

PROVIDER APPLICATION

Submit your completed form (all pages) and attachment(s)

- By Email: credentialing@rxadvance.com
- By Mail: ATTN: eternalHealth
Provider, PO Box 1358, Westborough, MA 01581
- By Fax: 866-347-8864

Please use NUCC (National Uniform Claim Committee) Codes for all relevant fields. Please see the attached Code List for your reference.

Required fields marked with with *

Section 1: Personal Information & Professional IDs			
Name			
Do not use nicknames or initials, unless they are part of your legal name.			
First Name*	Middle Initial	Last Name*	Suffix
Have you ever used another name? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list all other names and their dates of use below.			
Other First Name	Other M.I.	Other Last Name	Suffix
Date Started Using Other Name		Date Stopped Using Other Name	

Provider Type	
Provider Type	
Do you practice exclusively within the inpatient setting? (e.g. pathologists, anesthesiologists, ER physicians, nurse practitioners, radiologists, physician assistants, etc.)	
	<input type="checkbox"/> Yes <input type="checkbox"/> No

General Information				
Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.				
Gender*	Date of Birth* (MM/DD/YYYY)	City of Birth	State of Birth	Country of Birth
<input type="checkbox"/> Male <input type="checkbox"/> Female				
SSN*		Foreign National Identification Number (FNIN)		FNIN Country of Issue
Please enter all non-English languages you speak below.				

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Section 1: Personal Information & Professional IDs (cont.)

Home Address

Street Address		Apt Number
City	State	Zip Code
Phone Number		

Contact Information

This is the information we will use for any follow-ups.	
Email	
Fax	Preferred Method of Contact* <input type="checkbox"/> Email <input type="checkbox"/> Fax

Professional IDs

<ul style="list-style-type: none"> Include all state licenses, DEA Registration, and State Controlled Dangerous Substance (CDS) certification numbers. Provide all current and previous licenses/ certifications. Non-licensed professionals should enter certification/ registration number in the space provided for license number. If you have additional Professional IDs to report, please include additional information as an attachment to the completed form. 	
Federal DEA Number	DEA Issue Date
DEA State of Registration	DEA Expiration Date
CDS Certificate Number	CDS Issue Date
CDS State of Registration	CDS Expiration Date

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Section 1: Personal Information & Professional IDs (cont.)	
Professional IDs (cont.)	
<ul style="list-style-type: none"> Include all state licenses, DEA Registration, and State Controlled Dangerous Substance (CDS) certification numbers. Provide all current and previous licenses/ certifications. Non-licensed professionals should enter certification/ registration number in the space provided for license number. If you have additional Professional IDs to report, please include additional information as an attachment to the completed form. 	
State Licensing Number	License Issue Date
License Issuing State	License Expiration Date
If this is a state license, are you currently practicing in this state? <input type="checkbox"/> Yes <input type="checkbox"/> No	
License Status (e.g. active, pending, limited, etc.)	License Type
State Licensing Number	License Issue Date
License Issuing State	License Expiration Date
If this is a state license, are you currently practicing in this state? <input type="checkbox"/> Yes <input type="checkbox"/> No	
License Status (e.g. active, pending, limited, etc.)	License Type
Other ID Numbers	
Are you a participating Medicare Provider?* <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number
	UPIN
Are you a participating Medicaid Provider? * <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid Number
	Medicaid State
National Provider Identification (NPI) Number	USMLE Number (without hyphens)
Workers Compensation Number	
ECFMG Number (Non-US/Canadian Graduate Only)	ECFMG Certificate Issue Date (MM/DD/YYYY)

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Section 2: Education & Training			
Undergraduate School			
Provide the appropriate information for the school that issued your undergraduate degree and all schools attended.			
Official Name of Undergraduate School			
Street Address			
City	State	Zip/Postal Code	Country
Start Date (MM/YYYY)	End/Graduation Date (MM/YYYY)	Degree Awarded	
Did you complete your undergraduate education at this school?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Professional School		
<ul style="list-style-type: none"> Provide the appropriate information for the school that issued your professional degree. Fifth Pathway Graduates: please complete the following sections: U.S. School that issued your certificate, the Non-U.S. School where you attended, and attach information about the Fifth Pathway institution where you completed to the completed form. If you have additional Undergraduate or Professional Schools to report, please include additional information as an attachment to the completed form. 		
Graduate Type*	<input type="checkbox"/> U.S. or Canadian Graduate <input type="checkbox"/> Non-U.S./Canadian Graduate <input type="checkbox"/> Fifth Pathway Graduate	
U.S. or Canadian School		
Name of U.S./Canadian School		
Start Date* (MM/YYYY)	End/Graduation Date* (MM/YYYY)	Degree Awarded
Did you complete your graduate education at this school?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Section 2: Education & Training (cont.)			
Professional School			
Non-U.S. or Canadian School			
Official Name of Non-U.S./Canadian School			
Street Address			
City	Country	Postal Code	
Start Date* (MM/YYYY)	End/Graduation Date* (MM/YYYY)	Degree Awarded	
Did you complete your graduate education at this school?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Training			
<ul style="list-style-type: none"> List all training programs you attended. Use one section per institution. If you have additional post-graduate programs, include additional information as an attachment to the completed form. Please explain any training gap(s) of three (3) months or greater, or any gap(s) of a shorter duration if required by the organization for which you are being credentialed. 			
Institution/Hospital Name	School (e.g. affiliated medical school)		
Street Address			
City	State	Zip/Postal Code	Country
Telephone		Fax	
Did you complete this training program at this institution? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, please use the space below to explain.			

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Training		
<ul style="list-style-type: none"> List each department separately, if applicable. List Internship/Residency, Fellowship, or Other programs separately. 		
Type <input type="checkbox"/> Internship/Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Other	Start Date (MM/YYYY)	End Date (MM/YYYY)
Department/Specialty (do not abbreviate)		
Name of Director		
Type <input type="checkbox"/> Internship/Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Other	Start Date (MM/YYYY)	End Date (MM/YYYY)
Department/Specialty (do not abbreviate)		
Name of Director		
Type <input type="checkbox"/> Internship/Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Other	Start Date (MM/YYYY)	End Date (MM/YYYY)
Department/Specialty (do not abbreviate)		
Name of Director		

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Section 3. Professional/Medical Specialty Information

Primary Specialty

Specialty	Initial Certification Date (MM/DD/YYYY)	Do you wish to be listed in the directory under this specialty? HMO <input type="checkbox"/> Yes <input type="checkbox"/> No PPO <input type="checkbox"/> Yes <input type="checkbox"/> No POS <input type="checkbox"/> Yes <input type="checkbox"/> No
Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Recertification Date (MM/DD/YYYY)	
Certifying Board Code	Expiration Date (MM/DD/YYYY)	

If you are not board certified, please select one of the following.

