

# Non-Credentialed Health Care Practitioner Application

To begin the enrollment process, please complete all information as it applies to your specialty. Information that does not apply to your specialty may be left blank.

Last Name:		First Name:		Middle Initial:	
Date of Birth:		Social Security #:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Individual NPI #:		License/Registration #:		Licensed State:	
DEA Certificate #:		Medicare #:		Medicaid #:	
Primary Specialty:		Second Specialty:		Taxonomy Code:	
Group Name:		Group Tax ID:		Group NPI:	
Requested Effective Date:		Malpractice Insurance Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Facility <input type="checkbox"/> Collaborating Physician			
<b>Please select only one provider type:</b>	<input type="checkbox"/> Nurse Practitioner		<input type="checkbox"/> Registered Dietician		<input type="checkbox"/> Anesthesiologist
	<input type="checkbox"/> Physician Assistant		<input type="checkbox"/> Emergency Medicine		<input type="checkbox"/> Locum Tenen
	<input type="checkbox"/> CRNA		<input type="checkbox"/> Pathology		<input type="checkbox"/> Hospitalist (If yes, list specialty) _____
<i>If you selected Anesthesiologist, Emergency Room, Hospitalist, Locum Tenens or Pathologist, you <u>must</u> complete the disclosure questions on the last page</i>					
<b>Primary Office Address</b> (Servicing Location only, No PO Box):					Suite:
City:		County:	State:		Zip Code:
Office Phone:		Office Fax:	Handicap Accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No		Public Transportation: <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address:					
<b>Additional Office Address</b> (Street Level only, No PO Box):					Suite:
City:		County:	State:		Zip Code:
Office Phone:		Office Fax:	Handicap Accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No		Public Transportation: <input type="checkbox"/> Yes <input type="checkbox"/> No
Collaborating Physician Name:				Specialty:	
Collaborating Physician NPI:				Group NPI:	
Group Name:				Billing Tax Id:	
Please provide only <b>ONE</b> Remittance, <b>ONE</b> Correspondence, and <b>ONE</b> Medical Records address. Each address can be the same or different, but <b>must</b> be identified as a valid United States Postal Service mailing address. If <b>PO BOX</b> information is used, the corresponding City, State and ZIP Code for the PO Box must be provided and no street level information present.					
Same As: <input type="checkbox"/> Primary Address		Remittance Address:			Suite:
		City:		State:	Zip Code:
		Office Phone:		Office Fax:	
Same As: <input type="checkbox"/> Primary Address <input type="checkbox"/> Remittance		Correspondence Address:			Suite:
		City:		State:	Zip Code:
		Office Phone:		Office Fax:	Email
Same As: <input type="checkbox"/> Primary <input type="checkbox"/> Remittance <input type="checkbox"/> Correspondence		Medical Record Address:			Suite:
		City:		State:	Zip Code:
		Office Phone:		Office Fax:	<input type="checkbox"/> EMR <input type="checkbox"/> Paper EMR Vendor:
Medical Record Contact Name:				Phone:	
<b>ATTESTATION:</b> I, the undersigned, hereby verify and attest that I am the collaborating physician for the above-named applicant. As required by applicable laws, I have satisfied myself as to the ability and competency of this applicant and that the functions that the applicant will carry out are performed under my collaboration and oversight. (If additional collaborating physician signatures are required, please attach additional signatures of attestation to this form.)					
Collaborating Physician Name (Print):					
Collaborating Physician Name (Signature):					Date:

**Anesthesiologist, Emergency Room, Hospitalist, Locum Tenens and Pathologist**  
**Must complete the following disclosure questions:**

1. 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?  
 Yes  No  NA
  
2. Have your clinical privileges or medical staff membership at any hospital or health care institution (either 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 health care institution, medical staff or committee or governing board?  
 Yes  No  NA
  
3. 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 or health plans (including HMOs, PPOs, or provider organizations such as independent practice associations or private health organizations)?  
 Yes  No  NA
  
4. Has your federal Drug Enforcement Administration and/or state controlled dangerous substances (CDS) certificates(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?  
 Yes  No  NA
  
5. Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS-authorizing entities, education or training program, Medicare or Medicaid program, regulatory agency, or any other private, federal or state health program or been 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 sexual offense or sexual misconduct?  
 Yes  No  NA
  
6. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Databank or Healthcare Integrity and Protection Data Bank?  
 Yes  No  NA
  
7. Has your Professional liability coverage ever been cancelled, restricted, declined, or not renewed by the carrier based on your individual liability history?  
 Yes  No  NA

"I hereby attest, to the best of my knowledge that the information on this form is true accurate, and complete."

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_