

Application Checklist for Practitioners



Please use the following checklist to complete the credentialing process. Current copies of all items listed below are required for each practitioner to participate with AmeriHealth Caritas Louisiana.

Use this Application Checklist as a fax cover sheet. Fax all applicable items on the checklist to the Credentialing Department at **1-225-300-9199**, or signed documents may be scanned and submitted by secure e-mail to **Credentialing@amerihealthcaritasla.com**. Please ensure this checklist is submitted with the documents.

Please provide AmeriHealth Caritas Louisiana with the following:

| Practitioner information | |
|--|-------------------------------------|
| Applicant's full name: | Legal name: |
| Date of birth: | Gender: Male Female |
| Practice name to appear in directory (DBA): | |
| This practice is a: Federally qualified health center (FQHC) Rural health clinic (RHC) Indian tribal organization | |
| Practice Tax ID Number (TIN): | |
| Medical license number (state): | |
| Group National Provider Identifier (NPI) number: | |
| Applicant's NPI number: | |
| Individual Medicaid number: | |
| Council for Affordable Quality Healthcare (CAQH)-issued ID number (if applicable): | |
| Drug Enforcement Agency (DEA) number: | |
| Clinical Laboratory Improvement Amendments (CLIA) certificate type: | |
| CLIA certificate number: | |
| Primary care provider (PCP) Specialist Hospital-based only Allied health Behavioral health | |
| Patient-centered medical home? Yes No | |
| Add to an existing practice/group? Yes No If yes, please indicate affiliated practice/group: | |
| When did this practitioner start with this group/practice? | |
| Applicant's specialty: | Secondary specialty: |
| Taxonomy: | County/parish: |
| Fax number: | Hours of operation: |
| Accepting new patients? Yes No | Patient ages seen: |
| Maximum number of members accepted by PCP: | Remit address: |
| Remit phone number: | Remit fax number: |
| Credentialing contact name: | |
| Credentialing contact email address: | Credentialing contact phone number: |



Practitioner information (continued)

*Applicant race (choose only one): Black or African American White Native Hawaiian or Other Pacific Islander Asian
American Indian or Alaska Native Middle Eastern/North African Other race Decline to state

*Applicant ethnicity: Hispanic or Latino Non-Hispanic or Latino Unknown or decline to state

*Language(s) spoken by applicant and/or clinical staff:

*Providing race, ethnicity, and language information is optional. We collect this data to assist members in selecting a provider.

Please provide the following:

CAQH authorization allowing AmeriHealth Caritas Louisiana to access practitioner information. **(Please ensure all current copies of the below supporting documents are updated on the CAQH application. Do not submit until all documents are current.)**

Non-CAQH participants must submit copies of the following support documents:

Practitioner application (completed, signed, and dated within the last 90 days) NOTE: You may access the Practitioner credentialing application packet on our website here: <http://www.amerihealthcaritasla.com/provider/resources/credentialing/index.aspx>

State medical license

Board certification (if applicable)

Certifications for the following practitioners (if applicable)

- Social workers, professional counselors, and psychologists (behavioral health).
- Nurse practitioners.
- Physician assistants.
- Nurse midwives.

Federal Drug Enforcement Agency (DEA) registration certificate (if applicable)

- DEA must have the state in which the practitioner is rendering services to our members.

State controlled dangerous substance (CDS) license (if applicable)

Declarations page of malpractice insurance policy and Patient Compensation Fund certificate showing expiration dates and limits of liability. (Provider's name must be on declarations page. If name is not included, then a roster is required.)

Curriculum vitae (CV)/resumé (if applicable)

- CV/resumé must cover five years of work experience with no gaps. Provide an explanation of any gaps greater than six months.

Clinical Laboratory Improvement Amendments (CLIA) certificate (if applicable)

W-9 form

Hospital privileges indicating the practitioner's primary admitting hospital. Please forward a copy of a coverage agreement if the practitioner does not have admitting privileges, or a letter stating hospitalist service used.

