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 and 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_____ Dates of Affiliation

City, State_____ From_____ To_____

Hospital_____ Dates of Affiliation

City, State_____ From_____ To_____

Hospital_____ Dates of Affiliation

City, State_____ 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** _____