

# 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

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### 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_____

## 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** \_\_\_\_\_