Practitioner office hours must be completed on the application

Allied health practitioners outlined below are required to provide a collaborative agreement:

- Nurse practitioner (NP).
- Physician assistant (PA).
- Osteopathic assistant (OA).
- Certified nurse midwife (CNM).

Ownership disclosure (behavioral health providers only)

To check the status of your application or if you have any questions or concerns regarding this process, please contact the AmeriHealth Caritas Louisiana Credentialing Department at **1-888-913-0349**.

If you are new to AmeriHealth Caritas Louisiana and you or your group does not have a provider contract, you must first call **1-877-588-2248** to discuss obtaining an AmeriHealth Caritas Louisiana Provider Agreement.



LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

DIRECTIONS

Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 9 for a list of required documents.

**** All sections must be completed in their entirety. "See C.V.", not acceptable****

GENERAL INFORMATION

| | | | | | | |
|---|--|--------------------------------|---------------------------|--------------------------------|---|--------------------------|
| LAST NAME | | SUFFIX | FIRST | MIDDLE | GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | |
| DEGREE: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> DC <input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> OTHER _____ | | | | | | |
| Any other name under which you have been known? (AKA) LIST | | | ECFMG NUMBER | | UPIN NUMBER | |
| HOME STREET ADDRESS | | | CITY | | STATE | ZIP CODE |
| HOME PHONE NUMBER | | PAGER NUMBER/ANSWERING SERVICE | | HOME E-MAIL ADDRESS (Optional) | | |
| SOCIAL SECURITY NUMBER | | DATE OF BIRTH | BIRTH PLACE (CITY, STATE) | | RACE/ETHNICITY (Voluntary) | |
| NPI - INDIVIDUAL | | NPI - GROUP | | MEDICAID PROVIDER NUMBER | | MEDICARE PROVIDER NUMBER |

PRIMARY PRACTICE LOCATION

| | | | | | | | |
|---|------------------|--|--|---|------------------|---|--------------------------------------|
| INSTITUTION/GROUP/CLINIC NAME (If applicable) | | | | OFFICE MANAGER | | | |
| STREET ADDRESS | | | CITY | | STATE | ZIP CODE | |
| PHONE NUMBER | | FAX NUMBER | | OFFICE E-MAIL | | | |
| TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED | | | | | | | |
| TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER | | | | TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION | | | |
| Name to which Employer Identification Number (EIN) is registered with the IRS (Important: must match IRS information exactly) | | | | | | | |
| BILLING ADDRESS (Address to which you want payments sent) | | | CONTACT PERSON | | TELEPHONE NUMBER | | |
| CITY | | STATE | ZIP CODE | BILLING E-MAIL | | FAX NUMBER | |
| OFFICE HOURS | MON ____-____ | TUES ____-____ | WED ____-____ | THUR ____-____ | FRI ____-____ | SAT ____-____ | SUN ____-____ |
| Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify) _____ | | | | | | | |
| Languages spoken at this location: (other than English) _____ | | | | | | <input type="checkbox"/> Provider <input type="checkbox"/> Other | |
| Accepting Patients? | | <input type="checkbox"/> New <input type="checkbox"/> Existing Only | | <input type="checkbox"/> Only family members of existing patients <input type="checkbox"/> Other (Specify) _____ | | | |
| Age group(s) treated: | | <input type="checkbox"/> 0-6 years <input type="checkbox"/> Over 65 | | <input type="checkbox"/> 7-11 years <input type="checkbox"/> All Ages | | <input type="checkbox"/> 12-18 years <input type="checkbox"/> Other (Specify): _____ | <input type="checkbox"/> 19-65 years |
| Are PAs and/or nurse/paraprofessional practitioners used? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Is this facility handicapped accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Emergency After Hours Number | | | Arrangements for 24 hour / 7 day a week coverage (Specify) | | | | |