I have taken exam, results pending for Certifying Board Code	I intend to sit for an exam on (MM/DD/YYYY)	I do not intend to take a certified board exam.
---	--	---

If you have indicated that you do not intend to take a certifying board exam, please use the space below to explain your decision.

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Section 3. Professional/Medical Specialty Information (cont.)

Secondary Specialty

If you have additional Professional/Medical Specialties to report, please include additional information as an attachment to the completed form.

Specialty	Initial Certification Date (MM/DD/YYYY)	Do you wish to be listed in the directory under this specialty? HMO <input type="checkbox"/> Yes <input type="checkbox"/> No PPO <input type="checkbox"/> Yes <input type="checkbox"/> No POS <input type="checkbox"/> Yes <input type="checkbox"/> No
Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Recertification Date (MM/DD/YYYY)	
Certifying Board Code	Expiration Date (MM/DD/YYYY)	

If you are not board certified, please select one of the following

I have taken exam, results pending for Certifying Board Code	I intend to sit for an exam on (MM/DD/YYYY)	I do not intend to take a certified board exam.
---	--	---

If you have indicated that you do not intend to take a certifying board exam, please use the space below to explain your decision.

Certifications

Do you hold the following certifications? If yes, provide expiration dates.

	Yes	No	Expiration Date (MM/DD/YYYY)
Basic Life Support*			
CPR*			
Advanced Cardiac Life Support*			
Neonatal Advanced Life Support*			
Advanced Life Support in OB*			
Advanced Trauma Life Support*			
Pediatric Advanced Life Support*			

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Section 3. Professional/Medical Specialty Information (cont.)

Practice Interests

Please provide additional areas of professional practice interest, activities, procedures, diagnoses, or populations.

Primary Credentialing Contact

Check this box to use the office manager and the primary practice location as the primary credentialing contact. Otherwise, complete the following information.

First Name

Middle Initial

Last Name

Mailing Address (Street, City, State, Zip)

Phone

Fax

Email Address



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Section 4. Practice Location Information			
Primary Practice Location			
<p>NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT QUESTION ABOVE. SECTION 4 MAY BE LEFT BLANK. YOU MAY PROCEED TO SECTION 5.</p> <ul style="list-style-type: none"> If you have additional practice locations, please include additional information as an attachment to the completed form. “General Correspondence” refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information. Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise. 			
Are you currently practicing at this address?* Yes No		If no, what is your expected start date (MM/DD/YYYY)?	
Physician Group/Practice Name to Appear in Directory (do not abbreviate)*			
Group/Corporate Name as it appears on W-9, if different from above (do not abbreviate)			
Street Address*		Suite/Building	
City*	State*	Zip Code*	
Send general correspondence here? Yes No	Office Phone*	Fax	
Email Address			
Individual Tax ID	Group Tax ID	Please indicate what to use as the Primary Tax ID. Individual Tax ID Group Tax ID	

Office Manager or Business Office Staff Contact		
First Name	Middle Initial	Last Name
Mailing Address (Street, City, State, Zip)		
Phone	Fax	
Email Address		



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Section 4. Practice Location Information (cont.)		
Billing Contact		
Check here if the billing contact is the same as the office manager. <input type="checkbox"/>		
First Name	Middle Initial	Last Name
Mailing Address (Street, City, State, Zip)		
Phone	Fax	
Email Address		

Payment and Remittance		
Check here if the payee information is the same as the office manager. <input type="checkbox"/>		
First Name	Middle Initial	Last Name
Mailing Address (Street, City, State, Zip)		
Phone	Fax	
Email Address		
Electronic Billing Capabilities?*	Billing Department (if hospital-based)	
<input type="checkbox"/> Yes		
<input type="checkbox"/> No		
Checks Payable to*		

Office Hours					
After hours back office telephone will be used only by the health plan and will not be published under any circumstances.					
	Start Time (HH:MM)	End Time (HH:MM)		Start Time (HH:MM)	End Time (HH:MM)
Monday			Friday		
Tuesday			Saturday		
Wednesday			Sunday		
Thursday					
24/7 Phone Coverage?* <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes					
<input type="checkbox"/> Answering Service <input type="checkbox"/> Voicemail with Instructions to Call Answering Service <input type="checkbox"/> Voicemail with Other Instructions					

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Section 4. Practice Location Information (cont.)					
Open Practice Status					
	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Accept New Patients Into This Practice?*			Accept All New Patients?*		
Accept Existing Patients with Change of Payor?*			Accept New Medicare Patients?*		
Accept New Patients with Physician Referral?*			Accept New Medicaid Patients?*		
If any of the above information varies by plan, please explain.					
Are there any practice limitations?* <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, provide the following information.					
Gender Limitations		Age Limitations			
<input type="checkbox"/> Male Only		Minimum Age			
<input type="checkbox"/> Female Only		Maximum Age			
<input type="checkbox"/> None					
Please list any other limitations.					

Mid-Level Practitioners		
Do mid-level practitioners (nurse practitioners, physician assistants, etc.) care for patients in your practice?*		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide the information below.		
First Name	Middle Initial	Last Name
Practitioner Type (e.g. PA, CNP, NP)		
Practitioner License/Certificate Number		Practitioner State

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Mid-Level Practitioners		
First Name	Middle Initial	Last Name
Practitioner Type (e.g. PA, CNP, NP)		
Practitioner License/Certificate Number		Practitioner State
First Name	Middle Initial	Last Name
Practitioner Type (e.g. PA, CNP, NP)		
Practitioner License/Certificate Number		Practitioner State
First Name	Middle Initial	Last Name
Practitioner Type (e.g. PA, CNP, NP)		
Practitioner License/Certificate Number		Practitioner State
First Name	Middle Initial	Last Name
Practitioner Type (e.g. PA, CNP, NP)		
Practitioner License/Certificate Number		Practitioner State

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Section 4. Practice Location Information (cont.)

