office Site _____

Same as Primary Office Billing Address _____

Address _____

Additional Office Sites Check here if there are no additional office sites

Photocopy this page and complete one sheet for each additional office associated with the applicant's practice.

Name of Practice _____ Street Address _____
Suite/Bldg# _____ City _____ State _____ Zip _____
County _____ Phone _____ Fax _____

List Associates (If more space required, attach roster)

Specialties

Office Hours	Monday	Tuesday	Wednesday
Thursday	Friday	Saturday	Sunday
Office Manager's Name _____	Handicap Access? Yes _____ No _____		

List all languages (other than English) including sign, in which you are fluent.

Provider _____ Staff _____

Other arrangements for translating _____ TDD No.

Billing Information for Additional Office
(Check here if billing address is the same as the address above)

Street _____ City _____ State _____ Zip _____

Suite/Bldg# _____ Phone _____ Fax _____

Billing Manager _____ Claims payable to _____

Submit electronic claims? Yes _____ No _____ Electronic Mail Code _____

Federal Tax ID of Group _____

Cross Coverage Please list covering practitioners. If additional names and information, please attach.

Practitioner_____	Practitioner_____	Practitioner_____
Address_____	Address_____	Address_____
_____	_____	_____
Phone_____	Phone_____	Phone_____
Specialty_____	Specialty_____	Specialty_____
Hospital Affiliations_____	Hospital Affiliations_____	Hospital Affiliations_____
_____	_____	_____
Office Patients_____	Office Patients_____	Office Patients_____
Hospital Patients_____	Hospital Patients_____	Hospital Patients_____

If you utilize practitioners in addition to those listed above for 24 hour, 7 day a week coverage, list them.

Practitioner (Attach roster, if more space required)

Phone Number with Area Code

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you use physician extenders? Yes____ No____ If yes, list names and license numbers.

Name_____	Title/Degree_____	License Number_____
Name_____	Title/Degree_____	License Number_____
Name_____	Title/Degree_____	License Number_____
Name_____	Title/Degree_____	License Number_____

IV. CONFIDENTIAL INFORMATION

IF YOU HAVE ANY "YES" ANSWERS TO ANY QUESTIONS IN THE SECTIONS BELOW AND THOSE ON PAGE 9, REFERENCE THE QUESTIONS ON A SEPARATE SHEET, GIVE FULL DETAILS AND ATTACH.

Have any of the following at any time been, or are they currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state?

Medical or professional license	Yes ___	No ___
DEA or CDS/BNDD registration	Yes ___	No ___
Hospital medical staff membership	Yes ___	No ___
Clinical privileges or other rights on any hospital medical staff	Yes ___	No ___
Employment by any hospital, institution, or the military	Yes ___	No ___
Professional society memberships	Yes ___	No ___
Participation in any private, federal, or state health insurance program (i.e., Medicare, CHAMPUS, Medicaid)	Yes ___	No ___
Participation in an HMO, PPO, or any other managed care organization	Yes ___	No ___
Board Certification	Yes ___	No ___

At any time, have you ever been

Convicted of a criminal offense	Yes ___	No ___
Convicted of a felony	Yes ___	No ___
Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of trial, or an accelerated rehabilitation disposition in the disposition of felony charges in any state, territory or country	Yes ___	No ___

Have you ever at any time or are you currently

Under indictment for any crime	Yes ___	No ___
The subject of an investigation by any private, federal or state health insurance program or state licensing board	Yes ___	No ___
Under investigation by any state licensing board or federal agency	Yes ___	No ___
The subject of any adverse action reports to a state or federal databank	Yes ___	No ___

Have you ever either voluntarily or involuntarily

Withdrawn your application for medical staff membership at any facility	Yes ___	No ___
Withdrawn your request for any clinical privileges at any facility	Yes ___	No ___

Health Status

Are you able to perform the professional duties of the position with or without reasonable accommodation? (A "NO" answer to this question does require additional documentation)	Yes ___	No ___
Are you currently using illegal substances or illegally using substances?	Yes ___	No ___

V. PROFESSIONAL LIABILITY CARRIER INFORMATION

Current Insurance Carrier _____

Street Address _____ City _____ State _____ Zip Code _____

Suite/Bldg # _____ Date of Coverage _____ Coverage expiration _____

Coverage Amount _____ Policy Number _____ Type of coverage _____

Individual _____ Procedures excluded from coverage _____

Aggregate _____

Previous Insurance Carrier(s) (For the last 5 years, if you have not been with your current carrier for 5 years.)

Previous Insurance Carrier _____ Type of coverage _____

Street Address _____ Suite/Bldg# _____ City _____ State _____

Policy Number _____ Coverage To _____ From _____

Procedures excluded from coverage _____

Previous Insurance Carrier _____ Type of coverage _____

Street Address _____ Suite/Bldg# _____ City _____ State _____

Policy Number _____ Coverage To _____ From _____

Procedures excluded from coverage _____

Professional Liability History

In the past 10 years, has your liability insurance ever been canceled or denied? Yes _____ No _____

Do you have any malpractice judgments against you including arbitration in the last 10 years? Yes _____ No _____

Have you had any claim settlements not involving litigation or arbitration paid by you or on your behalf in the last 10 years? Yes _____ No _____

Are you now a defendant in a pending malpractice suit? Yes _____ No _____

IF YOU ANSWER YES TO ANY OF THE QUESTIONS ABOVE, PROVIDE THE FOLLOWING INFORMATION FOR EACH CASE/SITUATION

Date of occurrence of alleged malpractice _____ Plaintiff name _____

Name of the insurance carrier involved _____

Status of the case _____ Your status is/was in this case Primary Defendant _____ CoDefendant _____

Pending _____ If pending, list carrier _____

Found for plaintiff _____ Found for defendant _____ Dismissed / dropped _____

Settled _____ If settled, give the amount _____

Professional relationship to patient _____

Alleged harm to patient _____

Circumstances of patient's illness _____

Any other pertinent details _____

REQUIRED COPIES

REFER TO INSTRUCTIONS FROM EACH MANAGED CARE ORGANIZATION FOR DOCUMENTS REQUIRED FOR CREDENTIALS THAT ARE IN ADDITION TO THE INFORMATION YOU ATTACH TO PROPERLY RESPOND TO QUESTIONS ON THIS APPLICATION.

By signing this application, I hereby certify that all information contained in this application is true, correct and complete in all respects and agree to promptly notify the "recipient" immediately if there are any changes in the information provided.

Applicant's Signature _____ **Date** _____