Group or Covering Physicians: _____

SECOND PRACTICE LOCATION

| | | | | | | | |
|---|--|--|--|--|----------------|---|---|
| INSTITUTION/GROUP/CLINIC NAME (If applicable) | | | | | OFFICE MANAGER | | |
| STREET ADDRESS | | | | CITY | | STATE | ZIP CODE |
| PHONE NUMBER | | FAX NUMBER | | OFFICE E-MAIL | | | |
| TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED | | | | | | | |
| TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER | | | | TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION | | | |
| Name to which tax ID number is registered with the IRS (Important: must match the name given on IRS information given) | | | | | | | |
| BILLING ADDRESS (Address to which you want payments sent) | | | | CONTACT PERSON | | TELEPHONE NUMBER | |
| CITY | | STATE | | ZIP CODE | | BILLING E-MAIL | |
| OFFICE HOURS | | MON | TUES | WED | THUR | FRI | SUN |
| | | - | - | - | - | - | - |
| Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify): _____ | | | | | | | |
| Languages spoken at this location: (other than English) _____ | | | | | | | <input type="checkbox"/> Provider <input type="checkbox"/> Other |
| Accepting Patients? | | <input type="checkbox"/> New <input type="checkbox"/> Existing Only | | <input type="checkbox"/> Only family members of existing patients <input type="checkbox"/> Other (Specify): _____ | | | |
| Age group(s) treated: | | <input type="checkbox"/> 0-6 years <input type="checkbox"/> Over 65 | | <input type="checkbox"/> 7-11 years <input type="checkbox"/> All Ages | | <input type="checkbox"/> 12-18 years <input type="checkbox"/> 19-65 years <input type="checkbox"/> Other (Specify): _____ | |
| Are PAs and/or nurse/paraprofessional practitioners used? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Is this facility handicapped Accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Emergency After Hours Number | | | Arrangements for 24 hour / 7 day a week coverage (Specify) | | | | |
| Group or Covering Physicians: _____ _____ | | | | | | | |

THIRD PRACTICE LOCATION

| | | | | | | | |
|---|--|------------|------|---|----------------|-----------------------|---|
| INSTITUTION/GROUP/CLINIC NAME (If applicable) | | | | | OFFICE MANAGER | | |
| STREET ADDRESS | | | | CITY | | STATE | ZIP CODE |
| PHONE NUMBER | | FAX NUMBER | | OFFICE E-MAIL | | | |
| TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED | | | | | | | |
| TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER | | | | TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION | | | |
| Name to which tax ID number is registered with the IRS (Important: must match the name given on IRS information given) | | | | | | | |
| BILLING ADDRESS (Address to which you want payments sent) | | | | CONTACT PERSON | | TELEPHONE NUMBER | |
| CITY | | STATE | | ZIP CODE | | BILLING E-MAIL | |
| OFFICE HOURS | | MON | TUES | WED | THUR | FRI | SUN |
| | | - | - | - | - | - | - |
| Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify): _____ | | | | | | | |
| Languages spoken at this location: (other than English) _____ | | | | | | | <input type="checkbox"/> Provider <input type="checkbox"/> Other |

THIRD PRACTICE LOCATION CONTINUED

| | | |
|---|--|---|
| Accepting Patients? | <input type="checkbox"/> New | <input type="checkbox"/> Only family members of existing patients |
| | <input type="checkbox"/> Existing Only | <input type="checkbox"/> Other (Specify): _____ |
| Age group(s) treated: | <input type="checkbox"/> 0-6 years | <input type="checkbox"/> 7-11 years |
| | <input type="checkbox"/> Over 65 | <input type="checkbox"/> All Ages |
| | <input type="checkbox"/> 12-18 years | <input type="checkbox"/> 19-65 years |
| | <input type="checkbox"/> Other (Specify): _____ | |
| Are PAs and/or nurse/paraprofessional practitioners used? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Is this facility handicapped Accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emergency After Hours Number | Arrangements for 24 hour / 7 day a week coverage (Specify) | |
| Group or Covering Physicians: _____ _____ | | |