Languages

Please list all Non-English Languages Spoken by Office Personnel in the space below.

Interpreters Available? Yes No

If yes, please list all languages available in the space below.

Accessibility

Does this office meet ADA accessibility requirements? Yes No

Does this site offer handicapped access for the following:	Building?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Parking?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Restroom?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Other Handicapped Access	
Does the site offer other services for the disabled?*	Text Telephony (TTY)*	<input type="checkbox"/> Yes <input type="checkbox"/> No
	American Sign Language*	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Mental/Physical Impairment Services*	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Other Disability Services	
Accessibility by public transportation?*	Bus*	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Subway*	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Regional Train*	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Other Transportation Access	

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Section 4. Practice Location Information (cont.)			
Services			
<i>Does this location provide any of the following services?</i>			
Laboratory Services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide accrediting/certifying program (e.g. CLIA, COLA, MLE)	
Radiology Services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide X-ray certification type	
EKGs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergy Injections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Skin Testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Routine Office Gynecology (Pelvis/PAP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drawing Blood?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flexible Sigmoidoscopy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Age Appropriate Immunizations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typanometry/Audiometry Screening?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteopathic Manipulation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Stress Test?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary Function Testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Care of Minor Lacerations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Anesthesia Administered in Your Office?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what class/category do you use?	
		If yes, who administers it?	
Type of Practice (select one)	<input type="checkbox"/> Solo Practice <input type="checkbox"/> Single Specialty Group <input type="checkbox"/> Multi-Specialty Group		
Please list any additional office procedures provided (including surgical procedures).			

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Section 4. Practice Location Information (cont.)

Partners/Associates

If you have additional partners/associates at THIS location, please include additional information as an attachment to the completed form. Be certain to note that the additional partners/associates are for the "Primary Location".

List all partners/associates at this practice.

First Name	Middle Initial	Last Name
Specialty Code	Covering Colleague <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Type
First Name	Middle Initial	Last Name
Specialty Code	Covering Colleague <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Type
First Name	Middle Initial	Last Name
Specialty Code	Covering Colleague <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Type
First Name	Middle Initial	Last Name
Specialty Code	Covering Colleague <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Type

Covering Colleagues

If you have additional partners/associates at THIS location, please include additional information as an attachment to the completed form. Be certain to note that the additional covering colleagues are for the "Primary Location".

List all covering colleagues that are not partners/associates at this practice.

First Name	Middle Initial	Last Name
Specialty Code	Provider Type	
First Name	Middle Initial	Last Name
Specialty Code	Provider Type	

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Covering Colleagues		
First Name	Middle Initial	Last Name
Specialty Code	Provider Type	
First Name	Middle Initial	Last Name
Specialty Code	Provider Type	

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Section 5. Hospital Affiliations

Admitting Arrangements

Do you have hospital privileges?* Yes No

If you do not admit patients, what type of admitting arrangements do you have?

Hospital Privileges

- If applicable, list all hospital affiliations. List primary hospital, then other current affiliations, followed by previous affiliations in chronological order.
- If you have additional hospital privileges, please include additional information as an attachment to the completed form.
- Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

Primary Hospital

Hospital Name

Street Address

Suite/Building

City

State

Zip Code

Telephone

Fax

Department Name

Department Director's First Name

Department Director's Last Name

Affiliation Start Date (MM/DD/YYYY)

Affiliation End Date (MM/DD/YYYY)

Full, Unrestricted Privileges? Yes No

Are Privileges Temporary? Yes No

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Hospital Privileges			
Admitting Privilege Status (e.g. none, full unrestricted, provisional, temporary)			
Of your total annual admissions, what percentage is to this hospital?		%	
Other Hospital			
Hospital Name			
Street Address			
Suite/Building	City	State	Zip Code
Telephone		Fax	
Department Name			
Department Director's First Name		Department Director's Last Name	
Affiliation Start Date (MM/DD/YYYY)		Affiliation End Date (MM/DD/YYYY)	
Full, Unrestricted Privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are Privileges Temporary? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Admitting Privilege Status (e.g. none, full unrestricted, provisional, temporary)			
Of your total annual admissions, what percentage is to this hospital?		%	
Please explain terminated affiliation, if applicable.			

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Professional Liability Insurance Carrier					
IMPORTANT. If you do not carry malpractice insurance, check this box and skip this section. <input type="checkbox"/>					
Carrier or Self-Insured Name*				Self-Insured?*	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address*					
Suite/Building	City*		State*		Zip Code*
Original Effective Date* (MM/DD/YYYY)		Effective Date* (MM/DD/YYYY)		Expiration Date (MM/DD/YYYY)	
Type of Coverage?* <input type="checkbox"/> Individual <input type="checkbox"/> Shared					
Do you have unlimited coverage with this insurance carrier?		Amount of Coverage per Occurrence		Amount of Coverage Aggregate	
<input type="checkbox"/> Yes <input type="checkbox"/> No		\$		\$	
Policy Includes Tail Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Policy Number					
Other Carrier(s)					
<ul style="list-style-type: none"> List other current, future, or previous carrier(s) if current carrier is less than ten (10) years. NOTE: A longer period may be required by your healthcare entity. If you have additional insurance, please include additional information as an attachment to the completed form. 					
Carrier or Self-Insured Name*				Self-Insured?*	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address*					
Suite/Building	City*		State*		Zip Code*
Original Effective Date* (MM/DD/YYYY)		Effective Date* (MM/DD/YYYY)		Expiration Date (MM/DD/YYYY)	
Type of Coverage?* <input type="checkbox"/> Individual <input type="checkbox"/> Shared					
Do you have unlimited coverage with this insurance carrier?		Amount of Coverage per Occurrence		Amount of Coverage Aggregate	
<input type="checkbox"/> Yes <input type="checkbox"/> No		\$		\$	
Policy Includes Tail Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Policy Number					

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Section 7. Work History and References

Military Duty

Are you currently on active military duty or military reserve?* Yes No

Work History

- Include a chronological work history for the past 10 years.
- A longer period may be required by your healthcare entity.
- If you have additional work history, please include additional information as an attachment to the completed form.

