

OMCA

Credentialing Application

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

SS# _____ DOB _____

Specialty _____ Board Certified? Yes _____ No _____

DEA # _____ Exp. Date _____ Kentucky License # _____ UPIN # _____

Tax ID _____

Medical Education:

Medical School _____ Address _____ Degree _____ Year Graduated _____

Internship _____ Address _____ Specialty _____ From/To Dates _____

Residency _____ Address _____ Specialty _____ From/To Dates _____

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

Current Hospital Affiliation:

Name _____

Address _____
Street City State Zip

Medical Staff Status _____
Active, Courtesy, Consulting

Name _____

Address _____
Street City State Zip

Medical Staff Status _____
Active, Courtesy, Consulting

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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