FOURTH PRACTICE LOCATION

If you have more than four locations, attach additional sheets with the following information

| | | | |
|---|--|---|---|
| INSTITUTION/GROUP/CLINIC NAME (If applicable) | | OFFICE MANAGER | |
| STREET ADDRESS | | CITY | STATE |
| | | | ZIP CODE |
| PHONE NUMBER | FAX NUMBER | OFFICE E-MAIL | |
| TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED | | | |
| TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER | | TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION | |
| Name to which tax ID number is registered with the IRS (Important: must match the name given on IRS information given) | | | |
| BILLING ADDRESS (Address to which you want payments sent) | | CONTACT PERSON | TELEPHONE NUMBER |
| CITY | STATE | ZIP CODE | BILLING E-MAIL |
| | | | FAX NUMBER |
| OFFICE HOURS | MON | TUES | WED |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify): _____ | | | |
| Languages spoken at this location: (other than English) _____ | | | <input type="checkbox"/> Provider <input type="checkbox"/> Other |
| Accepting Patients? | <input type="checkbox"/> New | <input type="checkbox"/> Only family members of existing patients | |
| | <input type="checkbox"/> Existing Only | <input type="checkbox"/> Other (Specify): _____ | |
| Age group(s) treated: | <input type="checkbox"/> 0-6 years | <input type="checkbox"/> 7-11 years | |
| | <input type="checkbox"/> Over 65 | <input type="checkbox"/> All Ages | |
| | <input type="checkbox"/> 12-18 years | <input type="checkbox"/> 19-65 years | |
| | <input type="checkbox"/> Other (Specify): _____ | | |
| Are PAs and/or nurse/paraprofessional practitioners used? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Is this facility handicapped Accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Emergency After Hours Number | Arrangements for 24 hour / 7 day a week coverage (Specify) | | |
| Group or Covering Physicians: _____ _____ | | | |

CORRESPONDENCE

| | | | |
|---|---------------------------------|--------------------------------|---------------------------------|
| Please check location where you would like correspondence sent. | | | |
| <input type="checkbox"/> Primary | <input type="checkbox"/> Second | <input type="checkbox"/> Third | <input type="checkbox"/> Fourth |
| <input type="checkbox"/> Other Address _____ | | | <input type="checkbox"/> All |
| IF DIFFERENT FROM PRACTICE LOCATIONS: | | | |
| PHONE NUMBER | FAX NUMBER | E-MAIL | |
| | | | |

MEDICAL RECORDS

Please check location where you would like medical records requests sent.

- Primary
 Second
 Third
 Fourth
 Correspondence
 Other address _____

If different from practice or correspondence located checked above

| | | |
|--------------|------------|--------|
| PHONE NUMBER | FAX NUMBER | E-MAIL |
|--------------|------------|--------|

SPECIALTY

TYPE OF PROVIDER:
 PRIMARY CARE PHYSICIAN
 PHYSICIAN SPECIALIST
 BOTH
 OTHER SPECIALTY: _____

PLEASE LIST PRIMARY AND SUB-SPECIALTIES (as applicable)

BOARD CERTIFIED (ABMS)

Specialty: Yes No

Sub-Specialty: Yes No

Sub-Specialty: Yes No

BOARD CERTIFICATION

(as recognized by American Board of Medical Specialties)

(Please attach a copy of current certification(s).)

| | | | |
|----------------------------------|----------------|------------------|------------------|
| PRIMARY SPECIALTY BOARD (ABMS) | DATE CERTIFIED | DATE RECERTIFIED | STATUS/EXP. DATE |
| SECONDARY SPECIALTY BOARD (ABMS) | DATE CERTIFIED | DATE RECERTIFIED | STATUS/EXP. DATE |
| THIRD SPECIALTY BOARD (ABMS) | DATE CERTIFIED | DATE RECERTIFIED | STATUS/EXP. DATE |