Practice/Employer Name

Street Address

Suite/Building

City

State

Zip Code

Phone

Fax

Country

Start Date (MM/DD/YYYY)

End Date (MM/DD/YYYY)

Reason for Departure (if applicable)

Practice/Employer Name

Street Address

Suite/Building

City

State

Zip Code

Phone

Fax

Country

Start Date (MM/DD/YYYY)

End Date (MM/DD/YYYY)

Reason for Departure (if applicable)

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Section 7. Work History and References (cont.)			
Work History			
Practice/Employer Name			
Street Address		Suite/Building	
City	State	Zip Code	
Phone		Fax	
Country	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)	
Reason for Departure (if applicable)			

Gaps in Professional/Work History	
<p>Please explain any time periods or gaps in training or work history that have occurred since graduation from professional school and are longer than three months in duration, or a shorter duration if required by the organization for which you are being credentialed.</p> <ul style="list-style-type: none"> If you have additional professional/work history gaps, please include additional information as an attachment to the completed form. 	
Gap Start Date	Gap End Date
<p>Please include your explanation below.</p>	

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Section 7. Work History and References (cont.)

Professional References

Provide three professional references to whom you are not related or are not partners in your practice.

NOTE: You are required to provide exactly 3 references. Your application will not be complete without this information.

First Name*		Last Name*		Provider Type*
Street Address*			Suite/Building	
City*	State*		Zip Code*	
Phone		Fax		
First Name*		Last Name*		Provider Type*
Street Address*			Suite/Building	
City*	State*		Zip Code*	
Phone		Fax		
First Name*		Last Name*		Provider Type*
Street Address*			Suite/Building	
City*	State*		Zip Code*	
Phone		Fax		

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Section 8. Disclosure Questions

Answer all questions. For any “Yes” response, please include your explanation for each of the questions with your submission on a separate page. Be sure to mark the question for which you are providing an explanation in your response.

- **Allied Health Providers.** If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question “NO”.

Licensure

- | | |
|--|--|
| 1. Has your license, registration, or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation, or any conditions or limitations by any state or professional licensing, registration, or certification board?* | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Has there been any challenge to your licensure, registration, or certification?* | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Hospital Privileges and Other Affiliations

- | | |
|--|--|
| 3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected), or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?* | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you voluntarily or involuntarily surrendered, limited your privileges, or not reapplied for privileges while under investigation?* | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?* | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Education, Training, and Board Certification

- | | |
|---|--|
| 6. Were you ever placed on probation, disciplined, formally reprimanded, suspended, or asked to resign during an internship, residency, fellowship, preceptorship, or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended, or asked to resign?* | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?* | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Have any of your board certifications or eligibility ever been revoked?* | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?* | <input type="checkbox"/> Yes <input type="checkbox"/> No |

DEA or State Controlled Substance Registration

- | | |
|---|--|
| 10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|

Medicare, Medicaid, or Other Governmental Program Participation

- | | |
|---|--|
| 11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?* | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|

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Section 8. Disclosure Questions	
Other Sanctions or Investigations	
12. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal, or state health program, or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse, or a sexual offense or sexual misconduct?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g. CLIA, OSHA, etc.)?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined, or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Professional Liability Insurance Information and Claims History	
17. Has your professional liability coverage ever been cancelled, restricted, declined, or not renewed by the carrier based on your individual liability history?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Malpractice Claims History	
19. Have you ever had any professional liability actions (pending, settled, arbitrated, mediated, or litigated) within the past 10 years?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
IF YES , you must complete the Supplemental Malpractice Claims Explanation Form for each malpractice claim.	
Criminal/Civil History	
NOTE: A criminal record will not necessarily be bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.	
20. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. In the past ten years, have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse, or a sexual offense or sexual misconduct?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Have you ever been court-martialed for actions related to your duties as a medical professional?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ability to Perform Job	
23. Are you currently engaged in the illegal use of drugs?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that is has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)	

PROVIDER APPLICATION

Section 8. Disclosure Questions	
24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
25. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
26. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*	<input type="checkbox"/> Yes <input type="checkbox"/> No

PROVIDER APPLICATION

Malpractice Claims Explanation			
NOTE: You only need to complete this form if you answered "Yes" to Question 19 in the Disclosure Questions section.			
Date of Occurrence* (MM/DD/YYYY)		Date Claim Was Filed* (MM/DD/YYYY)	
Status of Claim* (if case is pending, select Open) <input type="checkbox"/> Open <input type="checkbox"/> Closed		If settled, enter date claim was settled (MM/DD/YYYY)	
Professional Liability Carrier Involved*			
Street Address*			
Suite/Building	City*	State*	Zip Code*
Telephone		Policy Number	
Amount of Award or Settlement* \$	Method of Resolution* <input type="checkbox"/> Dismissed <input type="checkbox"/> Settled <input type="checkbox"/> Mediation <input type="checkbox"/> Arbitration <input type="checkbox"/> Judgment for Defendant(s) <input type="checkbox"/> Judgment for Plaintiff(s)		
Description of Allegations*			
Were you the primary defendant or co-defendant?*		<input type="checkbox"/> Primary Defendant <input type="checkbox"/> Co-Defendant	Number of Other Co-Defendants, if any
Your Involvement in the Case* (attending, consulting, etc.)			
Description of Alleged Injury to Patient			
Did the alleged injury result in death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
To the best of your knowledge, is the case included in the National Practitioner Data Bank (NPDB)?* <input type="checkbox"/> Yes <input type="checkbox"/> No			

PROVIDER APPLICATION SUPPLEMENTAL INFORMATION

You may use the below space to provide additional information in your submission. Be sure to note what sections and details you are providing additional information for.



STANDARD AUTHORIZATION, ATTESTATION, AND RELEASE

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.



