

*Standardized
Credentialing
Application*

*To Be Used By Health Care Organizations
Licensed in the State of Kansas*

COMPLETE EACH SECTION AS THOROUGHLY AS POSSIBLE. PLEASE TYPE OR PRINT.

I. GENERAL INFORMATION

1. _____
Name (Last, First, MI, Degree/Prof. Designation-M.D./D.O./PH.D./M.S.W./D.C./D.P.M./D.D.S./D.M.D./A.P.N./P.A./Other)

2. _____
Home Address/Street

3. _____
City/County/State/ZIP

4. _____
E-Mail Address

5. _____
Other Names You May Have Used (i.e. Maiden, etc.)

6. _____
Date of Birth (Month/Day/Year)

7. _____
Place of Birth

8. _____
Social Security Number

9. Are You a U.S. Citizen? Yes _____ No _____

10. Sex: Male _____ Female _____

If Not a Citizen of the U.S., indicate the Current Status Of Your VISA:



II. OFFICE/PRACTICE INFORMATION

If More Than Two Offices, Check Here ___ and Attach a Copy of Page 3, Completing Questions 22-40 for Each Office.

1. Participation Status For Which You Are Applying: (Indicate Specialty)

Primary Care: _____ Specialty: _____ Subspecialty: _____ Both: _____ Patient Ages: _____

2. _____
PRIMARY OFFICE Address/Street/Building/Suite

3. _____
City/County/State/ZIP (Should this practice location be listed in provider directory? Yes _____ No _____)

4. _____
Tax ID # Owner/Corporate Name as Appears on SS4 or W-9 Form (or Full Legal Name)

5. _____
Business Name or Name By Which the Provider Group is Generally Known

6. _____ Office Phone Number
7. _____ After Hours/Emergency Number or Procedure

8. _____ Office Fax Number
9. _____ Office E-Mail Address

10. _____ Office Manager
11. _____ Federal Tax ID#

12. _____
Billing Address/Street (If Different From Above)

13. _____
Billing City/State/ZIP

14. List Routine Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday

15. Evening Hours Yes _____ No _____ If Yes, List Hours After 5:00 P.M.

Monday	Tuesday	Wednesday	Thursday	Friday

16. Weekend Hours: Yes _____ No _____

Saturday	Sunday

17.(a) Lab Service in Your Office:

Yes _____ No _____

17.(b) _____

If Yes, specify Waived, Physician Performed Microscopy, Moderately Complex, Highly Complex

18. Please check all of the following that you perform IN THIS OFFICE:

EKG _____ Office gynecology (Routine Pelvic/PAP) _____ Drawing Blood _____ Age appropriate immunizations _____
 X-Rays _____ Minor Surgery _____ Tympanometry/audiometry screening _____ Flexible sigmoidoscopy _____
 Laceration Repair _____ Pulmonary Function Studies _____ Asthma Treatment _____ Allergy Skin Testing _____
 Osteopathic manipulation _____ IV Hydration/treatment _____ Other (please specify) _____

19. (a) Languages Spoken (other than English): _____
(Health Care Provider)

(b) Are Interpreters Available? Yes _____ No _____
(Staff)

20. Does Your Office: (CIRCLE ONE)

- | | |
|--|--|
| (a) Have 24-hr. Phone Coverage Service? Y N | (b) Qualify as a Minority Business Enterprise? Y N |
| (c) Have Capability for Electronic Billing? Y N | (d) Provide Child Care Services for Patients? Y N |
| (e) Meet ADA Accessibility Standards? Y N | (f) Have Public Transportation Accessibility? Y N |
| (g) Collaborate With an Advanced Nurse Practitioner or Physician Assistant (P.A.)? Y N | |

If Yes, Provide a Copy of Appropriate Collaborative Practice or P.A. Agreement(s) & the name(s) of the individual(s).

(h) Type of Practice: Solo Single Specialty Group Multispecialty Group Other

If Group Practice, Attach a List of Other Members of Your Practice, Their Specialties, and Coverage Arrangements.