DIRECTORY INFORMATION

Check whether the specialty and/or subspecialty(ies) listed above are practiced at each location. Indicate if each specialty is to be noted in the directory. **DISCLAIMER: Use of information may vary by healthcare organization**

| Primary Location | Second Location | Third Location | Fourth Location |
|--|--|--|--|
| <input type="checkbox"/> Specialty | <input type="checkbox"/> Specialty | <input type="checkbox"/> Specialty | <input type="checkbox"/> Specialty |
| <input type="checkbox"/> Directory | <input type="checkbox"/> Directory | <input type="checkbox"/> Directory | <input type="checkbox"/> Directory |
| <input type="checkbox"/> Sub-specialty | <input type="checkbox"/> Sub-specialty | <input type="checkbox"/> Sub-specialty | <input type="checkbox"/> Sub-specialty |
| <input type="checkbox"/> Directory | <input type="checkbox"/> Directory | <input type="checkbox"/> Directory | <input type="checkbox"/> Directory |
| <input type="checkbox"/> Sub-specialty | <input type="checkbox"/> Sub-specialty | <input type="checkbox"/> Sub-specialty | <input type="checkbox"/> Sub-specialty |
| <input type="checkbox"/> Directory | <input type="checkbox"/> Directory | <input type="checkbox"/> Directory | <input type="checkbox"/> Directory |

IF DIFFERENT FROM PRACTICE LOCATIONS:

| | | |
|--------------|------------|--------|
| PHONE NUMBER | FAX NUMBER | E-MAIL |
|--------------|------------|--------|

PHO / IPA AFFILIATIONS*

List any other PHO's, IPA's, which you participate in and dates of participation: _____

** The intent of this section is to identify any contractual arrangements the physicians have that are in direct conflict with the Plan.*

CURRENT HOSPITAL AFFILIATION

List the hospital to which you primarily admit your patients: _____

List in **chronological** order from oldest to most current all hospitals at which you currently have privileges:

| HOSPITAL | LOCATION/ADDRESS | TYPE OF PRIVILEGES | EFFECTIVE DATE MO/YR |
|----------|------------------|--------------------|-------------------------|
| | | | |
| | | | |
| | | | |
| | | | |

IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHO ADMITS FOR YOU AND TO WHAT HOSPITAL? PLEASE LIST PROVIDER'S NAME, SPECIALTY AND HOSPITAL.

EDUCATION

IF ADDITIONAL TRAINING HAS BEEN COMPLETED, PLEASE ATTACH ON A SEPARATE FORM.

MEDICAL/PROFESSIONAL SCHOOL:

| | | |
|------|-------|-----|
| CITY | STATE | ZIP |
|------|-------|-----|

| | | |
|--------|--------------------|--|
| DEGREE | YEAR OF GRADUATION | DATES ATTENDED (MO/YR) From To |
|--------|--------------------|--|

| | |
|------------------------------|------------------|
| INTERNSHIP: INSTITUTION NAME | TYPE OF TRAINING |
|------------------------------|------------------|

| | |
|------|-------|
| CITY | STATE |
|------|-------|

| | | |
|------------------------|---|--|
| UNIVERSITY AFFILIATION | COMPLETED <input type="checkbox"/> YES <input type="checkbox"/> NO | DATES ATTENDED (MO/YR) From To |
|------------------------|---|--|

| | | |
|-----------------------------|-------------------|--|
| RESIDENCY: INSTITUTION NAME | TYPE OF RESIDENCY | <input type="checkbox"/> Clinical <input type="checkbox"/> Research |
|-----------------------------|-------------------|--|

| | | |
|------|-------|--|
| CITY | STATE | DATES ATTENDED (MO/YR) From To |
|------|-------|--|

| | |
|------------------------|---|
| UNIVERSITY AFFILIATION | COMPLETED <input type="checkbox"/> YES <input type="checkbox"/> NO |
|------------------------|---|

| | | |
|-----------------------------|-------------------|--|
| RESIDENCY: INSTITUTION NAME | TYPE OF RESIDENCY | <input type="checkbox"/> Clinical <input type="checkbox"/> Research |
|-----------------------------|-------------------|--|

| | | |
|------|-------|--|
| CITY | STATE | DATES ATTENDED (MO/YR) From To |
|------|-------|--|

| | |
|------------------------|---|
| UNIVERSITY AFFILIATION | COMPLETED <input type="checkbox"/> YES <input type="checkbox"/> NO |
|------------------------|---|