STANDARD AUTHORIZATION, ATTESTATION, AND RELEASE

(Not for Use for Employment Purposes)

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and out malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

Date Signed*

CODE LIST — PROVIDER TYPE

MD/DO

247 Allergy & Immunology
 246 Allergy & Immunology, Allergy
 291 Allergy & Immunology, Clinical & Laboratory Immunology
 249 Anesthesiology
 235 Anesthesiology, Addiction Medicine
 258 Anesthesiology, Critical Care Medicine
 126 Anesthesiology, Pain Medicine
 363 Clinical Pharmacology
 367 Colon & Rectal Surgery
 263 Dermatology
 292 Dermatology, Clinical & Laboratory Dermatological Immunology
 444 Dermatology, Dermatological Surgery
 266 Dermatology, Dermatopathology
 264 Dermatology, MOHS-Micrographic Surgery
 443 Dermatology, Pediatric Dermatology
 268 Emergency Medicine
 445 Emergency Medicine, Emergency Medical Services
 427 Emergency Medicine, Medical Toxicology
 348 Emergency Medicine, Pediatric Emergency Medicine
 395 Emergency Medicine, Sports Medicine
 446 Emergency Medicine, Undersea and Hyperbaric Medicine
 391 Facial Plastic Surgery
 272 Family Practice
 447 Family Practice, Addiction Medicine
 237 Family Practice, Adolescent Medicine
 448 Family Practice, Adult Medicine
 282 Family Practice, Geriatric Medicine
 396 Family Practice, Sports Medicine
 225 General Practice
 479 Hospitalist
 301 Internal Medicine
 449 Internal Medicine, Addiction Medicine
 236 Internal Medicine, Adolescent Medicine
 248 Internal Medicine, Allergy & Immunology
 255 Internal Medicine, Cardiovascular Disease
 294 Internal Medicine, Clinical & Laboratory Immunology
 253 Internal Medicine, Clinical Cardiac Electrophysiology
 257 Internal Medicine, Critical Care Medicine
 267 Internal Medicine, Endocrinology, Diabetes & Metabolism
 275 Internal Medicine, Gastroenterology
 285 Internal Medicine, Geriatric Medicine
 287 Internal Medicine, Hematology
 288 Internal Medicine, Hematology & Oncology
 450 Internal Medicine, Hepatology
 299 Internal Medicine, Infectious Disease
 451 Internal Medicine, Interventional Cardiology
 453 Internal Medicine, Magnetic Resonance Imaging (MRI)
 325 Internal Medicine, Medical Oncology
 309 Internal Medicine, Nephrology
 378 Internal Medicine, Pulmonary Disease
 390 Internal Medicine, Rheumatology
 397 Internal Medicine, Sports Medicine
 433 Laboratories, Clinical Medical Laboratory
 481 Legal Medicine
 278 Medical Genetics, Clinical Biochemical Genetics
 261 Medical Genetics, Clinical Cytogenetic
 277 Medical Genetics, Clinical Genetics (M.D.)
 280 Medical Genetics, Clinical Molecular Genetics
 455 Medical Genetics, Molecular Genetic Pathology
 454 Medical Genetics, Ph.D. Medical Genetics
 306 Neonatal-Perinatal Medicine
 308 Neopathology
 409 Neurological Surgery
 330 Neuromusculoskeletal Medicine & OMM
 440 Neuromusculoskeletal Medicine, Sports Medicine
 317 Nuclear Medicine
 318 Nuclear Medicine, In Vivo & In Vitro Nuclear Medicine
 315 Nuclear Medicine, Nuclear Cardiology
 316 Nuclear Medicine, Nuclear Imaging & Therapy
 321 Obstetrics & Gynecology
 260 Obstetrics & Gynecology, Critical Care Medicine
 326 Obstetrics & Gynecology, Gynecologic Oncology
 286 Obstetrics & Gynecology, Gynecology
 303 Obstetrics & Gynecology, Maternal & Fetal Medicine
 320 Obstetrics & Gynecology, Obstetrics
 271 Obstetrics & Gynecology, Reproductive Endocrinology
 328 Ophthalmology
 441 Oral & Maxillofacial Surgery
 411 Orthopaedic Surgery
 412 Orthopaedic Surgery, Adult Reconstructive Orthopaedic Surgery
 456 Orthopaedic Surgery, Foot and Ankle Orthopaedics
 406 Orthopaedic Surgery, Hand Surgery
 415 Orthopaedic Surgery, Orthopaedic Surgery of the Spine
 416 Orthopaedic Surgery, Orthopaedic Trauma
 457 Orthopaedic Surgery, Sports Medicine
 119 Orthopedic
 331 Otolaryngology
 458 Otolaryngology, Otolaryngic Allergy
 459 Otolaryngology, Otolaryngology/ Facial Plastic Surgery
 332 Otolaryngology, Otology & Neurotology
 357 Otolaryngology, Pediatric Otolaryngology
 417 Otolaryngology, Plastic Surgery within the Head & Neck
 480 Pain Medicine, Interventional Pain Medicine
 337 Pain Medicine
 338 Pathology, Anatomic Pathology
 340 Pathology, Anatomic Pathology & Clinical Pathology
 250 Pathology, Blood Banking & Transfusion Medicine
 344 Pathology, Chemical Pathology
 302 Pathology, Clinical Pathology/Laboratory Medicine
 262 Pathology, Cytopathology
 265 Pathology, Dermatopathology
 273 Pathology, Forensic Pathology
 290 Pathology, Hematology
 298 Pathology, Immunopathology
 305 Pathology, Medical Microbiology
 461 Pathology, Molecular Genetic Pathology
 312 Pathology, Neuropathology
 358 Pathology, Pediatric Pathology
 244 Pediatrics
 239 Pediatrics, Adolescent Medicine