21. Do You Currently: (CIRCLE ONE)

- | | |
|--|---|
| (a) Accept New Patients Into Practice Y N | (b) Accept New Patients By Physician Referral Only? Y N |
| (c) Have Medicare Certification? Y N | (d) Accept Medicare Assignment? Y N |
| (e) Provide Inpatient Care? Y N | (f) Accept Medicaid Assignment? Y N |

II. OFFICE/PRACTICE INFORMATION (cont'd.)

Attach Additional Copies As Necessary

22. _____
SECONDARY OFFICE Address/Street/Building/Suite

23. _____
City/County/State/ZIP (Should this practice location be listed in provider directory? Yes _____ No _____)

24. _____
Tax ID # Owner/Corporate Name as Appears on SS4 or W-9 Form (or Full Legal Name)

25. _____
Business Name or Name By Which the Provider Group is Generally Known

26. _____ Office Phone Number 27. _____ After Hours/Emergency Number or Procedure

28. _____ Office Fax Number 29. _____ Office E-Mail Address

30. _____ Office Manager 31. _____ Federal Tax ID#

32. _____
Billing Address/Street (If Different From Above)

33. _____
Billing City/State/ZIP

34. List Routine Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday

35. Evening Hours Yes _____ No _____ If Yes, List Hours After 5:00 P.M.

Monday	Tuesday	Wednesday	Thursday	Friday

36. Weekend Hours: Yes _____ No _____

Saturday	Sunday

37.(a) Lab Service in Your Office:
Yes _____ No _____

37.(b) _____
If Yes, specify Waived, Physician Performed Microscopy,
Moderately Complex, Highly Complex

38. Please check all of the following that you perform IN THIS OFFICE:

EKG _____	Office Gynecology (Routine Pelvic/PAP) _____	Drawing Blood _____	Age appropriate immunizations _____
X-Rays _____	minor Surgery _____	Tympanometry/audiometry screening _____	Flexible sigmoidoscopy _____
Laceration Repair _____	Pulmonary Function Studies _____	Asthma Treatment _____	Allergy Skin Testing _____
Osteopathic Manipulation _____	IV Hydration/treatment _____	Other (please specify) _____	

39. (a) Language Spoken (other than English): _____

(b) Are Interpreters Available? Yes _____ No _____

(Health Care Provider)

(Staff)

40. Does Your Office: (CIRCLE ONE)

- | | | | | | |
|--|---|---|--|---|---|
| (a) Have 24-hr. Phone Coverage Service? | Y | N | (b) Qualify as a Minority Business Enterprise? | Y | N |
| (c) Have Capability for Electronic Billing? | Y | N | (d) Provide Child Care Services for Patients? | Y | N |
| (e) Meet ADA Accessibility Standards? | Y | N | (f) Have Public Transportation Accessibility? | Y | N |
| (g) Collaborate With an Advanced Nurse Practitioner or Physician Assistant (P.A.)? | | | | Y | N |

If Yes, Provide a Copy of Appropriate Collaborative Practice or P.A. Agreement(s) & the name(s) of the individual(s).

(h) Type of Practice: Solo Single Specialty Group Multispecialty Group Other

If Group Practice, Attach a List of Other Members of Your Practice, Their Specialties, and Coverage Arrangements.

III(A). PROFESSIONAL EDUCATION

List All Medical Schools/Institutions Attended

Please Explain Any 30 Day or Greater Gap In Your Training. Attach Additional Sheets If Necessary.

- 1. _____
Medical/Professional School Name
- 2. _____
Address/Street
- 3. _____
City/State/Zip/Country
- 4. From: _____ To: _____
Dated Attended (month/year)
- 5. _____
Degree(s) Awarded
- 6. If You Are a Graduate of a Foreign Medical School, Are You Certified by the Education Council for Foreign Medical Graduates (ECFMG)? If Yes, Please Enclose a Copy of Your Certificate With This Application.
Yes _____ No _____

III(B). POSTGRADUATE TRAINING: INTERNSHIP

- 1. _____
Institution Name
- 2. _____
Address/Street
- 3. _____
City/State/Zip
- 4. From: _____ To: _____
Dated Attended (month/year)
- 5. _____
Department Chair/Program Director
- 6. _____
Type of Internship (Rotating/Straight). If Straight, Please List Specialty.