| | | |
|------------------------------|-----------------|--|
| FELLOWSHIP: INSTITUTION NAME | SPECIALTY FIELD | DATES ATTENDED (MO/YR) From To |
|------------------------------|-----------------|--|

| | | |
|------|-------|---|
| CITY | STATE | COMPLETED <input type="checkbox"/> YES <input type="checkbox"/> NO |
|------|-------|---|

| | | |
|--|--------------------|--|
| | TYPE OF FELLOWSHIP | <input type="checkbox"/> Clinical <input type="checkbox"/> Research |
|--|--------------------|--|

| | | |
|------------------------------|---------------------|--|
| FELLOWSHIP: INSTITUTION NAME | SUBSPECIALTY FIELDS | DATES ATTENDED (MO/YR) From To |
|------------------------------|---------------------|--|

| | | |
|------|-------|---|
| CITY | STATE | COMPLETED <input type="checkbox"/> YES <input type="checkbox"/> NO |
|------|-------|---|

| | | |
|--|--------------------|--|
| | TYPE OF FELLOWSHIP | <input type="checkbox"/> Clinical <input type="checkbox"/> Research |
|--|--------------------|--|

WORK HISTORY

Using the following codes, please list in **chronological order** from oldest to most current your work history from the time you completed your medical training to the present. **It is very important that you use the month and year for each entity listed.**
Work history is critical. Failure to provide this information may delay your credentialing.

CODE:

C = Clinic/Group **S** = Solo Practice **A** = Academic (Paid Teaching Appointments) **H** = Civilian Hospital Medical Staff Appointment
M = Military Service (Including Hospital Staff Appointments) **O** = Other

| CODE | NAME AND ADDRESS OF ENTITY | DATE (From MO/YR to MO/YR) |
|-------|----------------------------|----------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

In the following section, please explain any gaps of two months or more in your education, post-graduate training or work history:

PROFESSIONAL LICENSES

| PROFESSIONAL LICENSES | LICENSE NUMBER | DATE OBTAINED | EXPIRATION DATE |
|--------------------------|----------------|---------------|-----------------|
| STATE LICENSE | | | |
| FEDERAL DEA REG NUMBER | | | |
| STATE CDS LICENSE NUMBER | | | |
| CLIA CERTIFICATE | | | |

Are laboratory testing procedures (as covered by the Clinical Improvement Act – CLIA) currently being performed at your office site where members are seen?

Yes No **If yes, a current copy of your CLIA Registration must accompany this application.**

FOR DENTISTS ONLY - Do you perform any procedures in the office setting utilizing conscious sedation or any anesthesia (other than oral analgesic?)

Yes No **If yes, a copy of your Anesthesia Permit must accompany this application.**

Have you been or are you currently licensed in any other state? If YES, please complete the following:

| | | | |
|----------------|-------|---------------|-----------------|
| LICENSE NUMBER | STATE | DATE OBTAINED | EXPIRATION DATE |
| LICENSE NUMBER | STATE | DATE OBTAINED | EXPIRATION DATE |
| LICENSE NUMBER | STATE | DATE OBTAINED | EXPIRATION DATE |

(Please attach a copy of all licenses listed above and additional ones in other states not listed.)

REFERENCES

**List, as professional references, three or more peers (Physicians of the same or similar specialty) who are familiar with your work effort and skills during the past two years.
(References should not be relatives or current partners.)**

| | | |
|----------------|-----------|--------------|
| NAME | SPECIALTY | PHONE NUMBER |
| STREET ADDRESS | CITY | STATE ZIP |
| NAME | SPECIALTY | PHONE NUMBER |
| STREET ADDRESS | CITY | STATE ZIP |
| NAME | SPECIALTY | PHONE NUMBER |
| STREET ADDRESS | CITY | STATE ZIP |