CODE LIST — PROVIDER TYPE

295 Pediatrics, Clinical & Laboratory Immunology
 462 Pediatrics, Developmental – Behavioral Pediatrics
 354 Pediatrics, Medical Toxicology
 356 Pediatrics, Neurodevelopmental Disabilities
 345 Pediatrics, Pediatric Allergy & Immunology
 346 Pediatrics, Pediatric Cardiology
 347 Pediatrics, Pediatric Critical Care Medicine
 463 Pediatrics, Pediatric Emergency Medicine
 349 Pediatrics, Pediatric Endocrinology
 350 Pediatrics, Pediatric Gastroenterology
 351 Pediatrics, Pediatric Hematology- Oncology
 352 Pediatrics, Pediatric Infectious Diseases
 355 Pediatrics, Pediatric Nephrology
 359 Pediatrics, Pediatric Pulmonology
 361 Pediatrics, Pediatric Rheumatology
 398 Pediatrics, Sports Medicine
 365 Physical Medicine & Rehabilitation
 468 Physical Medicine & Rehabilitation, Pain Medicine
 389 Physical Medicine & Rehabilitation, Pediatric Rehabilitation
 Medicine
 466 Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine
 469 Physical Medicine & Rehabilitation, Sports Medicine
 419 Plastic Surgery
 470 Plastic Surgery, Plastic Surgery Within the Head and Neck
 407 Plastic Surgery, Surgery of the Hand
 242 Preventive Medicine, Aerospace Medicine
 429 Preventive Medicine, Medical Toxicology
 112 Preventive Medicine, Occupational Medicine
 471 Preventive Medicine, Sports Medicine
 431 Preventive Medicine, Undersea and Hyperbaric Medicine
 114 Preventive Medicine/Occupational Environmental Medicine
 370 Psychiatry & Neurology, Addiction Medicine
 473 Psychiatry & Neurology, Addiction Psychiatry
 371 Psychiatry & Neurology, Child & Adolescent Psychiatry
 313 Psychiatry & Neurology, Clinical Neurophysiology
 274 Psychiatry & Neurology, Forensic Psychiatry
 373 Psychiatry & Neurology, Geriatric Psychiatry
 472 Psychiatry & Neurology, Neurodevelopmental Disabilities
 100 Psychiatry & Neurology, Neurology
 311 Psychiatry & Neurology, Neurology with Special Qualifications in
 Child Neurology
 474 Psychiatry & Neurology, Pain Medicine
 368 Psychiatry & Neurology, Psychiatry
 475 Psychiatry & Neurology, Sports Medicine
 476 Psychiatry & Neurology, Vascular Neurology
 366 Public Health & General Preventive Medicine
 252 Radiology, Body Imaging
 173 Radiology, Diagnostic Radiology
 430 Radiology, Diagnostic Ultrasound
 314 Radiology, Neuroradiology
 319 Radiology, Nuclear Radiology
 360 Radiology, Pediatric Radiology
 380 Radiology, Radiation Oncology
 477 Radiology, Radiological Physics
 381 Radiology, Therapeutic Radiology
 384 Radiology, Vascular & Interventional Radiology

434 Supplier
 399 Surgery
 418 Surgery, Pediatric Surgery
 420 Surgery, Plastic and Reconstructive Surgery
 405 Surgery, Surgery of the Hand
 425 Surgery, Surgical Critical Care
 413 Surgery, Surgical Oncology
 423 Surgery, Trauma Surgery
 400 Surgery, Vascular Surgery
 421 Thoracic Surgery (Cardiothoracic Vascular Surgery)
 442 Transplant Surgery
 424 Urology

DDS / DMD

2 Dentist
 13 Dentist, Dental Public Health
 14 Dentist, Endodontics
 438 Dentist, General Practice
 16 Dentist, Oral and Maxillofacial Pathology
 439 Dentist, Oral and Maxillofacial Radiology
 20 Dentist, Oral and Maxillofacial Surgery
 15 Dentist, Orthodontics and Dentofacial Orthopedics
 17 Dentist, Pediatric Dentistry
 18 Dentist, Periodontics
 19 Dentist, Prosthodontics

DPM

3 Podiatrist
 231 Podiatrist, Foot & Ankle Surgery
 230 Podiatrist, Foot Surgery
 225 Podiatrist, General Practice
 227 Podiatrist, Primary Podiatric Medicine
 226 Podiatrist, Public Medicine
 228 Podiatrist, Radiology
 229 Podiatrist, Sports Medicine

DC

1 Chiropractor
 5 Chiropractor, Internist
 6 Chiropractor, Neurology
 7 Chiropractor, Nutrition
 8 Chiropractor, Occupational Medicine
 9 Chiropractor, Orthopedic
 10 Chiropractor, Radiology
 11 Chiropractor, Sports Physician
 12 Chiropractor, Thermography

CODE LIST — ALLIED PROVIDERS

501 Acupuncturist	653 Nurse Anesthetist, Certified Registered
503 Audiologist	654 Nurse Practitioner
504 Audiologist, Assistive Technology Practitioner	655 Nurse Practitioner, Acute Care
505 Audiologist, Assistive Technology Supplier	656 Nurse Practitioner, Adult Health
531 Christian Science Practitioner	658 Nurse Practitioner, Community Health
727 Clinical Nurse Specialist	657 Nurse Practitioner, Critical Care Medicine
728 Clinical Nurse Specialist, Acute Care	659 Nurse Practitioner, Family
729 Clinical Nurse Specialist, Adult Health	660 Nurse Practitioner, Gerontology
730 Clinical Nurse Specialist, Chronic Care	661 Nurse Practitioner, Neonatal
731 Clinical Nurse Specialist, Community Health/Public Health	662 Nurse Practitioner, Neonatal, Critical Care
732 Clinical Nurse Specialist, Critical Care Medicine	670 Nurse Practitioner, Obstetrics & Gynecology
733 Clinical Nurse Specialist, Emergency	671 Nurse Practitioner, Occupational Health
734 Clinical Nurse Specialist, Ethics	663 Nurse Practitioner, Pediatrics
735 Clinical Nurse Specialist, Family Health	664 Nurse Practitioner, Pediatrics, Critical Care
736 Clinical Nurse Specialist, Gerontology	666 Nurse Practitioner, Perinatal
737 Clinical Nurse Specialist, Holistic	667 Nurse Practitioner, Primary Care
738 Clinical Nurse Specialist, Home Health	665 Nurse Practitioner, Psych/Mental Health
739 Clinical Nurse Specialist, Informatics	668 Nurse Practitioner, School
740 Clinical Nurse Specialist, Long-Term Care	669 Nurse Practitioner, Women's Health
741 Clinical Nurse Specialist, Medical-Surgical	537 Nutritionist
742 Clinical Nurse Specialist, Neonatal	538 Nutritionist, Nutrition, Education
743 Clinical Nurse Specialist, Neuroscience	555 Occupational Therapist
744 Clinical Nurse Specialist, Occupational Health	556 Occupational Therapist, Ergonomics
745 Clinical Nurse Specialist, Oncology	557 Occupational Therapist, Hand
746 Clinical Nurse Specialist, Oncology, Pediatrics	558 Occupational Therapist, Human Factors
747 Clinical Nurse Specialist, Pediatrics	559 Occupational Therapist, Neurorehabilitation
748 Clinical Nurse Specialist, Perinatal	560 Occupational Therapist, Pediatrics
749 Clinical Nurse Specialist, Perioperative	561 Occupational Therapist, Rehabilitation, Driver
750 Clinical Nurse Specialist, Psychiatric/Mental Health	563 Optician
751 Clinical Nurse Specialist, Psychiatric/Mental Health, Adult	565 Optometrist
752 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent	566 Optometrist, Corneal and Contact Management
753 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family	567 Optometrist, Low Vision Rehabilitation
754 Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill	571 Optometrist, Occupational Vision
755 Clinical Nurse Specialist, Psychiatric/Mental Health, Community	568 Optometrist, Pediatrics
756 Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric	569 Optometrist, Sports Vision
757 Clinical Nurse Specialist, Rehabilitation	570 Optometrist, Vision Therapy
759 Clinical Nurse Specialist, School	573 Pharmacist
758 Clinical Nurse Specialist, Transplantation	574 Pharmacist, General Practice
760 Clinical Nurse Specialist, Women's Health	575 Pharmacist, Nuclear Pharmacy
513 Counselor	576 Pharmacist, Nutrition Support
514 Counselor, Addiction (Substance Use Disorder)	577 Pharmacist, Pharmacotherapy
515 Counselor, Mental Health	578 Pharmacist, Psychopharmacy
516 Counselor, Professional	580 Physical Therapist
533 Dietitian, Registered	581 Physical Therapist, Cardiopulmonary
536 Dietitian, Registered, Nutrition, Metabolic	583 Physical Therapist, Electrophysiology, Clinical
534 Dietitian, Registered, Nutrition, Pediatric	582 Physical Therapist, Ergonomics
535 Dietitian, Registered, Nutrition, Renal	584 Physical Therapist, Geriatrics
651 Licensed Practical Nurse	585 Physical Therapist, Hand
517 Marriage & Family Therapist	586 Physical Therapist, Human Factors
547 Massage Therapist	587 Physical Therapist, Neurology
549 Midwife, Certified	590 Physical Therapist, Orthopedic
652 Midwife, Certified Nurse	588 Physical Therapist, Pediatrics
551 Naturopath	589 Physical Therapist, Sports
553 Neuropsychologist	592 Physician Assistant
	593 Physician Assistant, Medical
	594 Physician Assistant, Surgical

