Credentialing Application

Name____
Last First Middle Initial Degree-(M.D., D.O. etc.)

Practice Address ____
Street City State Zip

Telephone # (______)_____________________ Fax # (__)____________________________________

Name of Associates/Group____

After Hours On-Call Coverage____

SS#____________________________________ DOB _______________________________________

Specialty ____ Board Certified? Yes _____ No _____

DEA # _________________ Expiration Date _______________ Federal Tax # ____________________

Kentucky Medical License # ___________ **UPIN #** ___________

NPI (Individual) _ _ _ _ _ _ _ _ _ _ **NPI (Group)** _ _ _ _ _ _ _ _ _ _ _ **Taxonomy** _ _ _ _ _ _ _ _ _ _

Malpractice Insurance: (Attach proof of current insurance coverage)

Amount $_____________ Company __________________________ Expiration Date _________

Work History:

____
Current Practice Name Address Month/Year to Month/Year

____
Practice Name Address Month/Year to Month/Year

____
Practice Name Address Month/Year to Month/Year

Medical Education:

____
Medical School Address Degree Year Graduated

____
Internship Address Specialty From/To Dates

____
Residency Address Specialty From/To Dates

Credentialing Application
Part 2

Current Hospital Affiliation:

Name ____

Address ____
Street City State Zip

Medical Staff Status ________________ (Active, Courtesy, Consulting, Other)

Admitting Privileges: Yes or No (circle one)

Name ____

Address ____
Street City State Zip

Medical Staff Status ________________ (Active, Courtesy, Consulting, Other)

Admitting Privileges: Yes or No (circle one)

Billing Information

Please complete if the information is different than the office address

Check Made Payable to: ____

Address ____

City _________________________ State _____ Zip Code__________

Contact ___________________ Phone __________________

Credentialing Information

Contact ________________ Company Name (if different than office) ________________________________

Address ____

City _________________________________ State __________ Zip Code ________________________________

Phone __________________ Fax __________________ E-Mail Address _____________________________

Credentialing Application
Part 3

	YES	NO
Has your DEA license ever been limited or suspended?	____	____
Has your medical license every been limited or suspended?	____	____
Have you ever been censored or excluded by any third party or payor including Medicaid or Medicare?	____	____
Have you ever been refused hospital privileges or have your hospital privileges ever been limited, suspended or revoked?	____	____
Do you have any impairments or conditions which make you unable To perform the essential functions in your area of practice, without a direct threat to health an safety of others?	____	____
Are you currently using illegal drugs?	____	____
Have you had any malpractice claims during the past five (5) years? If so, give details in writing, **including amount of judgments/settlements**?	____	____
To your knowledge, have you ever been reported to the National Practitioner Data Bank?	____	____
Do you, or any family member own, or have an interest, in any diagnostic testing center, clinical laboratory, radiology service or surgery center, durable medical equipment company, or other health related service entity?	____	____
Have you, or are you presently, been indicted and/or convicted of a felony?	____	____

If the answer to any of the above questions is yes, please give detail in writing.

To the best of my knowledge, the answers to the above statements and questions are accurate. Should there be any change in the information, I agree to notify OMCA within two (2) weeks of the changes.

I further understand, that falsification of the above information could result in automatic termination of my Preferred Provider status with OMCA. I hereby authorize any third party which has information about my qualifications as a physician, to release such information to OMCA upon request.

___________________________________ ____________________

Physician Signature Date

____

Print Name