III(C). POSTGRADUATE TRAINING: FIRST RESIDENCY

- 1. _____
Institution Name
- 2. _____
Address/Street
- 3. _____
City/State/Zip
- 4. From: _____ To: _____
Dated Attended (month/year)
- 5. _____
Department Chair/Program Director
- 6. _____
Type of Residency

III(D). POSTGRADUATE TRAINING: SECOND RESIDENCY OR FELLOWSHIP

- 1. _____
Institution Name
- 2. _____
Address/Street
- 3. _____
City/State/Zip
- 4. From: _____ To: _____
Dated Attended (month/year)
- 5. _____
Department Chair/Program Director
- 6. _____
Type of Residency/Fellowship

III(E). POSTGRADUATE TRAINING: FELLOWSHIP/OTHER

- 1. _____
Institution Name
- 2. _____
Address/Street
- 3. _____
City/State/Zip
- 4. From: _____ To: _____
Dated Attended (month/year)
- 5. _____
Department Chair/Program Director
- 6. _____
Type of Fellowship/Other Explanation

IV(A). HOSPITAL AFFILIATIONS: PRIMARY

- 1. _____
CURRENT PRIMARY HOSPITAL NAME
- 2. _____
Address/Street
- 3. _____
City/State/Zip

Status of Privileges Key

- | | | | | |
|-------------------------------|--------------|-----------------|------------------|-----------------|
| 1. Active | 4. Associate | 7. Courtesy | 10. Senior Staff | 13. Consulting |
| 2. Courtesy Provisional Staff | 5. Visiting | 8. Admitting | 11. Provisional | 14. Pending |
| 3. Active Provisional Staff | 6. Temporary | 9. Co-Admitting | 12. Suspended | 15. Other _____ |

- 4. _____
Status of Privileges (INDICATE BY USING KEY)
If Co-Admitting Status, List Other Admitting Physician(s) _____
- 5. From: _____ To: _____
Dates Affiliated (month/year)
- 6. Any past or present restriction of privileges? Yes _____ No _____ (If Yes, explain) _____

IV(B). HOSPITAL AFFILIATIONS: OTHER

List All Other Hospitals At Which You Have Or Have Had Privileges.

- 1a. _____
HOSPITAL NAME
- 2a. _____
Address/Street
- 3a. _____
City/State/Zip
- 4a. _____
Status of Privileges (INDICATE BY USING KEY)
If Co-Admitting Status, List Other Admitting Physician(s) _____
- 5a. From: _____ To: _____
Dates Affiliated (month/year)
- 6a. Any past or present restriction of privileges? Yes _____ No _____ (If Yes, explain) _____

- 1b. _____
HOSPITAL NAME
- 2b. _____
Address/Street
- 3b. _____
City/State/Zip
- 4b. _____
Status of Privileges (INDICATE BY USING KEY)
If Co-Admitting Status, List Other Admitting Physician(s) _____
- 5b. From: _____ To: _____
Dates Affiliated (month/year)
- 6b. Any past or present restriction of privileges? Yes _____ No _____ (If Yes, explain) _____

IV(B). HOSPITAL AFFILIATIONS: OTHER (cont'd.)

1c. _____
HOSPITAL NAME

2c. _____
Address/Street

3c. _____
City/State/Zip

4c. _____ 5c. From: _____ To: _____
Status of Privileges (INDICATE BY USING KEY) Dates Affiliated (month/year)
If Co-Admitting Status, List Other Admitting Physician(s) _____

6c. Any past or present restriction of privileges? Yes _____ No _____ (If Yes, explain) _____

IV(C). OTHER PRACTICE AFFILIATIONS (e.g. HMOs, PPOs, IPAs, PHOs, etc.)

