ehp STANDARD APPLICATION

This form should be typed or printed in black or blue ink. Please answer all questions completely. If more space is needed, attach additional sheets and reference the question being answered. If a question is not applicable put "N/A". Incomplete applications will delay credentialing. Refer to EHP's credentialing references for additional documentation to 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 ____ Date of Birth ____/ _____/ _________

If not a US Citizen, are you authorized to work in the US? Yes ☐ No ☐ N/A ☐ (Optional) Male ☐ Female ☐ Ethnicity _____________

Primary Office Address

Name of Practice ____ Street Address ____

Suite/Building # _______________ City _______________________ County ____________________ State ______ Zip Code ____________

Phone (_______) __________________ Fax (_________) ___________________ Federal Tax ID of Group ____________________________

Billing Information (Check ☐ if billing address is same as address above. If not please complete below:

Street ____ Suite/Building # ____________ City __________________ State ______ Zip _____
Phone (_______) __________________ Fax (_________) ___________________ Billing Manager Name ______________________________
Claims submitted electronically? Yes ☐ No ☐ Electronic Mail Code _______________________ Claims Paid to: _____________________

Are you applying for affiliation as:

Primary Care ☐ Indicate specialty - Family Practice ☐ General Practice ☐ Internal Medicine ☐ Pediatrics ☐ IM/Pediatrics ☐ Other ☐
If you have a subspecialty, please identify ____

Specialist ☐ Indicate specialty ___________________________________ Subspecialty(ies) _____________________________________

Both (Primary Care and Specialist as completed above) ☐

Non-physician Practitioner ☐ Please specify ____

Medical Licensure and Registration (Attach copy of current license and DEA certificate)

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

 Applicant Name _______________________________________

II. EDUCATION, TRAINING and BOARD CERTIFICATION

Undergraduate / Professional Training (must include month and year)

Institution ______________________ Degree __________ Date of Entry ______________

City ______________ State ________ Country ______________ Graduation Date ______________

Medical School (Attach copy of certificate)

Institution ______________________ Degree __________ Date of Entry ______________

City ______________ State ________ Country ______________ Graduation Date ______________

International Medical Graduates

ECFMG Number ______________________ Issue Date ______________

Internship/ Residency (Attach copy of certificate)

Institution ______________________ Type of Training ______________

City ______________ State ________ Country ______________ Date of Entry ______________

Program completed? Yes ☐ Date ______________ Specialty ______________
No ☐ Explain ______________________

Residency/ Fellowship (Attach copy of certificate)

Institution ______________________ Type of Training ______________

City ______________ State ________ Country ______________ Date of Entry ______________

Program completed? Yes ☐ Date ______________ Specialty ______________
No ☐ Explain ______________________

Additional Residency/ Fellowship (Attach copy of certificate)

Institution ______________________ Type of Training ______________

City ______________ State ________ Country ______________ Date of Entry ______________

Program completed? Yes ☐ Date ______________ Specialty ______________
No ☐ Explain ______________________

Other Experience or Training (such as allied health, public service or military)

Institution ______________________ Type of Training ______________

City ______________ State ________ Country ______________ Date of Attendance ______________

Program completed? Yes ☐ No ☐ Supervised Clinical Hours ______________ Additional Information ______________

Work History (Attach Curriculum Vitae or start with current and list all employment since post graduate training.)

Employer/Practice	Location (City & State)	Dates (inclusive) Month and Year
______________	______________	______________
______________	______________	______________

Board Certification (Attach copy of certificate(s))

Board Certified? Yes ☐ Certifying Board ______________ Certificate # ______________Org Date ___/___/__________
Most Recent Recertification Date _____/____/__________ Expiration Date ___/___/__________
Additional Board? ______________ Certificate # ______________ Org Date ___/___/__________
Most Recent Recertification Date _____/____/__________ Expiration Date ___/___/__________

No ☐ Are you pursuing Board Certification? Yes ☐ When do you plan to take board exam? ______________
No ☐ Explain ______________

 Applicant Name ______________________

III. HOSPITAL PRIVILEGES and PRIMARY OFFICE PRACTICE INFORMATION

Primary Hospital Affiliation - Do you admit/care for patients at hospital? Yes ☐ No ☐ If Yes, Adult ☐ Child ☐ Infant ☐