CODE LIST — ALLIED PROVIDERS

596 Psychologist	722 Registered Nurse, Oncology
597 Psychologist, Addiction (Substance Use Disorder)	725 Registered Nurse, Ophthalmic
598 Psychologist, Adult Development & Aging	724 Registered Nurse, Orthopedic
599 Psychologist, Behavioral	726 Registered Nurse, Ostomy Care
602 Psychologist, Child, Youth & Family	723 Registered Nurse, Otorhinolaryngology & Head-Neck
600 Psychologist, Clinical	704 Registered Nurse, Pain Management
601 Psychologist, Counseling	706 Registered Nurse, Pediatric Oncology
603 Psychologist, Educational	705 Registered Nurse, Pediatrics
604 Psychologist, Exercise & Sports	710 Registered Nurse, Perinatal
605 Psychologist, Family	714 Registered Nurse, Plastic Surgery
606 Psychologist, Forensic	708 Registered Nurse, Psych/Mental Health
607 Psychologist, Health	709 Registered Nurse, Psych/Mental Health, Adult
608 Psychologist, Men & Masculinity	707 Registered Nurse, Psych/Mental Health, Child & Adolescent
609 Psychologist, Mental Retardation & Developmental Disabilities	712 Registered Nurse, Rehabilitation
610 Psychologist, Psychoanalysis	713 Registered Nurse, Reproductive Endocrinology/Infertility
611 Psychologist, Psychotherapy	715 Registered Nurse, School
612 Psychologist, Psychotherapy, Group	716 Registered Nurse, Urology
613 Psychologist, Rehabilitation	718 Registered Nurse, Women's Health Care, Ambulatory
614 Psychologist, School	717 Registered Nurse, Wound Care
615 Psychologist, Women	617 Respiratory Therapist, Certified
672 Registered Nurse	618 Respiratory Therapist, Certified, Critical Care
673 Registered Nurse, Addiction (Substance Use Disorder)	620 Respiratory Therapist, Certified, Educational
674 Registered Nurse, Administrator	619 Respiratory Therapist, Certified, Emergency Care
711 Registered Nurse, Ambulatory Care	622 Respiratory Therapist, Certified, General Care
681 Registered Nurse, Cardiac Rehabilitation	621 Respiratory Therapist, Certified, Geriatric Care
676 Registered Nurse, Case Management	623 Respiratory Therapist, Certified, Home Health
677 Registered Nurse, College Health	628 Respiratory Therapist, Certified, Neonatal/Pediatrics
678 Registered Nurse, Community Health	627 Respiratory Therapist, Certified, Palliative/Hospice
680 Registered Nurse, Continence Care	629 Respiratory Therapist, Certified, Patient Transport
679 Registered Nurse, Continuing Education/Staff Development	624 Respiratory Therapist, Certified, Pulmonary Diagnostics
675 Registered Nurse, Critical Care Medicine	626 Respiratory Therapist, Certified, Pulmonary Function Technologist
682 Registered Nurse, Diabetes Educator	625 Respiratory Therapist, Certified, Pulmonary Rehabilitation
683 Registered Nurse, Dialysis, Peritoneal	630 Respiratory Therapist, Certified, SNF/Subacute Care
684 Registered Nurse, Emergency	631 Respiratory Therapist, Registered
685 Registered Nurse, Enterostomal Therapy	632 Respiratory Therapist, Registered, Critical Care
686 Registered Nurse, Flight	634 Respiratory Therapist, Registered, Educational
688 Registered Nurse, Gastroenterology	633 Respiratory Therapist, Registered, Emergency Care
687 Registered Nurse, General Practice	636 Respiratory Therapist, Registered, General Care
689 Registered Nurse, Gerontology	635 Respiratory Therapist, Registered, Geriatric Care
691 Registered Nurse, Hemodialysis	637 Respiratory Therapist, Registered, Home Health
690 Registered Nurse, Home Health	642 Respiratory Therapist, Registered, Neonatal/Pediatrics
692 Registered Nurse, Hospice	641 Respiratory Therapist, Registered, Palliative/Hospice
694 Registered Nurse, Infection Control	643 Respiratory Therapist, Registered, Patient Transport
693 Registered Nurse, Infusion Therapy	638 Respiratory Therapist, Registered, Pulmonary Diagnostics
695 Registered Nurse, Lactation Consultant	640 Respiratory Therapist, Registered, Pulmonary Function Technologist
696 Registered Nurse, Maternal Newborn	639 Respiratory Therapist, Registered, Pulmonary Rehabilitation
697 Registered Nurse, Medical-Surgical	644 Respiratory Therapist, Registered, SNF/Subacute Care
699 Registered Nurse, Neonatal Intensive Care	646 Social Worker, Clinical
700 Registered Nurse, Neonatal, Low-Risk	648 Specialist/Technologist, Other, Biomedical Engineering
701 Registered Nurse, Nephrology	506 Speech-Language Pathologist
702 Registered Nurse, Neuroscience	649 Technician, Other, Biomedical
698 Registered Nurse, Nurse Massage Therapist (NMT)	
703 Registered Nurse, Nutrition Support	
719 Registered Nurse, Obstetric, High-Risk	
720 Registered Nurse, Obstetric, Inpatient	
721 Registered Nurse, Occupational Health	