Attach Additional Pages If Necessary

1a. _____
Institution/Organization Name

2a. _____
Address/Street

3a. _____
City/State/Zip

4a. _____ 5a. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1b. _____
Institution/Organization Name

2b. _____
Address/Street

3b. _____
City/State/Zip

4b. _____ 5b. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1c. _____
Institution/Organization Name

2c. _____
Address/Street

3c. _____
City/State/Zip

4c. _____ 5c. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1d. _____
Institution/Organization Name

2d. _____
Address/Street

3d. _____
City/State/Zip

4d. _____ 5d. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1e. _____
Institution/Organization Name

2e. _____
Address/Street

3e. _____
City/State/Zip

4e. _____ 5e. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

V. PRACTICE SPECIALTY

Attach Copy of Certificate(s). If Not Applicable to Your Profession/Specialty, Complete With N/A.

1. _____ 2. _____
 PRIMARY SPECIALTY/BOARD CERTIFICATION Certification Number

3. _____ 4. _____
 Name of Board Date of Certification

5. _____ 6. _____
 Expiration Date Date of Recertification (If Applicable)

7. _____
 If Not Certified, Indicate Current Status and/or Date Intending to Sit For Boards

8. _____ 9. _____
 SECONDARY SPECIALTY/BOARD CERTIFICATION Certification Number

10. _____ 11. _____
 Name of Board Date of Certification

12. _____ 13. _____
 Expiration Date Date of Recertification (If Applicable)

14. _____
 If Not Certified, Indicate Current Status and/or Date Intending to Sit For Boards

VI. WORK/PRACTICE HISTORY

List Chronologically All Employment, Including Self Employment, For the Last Ten (10) Years, For Any Gap in Chronology, Explain On a Separate Sheet. Leave no Time Period Unaccounted For Within the Last Ten (10) Years, Excluding Previously Stated Training. Attach Additional Sheets If Necessary.

1a. _____
 NAME OF PREVIOUS PRACTICE

2a. _____
 Address/Street

3a. _____ 4a. _____
 City/State/Zip Phone Number

5a. _____ 6a. From: _____ To: _____
 Title or Professional Occupation Dates of Employment (month/year)

1b. _____
 NAME OF PREVIOUS PRACTICE

2b. _____
 Address/Street

3b. _____ 4b. _____
 City/State/Zip Phone Number

5b. _____ 6b. From: _____ To: _____
 Title or Professional Occupation Dates of Employment (month/year)

1c. _____
 NAME OF PREVIOUS PRACTICE

2c. _____
 Address/Street

3c. _____ 4c. _____
 City/State/Zip Phone Number

5c. _____ 6c. From: _____ To: _____
 Title or Professional Occupation Dates of Employment (month/year)

1d. _____
 NAME OF PREVIOUS PRACTICE

2d. _____
 Address/Street

3d. _____ 4d. _____
 City/State/Zip Phone Number

5d. _____ 6d. From: _____ To: _____
 Title or Professional Occupation Dates of Employment (month/year)

VII. PROFESSIONAL CERTIFICATES/LICENSE NUMBERS

List All States in Which You Have Held, or Currently Hold, a License to Practice Your Profession. Please Attach Copies.

- 1. _____ 2. _____
License/Certification/Registration Number; Licensing State Expiration Date
- 3. _____ 4. _____
Other License/Certification/Registration Number; Licensing State Expiration Date
- 5. _____ 6. _____
Other License/Certification/Registration Number; Licensing State Expiration Date
- 7. _____ 8. _____
Federal Drug Enforcement Agency (DEA) Number(s) Expiration Date(s)
- 9. _____ 10. _____
CDS Certification Number (BNDD Number for Missouri) Expiration Date
- 11. _____ 12. _____
Medicare/Unique Provider ID Number (UPIN) National Provider ID Number (NPI)
- 13. _____ 14. _____
State Medicaid Number(s); Licensing State ECFMG Number

VIII. PROFESSIONAL LIABILITY INSURANCE INFORMATION

Please Attach a Copy of Your Current Certificate(s) or Declaration(s) of Insurance, Including HCSF for Kansas Practitioners.