Hospital Name ______________________ Dates of Affiliation - From _________ to __________
Address ______________________ Staff Category ____________ % of Admissions ______
City ______________________ State _________ Zip Code ______________

Additional Hospital Affiliation

Hospital Name ______________________ Dates of Affiliation - From _________ to __________
Address ______________________ Staff Category ____________ % of Admissions ______
City ______________________ State _________ Zip Code ______________

Additional Hospital Affiliation

Hospital Name ______________________ Dates of Affiliation - From _________ to __________
Address ______________________ Staff Category ____________ % of Admissions ______
City ______________________ State _________ Zip Code ______________

Primary Office Practice - Corporation ☐ Partnership ☐ Solo ☐ Institution ☐ FQHC ☐

Give narrative of practice (type medicine, special interests and procedures performed in office) ______________________

____

Office Hours:
Monday ________ Tuesday ________ Wednesday _________ Thursday _________ Friday _________ Saturday _______ Sunday ___________

Handicap Access? Yes ☐ No ☐ Do you receive vaccines purchased by city/county through public funding? Yes ☐ No ☐ N/A ☐

List all languages other than English (including sign) in which you or staff are fluent:
Language: ______________________ Name of Staff Member ______________________
Language: ______________________ Name of Staff Member ______________________

Other arrangements for translating? ______________________ TDD# ______________________
Do you use a different Tax ID other than the one shown on Page 1 at this practice? Yes ☐ - # ______________________ No ☐
Define any age restrictions or other practice limitations ______________________

____

List HMOs, PPOs, PHOs and other managed care programs in which you participate ______________________

____

List Associates and if a covering practitioner for you at Primary Office Site (attach roster if more space is needed) (Check below if applicable)

Name	Specialty	Cross Coverage?	Office?	Hospital?
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

Do you use other practitioners for 24/7 coverage? Yes ☐ No ☐ If Yes, List below:

Name	Phone number with Area Code

Do you use physician extenders? Yes ☐ No ☐ If Yes, List below with license numbers.

Name	Title/Degree	License Number

 Applicant Name ______________________

IV. ADDITIONAL OFFICE SITES (Check ☐ if there are no additional office sites.)

Photocopy this page and complete for each additional office associated with the applicant's practice.

Name of Practice ______________________________ Street Address ______________________________

Suite/Building # __________ City ______________ County ______________ State _____ Zip Code _________

Phone (______) ____________ Fax (______) ____________ Federal Tax ID of Group ____________________

Billing Information (Check ☐ if billing address is same as address above. If not please complete below:

Street ______________________________ Suite/Building # ________ City ____________ State _____ Zip _____

Phone (______) ____________ Fax (______) ____________ Billing Manager Name ____________________

Claims submitted electronically? Yes ☐ No ☐ Electronic Mail Code ______________ Claims Paid to: ______________

Office Hours

Monday ______ Tuesday ______ Wednesday ______ Thursday ______ Friday ______ Saturday _____ Sunday ________

Handicap Access? Yes ☐ No ☐ Do you receive vaccines purchased by city/county through public funding? Yes ☐ No ☐ N/A ☐

List all languages other than English (including sign) in which you or staff are fluent:

Language: ________________________ Name of Staff Member ______________________________

Language: ________________________ Name of Staff Member ______________________________

Other arrangements for translating? ________________________ TDD# ______________________________

List Associates and if a covering practitioner for you at Additional Office Site (attach roster if more space needed) (Check below if applicable)

Name	Specialty	Cross Coverage?	Office?	Hospital?
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

Do you use **Physician Extenders**? Yes ☐ No ☐ If Yes, List below with license numbers.

Name	Title/Degree	License Number

 Applicant Name ______________________________

V. CONFIDENTIAL INFORMATION - **Instructions:** Please answer the following. If you answer "Yes" to any question, reference in the space provided **or** on a separate sheet, giving 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?