PROFESSIONAL LIABILITY INSURANCE COVERAGE

| | |
|--|--|
| NAME OF CARRIER | POLICY NUMBER |
| ADDRESS AND PHONE NUMBER OF CARRIER | |
| AMOUNTS PER OCCURRENCE/AGGREGATE | DATES OF COVERAGE |
| Do you participate in the Louisiana Patients' Compensation Fund? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Has current liability insurance carrier required exclusion of any procedures from insurance coverage? (If yes, attach explanation) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Are you self-insured in accordance with the Louisiana Medical Malpractice Act? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Please attach a copy of the current Certificates of Insurance. | |

GENERAL QUESTIONS

Please check the appropriate response to the following questions:
If you answered YES to any of the questions below, please attach a full explanation on a separate page.

| | YES | NO | N/A |
|--|--------------------------|--------------------------|--------------------------|
| 1. Has any disciplinary action ever been instituted against your license to practice in your profession in any state or country, or is any such action currently pending against you? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has any disciplinary action ever been instituted against your DEA registration or CDS license, or have you voluntarily surrendered or limited your registration, or is any such action pending? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been convicted of, or pleaded nolo contendere to, or are you currently under investigation for federal or state felony or other criminal charge or have you ever served a prison sentence? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have your clinical privileges at any hospital or healthcare institutions been voluntarily or involuntarily revoked, not renewed, or subjected to probationary or other disciplinary conditions, or has any proceeding been instituted or recommended by a hospital administration, medical staff committee or governing board? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever received a sanction from any regulatory agency (e.g., CLIA, OSHA, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you engaged in the illegal use of drugs within the past two years? "Illegal use of drugs" means the use of controlled substances obtained illegally, not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you currently have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you, your business entity or any family member have an ownership greater than 5% in any medical enterprise or business? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are you presently a named defendant in a pending professional liability lawsuit? If YES, please enter the number of cases _____ and attach a full explanation of each. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. During the past 5 years has any adverse medical review panel opinion been rendered, has any settlement or judgment been made, or has any payment been made by you or on your behalf in a professional liability action or potential action? If YES, please enter the number of cases _____ and attach a full explanation of each. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

REQUIRED ATTACHMENTS

- ✓ State Licenses including current licenses held in other states, State CDS license and Federal DEA Registration
- ✓ Curriculum Vitae
- ✓ Certificate(s) of Professional Liability Insurance
- ✓ History of Malpractice suits in past 5 years, regardless of whether judgments or settlements paid.
- ✓ Explanation of any "Yes" Answer(s) from General Questions Section on page 8.
- ✓ Current Employer Identification Number (EIN) **and** W-9 Form or Federal Tax Deposit Coupon
- ✓ Education Certificate for Foreign Medical Graduates (ECFMG) (If applicable)
- ✓ Health Plan Agreement (If applicable)

STATEMENT TO APPLICANTS

All providers applying for network participation have the right to review the credentialing application and supporting documents. Exceptions may vary as prohibited by law or health plan policy.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have the opportunity to submit additional information to correct the discrepancy or provide clarification that might positively impact the credentialing decision.

According to La. R.S. 22:1009 (A) (8) an adverse medical review panel opinion is included in the type of information a health plan may require you to submit on a credentialing or re-credentialing application.

According to La. R.S. 22:1009, a health insurance issuer is required to complete the credentialing process within 90 days from the date of receipt of all information needed. The issuer is required to inform you within 30 days of receipt all defects and reasons known at the time in the event an application is deemed to be not correctly completed. The issuer is also required to inform you in the event that any needed verification or verification supporting statement has not been received from a third party within 60 days of the date of such a request.

PROVIDER STATEMENT TO RELEASE INFORMATION

All information and documentation submitted by me in this application is correct and complete to my best knowledge and belief.

I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for network participation.

I consent to the release of all information that may be relevant to an evaluation of my credentials, including information about disciplinary actions or other confidential or privileged information, to Plan or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which I am Plan provider. I release Plan, its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials. Plan is defined as the Health Plan that is requesting the credentialing information.

X

NAME (Please Print)

SIGNATURE

ORIGINAL ATTESTATION DATE

SECOND ATTESTATION DATE

THIRD ATTESTATION DATE

Plan accreditation guidelines may require this application signature date to be no more than 180 days old at the time of credentialing.