- 1a. _____
CURRENT CARRIER NAME
- 2a. _____
Address/Street
- 3a. _____ 4a. _____
City/State/Zip Phone Number
- 5a. _____ 6a. From: _____ To: _____
Policy Number Dates of Coverage (month/year)
- 7. Indicate Coverage Type: Claims Based _____ Occurrence Based _____
- 8. Policy Limits: Per Occurrence \$ _____ Aggregate \$ _____

Prior Carriers Within the Last Ten (10) Years. Attach Additional Sheets If Necessary.

- 1b. _____
PREVIOUS CARRIER NAME
- 2b. _____
Address/Street
- 3b. _____ 4b. _____
City/State/Zip Phone Number
- 5b. _____ 6b. From: _____ To: _____
Policy Number Dates of Coverage (month/year)

- 1c. _____
PREVIOUS CARRIER NAME
- 2c. _____
Address/Street
- 3c. _____ 4c. _____
City/State/Zip Phone Number
- 5c. _____ 6c. From: _____ To: _____
Policy Number Dates of Coverage (month/year)

- 1d. _____
PREVIOUS CARRIER NAME
- 2d. _____
Address/Street
- 3d. _____ 4d. _____
City/State/Zip Phone Number
- 5d. _____ 6d. From: _____ To: _____
Policy Number Dates of Coverage (month/year)

IX. MALPRACTICE CLAIMS HISTORY

Are You Currently or Have You Within The Last Ten (10) Years Been Involved in a Malpractice Suit or Other Suit or Claim In Which Your Care and Treatment of a Patient Was At Issue, Including Pending or Dismissed Cases or Claims Settled Before or During Trial, or Settled to Avoid a Lawsuit? Yes _____ No _____ If Yes, Answer the Following Questions For EACH Such Claim. Duplicate This Page As Necessary.

1. _____ 2. _____
Patient Name Plaintiff Name, If Other Than Patient
3. _____ 4. _____
Your Involvement in the Case (Attending, Consulting, Etc.) Date of Occurrence (month/day/year)
5. _____ 6. _____
Your Status in the Case (Primary Defendant, Co-Defendant, Etc.) Date Claim Was Filed (month/day/year)
7. _____
Professional Liability Insurance Carrier Involved
8. _____ 9. _____
Carrier's Phone Number Policy Number
10. _____
Additional Defendants
11. Describe the Allegations Against You: _____

12. Describe the Alleged Injury to the Patient: _____

13. Claimant/Plaintiff Filed Suit In Court? Yes _____ No _____
14. _____ 15. _____ 16. _____
State Court Case Number State County/Parish
17. _____ 18. _____
Federal Court (U.S. District Court) Case Number District
19. Present Status of Claim: Open _____ Closed _____ Pending _____

If PENDING, DO NOT Complete the Rest of This Page EXCEPT For Signature and Date.

20. If Closed, Indicate the Method of Resolution:

- | | |
|-----------------------------------|-------------|
| _____ Dismissed | Date: _____ |
| _____ Settled (With Prejudice) | Date: _____ |
| _____ Settled (Without Prejudice) | Date: _____ |
| _____ Judgment for Defendant(s) | Date: _____ |
| _____ Judgment for Plaintiff(s) | Date: _____ |
| _____ Other | Date: _____ |

21. _____
Settlement Amount Paid On Your Behalf (If Any)

22. Additional Information/Explanation:

(e.g. Patient Condition and Diagnosis At Time of Incident, Description of Treatment, Subsequent Patient Outcome, Etc.)

Signature

Date (month/day/year)

X. ADDITIONAL INFORMATION

Please Answer the Following Questions By Circling "Y" (Yes) or "N" (No).

Please Provide an Explanation For Any "Yes" Responses on a Separate Page.