	Yes	No
1) Medical or professional license	☐	☐
2) DEA or CDS/BNDD registration	☐	☐
3) Hospital medical staff membership	☐	☐
4) Clinical privileges or other rights on any hospital medical staff	☐	☐
5) Employment by any hospital, institution or the military	☐	☐
6) Professional society memberships	☐	☐
7) Participation in private, federal or state health insurance (i.e. Medicare, Medicaid)	☐	☐
8) Participation in an HMO, PPO or any other managed care organization	☐	☐
9) Board Certification	☐	☐

At any time, have you ever been

	Yes	No
10) Convicted of a criminal offense	☐	☐
11) Convicted of a felony	☐	☐
12) 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	☐	☐

Have you ever at any time or are you currently

	Yes	No
13) Under indictment for any crime	☐	☐
14) The subject of an investigation by any private, federal or state health insurance program or state licensing board	☐	☐
15) Under investigation by any state licensing board or federal agency	☐	☐
16) The subject of any adverse action reports to a state or federal databank	☐	☐

Have you ever either voluntarily or involuntarily

	Yes	No
17) Withdrawn your application for medical staff membership at any facility	☐	☐
18) Withdrawn your request for any clinical privileges at any facility	☐	☐

Health Status

	Yes	No
19) Are you able to perform the professional duties of the position with or without reasonable accommodation? (A "Yes" answer does not require additional documentation)	☐	☐
20) Are you currently using illegal substances or illegally using substances?	☐	☐

If you answered "Yes" to any question (except 19) please provide the following for each case –

Date of occurrence of alleged malpractice ________________ Plaintiff name ________________________________
Name of insurer involved ______________________________ Status of Case ______________________________
You were ☐ Primary Defendant ☐ Codefendant Relationship to Patient ______________________________
The case is: ☐ Pending ☐ Found for Plaintiff ☐ Found for Defendant ☐ Dismissed ☐ Settled (Give amount ____________)
Alleged harm to Patient ____
Circumstances of Patient's Illness ____
Any other Pertinent Details ____

 Applicant Name ______________________________

VI. PROFESSIONAL LIABILITY, CREDENTIALING AND SIGNATURE

Professional Liability Carrier Information (Attach copy of policy/certificate summary page)

Current Insurance Carrier ____

Street ______________________ Suite/Building # __________ City ______________ State _____ Zip _____

Date of Coverage ________________ Coverage Expiration Date ________________ Coverage Amount ________________

Policy # ____________________ Type of Coverage ____________________ Individual Amount ________________

Procedures excluded? ______________________________________ Aggregate Amount ________________

Previous Liability Carrier(s) – Complete only if you have not been with the carrier above for 5 years.

Previous Insurance Carrier ____

Street ______________________ Suite/Building # __________ City ______________ State _____ Zip _____

Coverage From ________________ To Expiration Date ____________________ Coverage Amount ________________

Policy # ____________________ Procedures excluded? ______________________________________

Previous Insurance Carrier ____

Street ______________________ Suite/Building # __________ City ______________ State _____ Zip _____

Coverage From ________________ To Expiration Date ____________________ Coverage Amount ________________

Policy # ____________________ Procedures excluded? ______________________________________

Professional Liability History. **In the past 10 years -**

	Yes	No
1) Has your liability insurance ever been canceled or denied?	☐	☐
2) Do you have any malpractice judgments against you including arbitration?	☐	☐
3) Have you had any claim settlements not involving litigation or arbitration paid by you or on your behalf?	☐	☐
4) Are you now a defendant in a pending malpractice suit?	☐	☐

Credentialing Contact Information

Contact Person ______________________________________ Title: ________________________

Telephone ________________ Email ____________________ Same Address as: Primary Office ☐ Primary Billing ☐

Address (if Different): ____

Signature By signing below you: 1) represent and warrant that all information provided herein is complete and accurate to the best of your knowledge and belief; 2) understand to promptly inform of any material change in this information as it occurs, whether before or after you enter into an agreement with Significa; 3) understand that any misstatement may constitute grounds for denial; and, 4) agree your signature on this form when communicated by facsimile transmission or as a scanned document sent via email is binding if transmitted in either fashion with electronically reproduced signatures treated as original.

Applicant's Signature: ______________________________________ Date: ________________

Send completed form to: Manager of Credentialing, Significa Benefit Services, PO Box 8737, Lancaster, PA 17604-8737
Fax 717-399-1693 or email scanned document(s) to providerrelations@ehpservices.com

 Applicant Name ______________________________