CODE LIST — SPECIALTY BOARD

MD/DDS / DMD/DO/DPM

MD Boards

044 American Board of Allergy & Immunology
 045 American Board of Anesthesiology
 046 American Board of Colon & Rectal Surgery
 047 American Board of Dermatology
 048 American Board of Emergency Medicine
 049 American Board of Family Medicine
 050 American Board of Internal Medicine
 051 American Board of Medical Genetics
 052 American Board of Neurological Surgery
 053 American Board of Nuclear Medicine
 054 American Board of Obstetrics & Gynecology
 055 American Board of Ophthalmology
 109 American Board of Oral & Maxillofacial Surgeons
 056 American Board of Orthopedic Surgery
 057 American Board of Otolaryngology
 058 American Board of Pathology
 059 American Board of Pediatrics
 060 American Board of Physical Medicine & Rehabilitation
 061 American Board of Plastic Surgery
 062 American Board of Preventive Medicine
 063 American Board of Psychiatry & Neurology
 064 American Board of Radiology
 065 American Board of Surgery
 066 American Board of Thoracic Surgery
 067 American Board of Urology
 142 Boards other than ABMS/AOA

Dental Boards

113 American Board of Endodontics
 114 American Board of Oral & Maxillofacial Pathology
 117 American Board of Oral & Maxillofacial Radiology
 109 American Board of Oral & Maxillofacial Surgeons
 108 American Board of Orthodontics
 112 American Board of Pediatric Dentistry
 111 American Board of Periodontology
 115 American Board of Prosthodontics
 106 American Board of Public Health Dentistry
 120 Boards other than ABMS/AOA

DO Boards

118 American Osteopathic Board of Anesthesiology
 119 American Osteopathic Board of Dermatology
 120 American Osteopathic Board of Emergency Medicine
 121 American Osteopathic Board of Family Practice
 123 American Osteopathic Board of Internal Medicine
 124 American Osteopathic Board of Neurology and Psychiatry
 125 American Osteopathic Board of Neuromusculoskeletal Medicine
 126 American Osteopathic Board of Nuclear Medicine
 127 American Osteopathic Board of Obstetrics and Gynecology
 128 American Osteopathic Board of Ophthalmology and Otolaryngology
 129 American Osteopathic Board of Orthopedic Surgery
 130 American Osteopathic Board of Pathology

131 American Osteopathic Board of Pediatrics
 132 American Osteopathic Board of Preventive Medicine
 133 American Osteopathic Board of Proctology
 134 American Osteopathic Board of Radiology
 135 American Osteopathic Board of Rehabilitation Medicine
 136 American Osteopathic Board of Surgery

DPM Boards

140 American Board of Medical Specialists in Podiatry
 137 American Board of Podiatric Orthopedics and Primary Podiatric Medicine
 138 American Board of Podiatric Surgery
 139 American Council of Certified Podiatric Surgeons and Physicians

Allied Providers

940 Academy of Certified Social Workers
 1150 ACNM Certification Council
 360 American Academy of Ambulatory Care Nursing
 1550 American Academy of Anesthesiologist Assistants
 230 American Academy of Audiology
 370 American Academy of Experts in Traumatic Stress
 270 American Academy of Health Providers in the Addictive Disorders
 200 American Academy of Medical Acupuncture
 405 American Academy of Nurse Practitioners
 380 American Academy of Nursing
 1330 American Academy of Optometry
 1480 American Academy of Physician Assistants
 1110 American Association for Marriage and Family Therapy
 390 American Association of Critical Care Nurses
 1590 American Association of Nurse Anesthetists
 330 American Association of Pastoral Counselors
 1010 American Association of Sex Educators, Counselors and Therapists
 710 American Board Medical Psychotherapists
 280 American Board of Addiction Medicine
 950 American Board of Examiners in Clinical Social Work
 720 American Board of Medical Psychotherapists & Psychodiagnosticians
 400 American Board of Nursing Specialties
 1240 American Board of Nutrition
 1300 American Board of Occupational Medicine
 1360 American Board of Ophthalmology
 1510 American Board of Physical Therapy Specialties
 700 American Board of Professional Psychology
 1130 American Naturopath Certification Board
 350 American Nurses Credentialing Center
 740 American Psychological Association
 750 American Psychological Society
 760 American Psychotherapy Association
 290 American Society of Addiction Medicine
 1650 American Speech-Language-Hearing Association
 250 Biofeedback Certification Institute of America
 1430 Board of Pharmaceutical Specialties
 1250 Commission on Dietetic Registration
 960 Employee Assistance Professionals Association

CODE LIST — SPECIALTY BOARD

780 National Association for the Advancement of Psychoanalysis	1630 National Board for Respiratory Care
1450 National Association of Boards of Pharmacy	300 National Board of Addiction Examiners
1600 National Association of Nurse Anesthetists	800 National Board of Cognitive Behavioral Therapists
770 National Association of School Psychologists	1350 National Board of Examiners in Optometry
980 National Association of Social Workers	1090 National Certification Board for Therapeutic Massage and Bodywork
1310 National Board for Certification in Occupational Therapy	210 National Certification Commission for Acupuncture and Oriental Medicine
1490 National Board for Certification of Orthopaedic Physician Assistants	1440 National Institute for Standards in Pharmacist Credentialing
790 National Board for Certified Clinical Hypnotherapists	220 Other - Not Listed
310 National Board for Certified Counselors	