- | | | | |
|--|---|---|-----|
| 1. Have any of your board certifications ever been suspended, revoked, not renewed, denied renewal, or voluntarily or involuntarily surrendered? | Y | N | N/A |
| 2. Have you ever been named as a defendant in any criminal case? | Y | N | N/A |
| 3. Have you ever been convicted, pled guilty, or pled nolo contendere to any felony, any offense reasonably related to your qualifications, functions, or duties as a medical professional, or any offense an essential element of which is fraud, dishonesty, or an act of violence? | Y | N | N/A |
| 4. Has your malpractice insurance ever been canceled, suspended, not renewed, special rated, or restricted by the exclusion of any specific procedures from coverage? | Y | N | N/A |
| 5. Have you ever been denied participation, suspended from, or denied renewal from the Medicare or Medicaid program, or had participation status modified? | Y | N | N/A |
| 6. Has your authority to practice in any state been suspended, revoked, voluntarily or involuntarily surrendered, been subject to a consent order or stipulation, not renewed, denial renewal, or has probation ever been invoked? | Y | N | N/A |
| 7. Has your federal or state controlled substance license ever been suspended, revoked, voluntarily or involuntarily surrendered, restricted, not renewed, denied renewal, or has probation ever been invoked? | Y | N | N/A |
| 8. Have your privileges at any hospital or other health care setting ever been suspended, revoked, voluntarily or involuntarily surrendered, reduced, restricted, not renewed, denied renewal, or has probation ever been invoked? | Y | N | N/A |
| 9. Within the last five years, have you ever been a participating provider of another HMO, PPO, PHO, or MSO, etc., with which you are not affiliated at this time? | Y | N | N/A |
| 10. Have you ever received sanctions from a regulatory agency (e.g., CLIA, OSHA, etc.) | Y | N | N/A |
| 11. Has any information on you ever been reported to the National Practitioner Data Bank? | Y | N | N/A |
| 12. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances which are obtained illegally, as well as use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner). | Y | N | N/A |
| 13. Within the last five years, have you ever been reprimanded or disciplined in any manner by any state licensing authority or other professional board or peer review committee for conduct related to the use of alcohol or the use of any drug? | Y | N | N/A |
| 14. Have you discontinued practice for any reason (other than for routine vacation) for one month (30 days) or more? | Y | N | N/A |
| 15. Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital ambulatory surgery center, or other business dealing with the provision of ancillary health services, equipment or suppliers? | Y | N | N/A |

If so, please provide the following information, attaching additional copies as necessary:

- | | |
|--|---|
| (a) _____
Organization Name | (b) _____
Type of Organization |
| (c) _____
Address/Street | |
| (d) _____
City/State/Zip | |
| (e) _____
Phone Number | (f) _____
Federal Tax ID# |
| (g) _____
Percent of Business Owned/Invested by Applicant | (h) _____
Nature of Business Interest (owner, partner, investor) |

XI. ADDITIONAL DOCUMENTATION/ATTACHMENTS

Please Attach Copies of the Following Documents (if specifically requested):

1. W9 form for each entity the applicant expects will receive payments or reimbursements.
2. Collaborative practice and/or physician assistant agreement(s).
3. A list of other members of your practice, their specialties, and coverage arrangements.
4. Education Council for Foreign Medical Graduates (ECFMG) certificate.
5. Board certification certificate(s).
6. Copies of professional diplomas, internship, residency, and fellowship certificates, as applicable.
7. Current state licenses (for all states practicing).
8. Federal DEA certificate.
9. State controlled substance certificate(s) for all states practicing (i.e. BNDD for Missouri).
10. Current certificate(s) or declaration(s) of insurance, including HCSF for Kansas practitioners.
11. Curriculum Vitae (if required by health carrier).
12. Professional references (if required by health carrier).
13. Signed copy of an affirmation and release of information document (attestation page) as stipulated by the health carrier to which the applicant is seeking to become a participating provider.
14. Attach a copy of all postgraduate (CME) activities which you have attended and for which you have received credit in the past 2 years.
15. A list of societies of which you are currently a member.
16. United States Military discharge papers/DD214 if discharged from U.S. Military, or status if currently serving.
17. CLIA waiver number and identification number (or copy of certificate).
18. Provide a statement regarding the reasons for any inability to perform the essential functions, with or without reasonable accommodation, for the practice in which you are seeking to become a participating provider.