Allied Provider Application

CORRECT NUMBERS AND LETTERS: A B C 1 2 3 CORRECT MARK: X INCORRECT MARKS:

Instructions

Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays:

1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 30 - 34.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1 — Personal Information and Professional IDs

Provider Type

Code list is found on page 30. Enter the associated 3-digit code in the space provided.*

YES NO

DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (MAY INCLUDE NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, PHYSICAL THERAPISTS, ETC.)

Name

Do not use nicknames or initials, unless they are part of your legal name.

LAST NAME* SUFFIX (JR, III)

FIRST NAME* MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?* YES NO IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE:

OTHER LAST NAME SUFFIX (JR, III)

OTHER FIRST NAME OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME (MMDDYYYY) DATE STOPPED USING OTHER NAME (MMDDYYYY)

OTHER LAST NAME SUFFIX (JR, III)

OTHER FIRST NAME OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME (MMDDYYYY) DATE STOPPED USING OTHER NAME (MMDDYYYY)

General Information

Only enter a National Identification Number if you do not have a SSN.

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

GENDER*: MALE FEMALE DATE OF BIRTH* (MMDDYYYY)

SSN*: ___-___-____ NATIONAL IDENTIFICATION NUMBER NID COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK: LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE

Home Address

NUMBER STREET APT NUMBER

CITY STATE ZIP CODE

E-MAIL:

FAX: ___-___-____

PREFERRED METHOD OF CONTACT*: E-MAIL FAX NOTE: All correspondence for application follow-up will use this method.

4047

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1 — Personal Information and Professional IDs (Continued)

Professional IDs

Include all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/ certifications.

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 17.

FEDERAL DEA NUMBER | DEA STATE OF REGISTRATION | DEA EXPIRATION DATE: (MMDDYYYY)

CDS CERTIFICATE NUMBER | CDS STATE OF REGISTRATION | CDS EXPIRATION DATE: (MMDDYYYY)

STATE LICENSE NUMBER* | LICENSE ISSUING STATE* | LICENSE EXPIRATION DATE:* (MMDDYYYY)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE?* YES NO

STATE LICENSE NUMBER | LICENSE ISSUING STATE | LICENSE EXPIRATION DATE: (MMDDYYYY)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

Other ID Numbers

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 17.

ARE YOU A PART-ICIPATING MEDICARE PROVIDER?* YES NO — MEDICARE NUMBER — UPIN

ARE YOU A PART-ICIPATING MEDICAID PROVIDER?* YES NO — MEDICAID NUMBER

0 — — — ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY) — ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY) (MMDDYYYY)

Section 2 — Education and Training

Education

Provide the appropriate information for your completed highest level of education.

Fifth Pathway Graduates please complete the following sections: U.S. School that issued your certificate, the Non-U.S. School where your attended, and the Fifth Pathway institution where you completed your training.

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

GRADUATE TYPE*: U.S. OR CANADIAN GRADUATE | NON-U.S./CANADIAN GRADUATE | FIFTH PATHWAY GRADUATE

U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF U.S. / CANADIAN SCHOOL

ADDRESS

CITY | STATE | POSTAL CODE | COUNTRY CODE

START DATE* (MMYYYY) | END DATE (I.E., GRADUATION DATE)* (MMYYYY) | DEGREE AWARDED*

NON - U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL

ADDRESS

CITY | COUNTRY CODE | POSTAL CODE

START DATE* (MMYYYY) | END DATE (I.E., GRADUATION DATE)* (MMYYYY) | DEGREE AWARDED*

4048

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2 — Education and Training (Continued)

FIFTH PATHWAY GRADUATES ONLY

INSTITUTION/HOSPITAL WHERE U.S. CLINICAL TRAINING WAS PERFORMED (DO NOT ABBREVIATE)

ADDRESS

CITY | STATE | ZIP CODE

Other Relevant Education

List any other relevant degrees you have earned.

If you have additional information to report, use the Other Relevant Education Supplemental Form on page 18.

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)

NUMBER | STREET | SUITE/BLDG.

CITY | STATE | POSTAL CODE

COUNTRY CODE | START DATE (MMYYYY) | END DATE (I.E., GRADUATION DATE) (MMYYYY) | DEGREE AWARDED

Training

List all training programs you attended. Use one section per institution.

If you have additional post-graduate training programs, use the Supplemental Training Form on page 18.

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

NUMBER | STREET | SUITE/BLDG.

CITY | STATE | POSTAL CODE

COUNTRY CODE

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

INTERNSHIP/ RESIDENCY | FELLOWSHIP | OTHER | START DATE (MMYYYY) | END DATE (MMYYYY)

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

INTERNSHIP/ RESIDENCY | FELLOWSHIP | OTHER | START DATE (MMYYYY) | END DATE (MMYYYY)

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

INTERNSHIP/ RESIDENCY | FELLOWSHIP | OTHER | START DATE (MMYYYY) | END DATE (MMYYYY)

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

4049

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3 — Professional / Medical Specialty Information

Primary Specialty

Code lists are found on pages 30-34. Enter the associated code in the space provided.

SPECIALTY CODE: | INITIAL CERTIFICATION DATE: M M D D Y Y Y Y | DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? HMO: YES NO

BOARD CERTIFIED? YES NO | RECERTIFICATION DATE (IF APPLICABLE): M M D D Y Y Y Y | PPO: YES NO

CERTIFYING BOARD CODE: | EXPIRATION DATE (IF APPLICABLE): M M D D Y Y Y Y | POS: YES NO

IF NOT BOARD CERTIFIED (SELECT ONE):
- I HAVE TAKEN EXAM, RESULTS PENDING FOR: CERTIFYING BOARD CODE
- I INTEND TO SIT FOR AN EXAM ON: M M D D Y Y Y Y
- I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

Secondary Specialty

Code lists are found on pages 30-34. Enter the associated code in the space provided.

SPECIALTY CODE: | INITIAL CERTIFICATION DATE: M M D D Y Y Y Y | DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? HMO: YES NO

BOARD CERTIFIED? YES NO | RECERTIFICATION DATE (IF APPLICABLE): M M D D Y Y Y Y | PPO: YES NO

CERTIFYING BOARD CODE: | EXPIRATION DATE (IF APPLICABLE): M M D D Y Y Y Y | POS: YES NO

IF NOT BOARD CERTIFIED (SELECT ONE):
- I HAVE TAKEN EXAM, RESULTS PENDING FOR: CERTIFYING BOARD CODE
- I INTEND TO SIT FOR AN EXAM ON: M M D D Y Y Y Y
- I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

Additional Specialty

Code lists are found on pages 30-34. Enter the associated code in the space provided.

SPECIALTY CODE: | INITIAL CERTIFICATION DATE: M M D D Y Y Y Y | DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? HMO: YES NO

BOARD CERTIFIED? YES NO | RECERTIFICATION DATE (IF APPLICABLE): M M D D Y Y Y Y | PPO: YES NO

CERTIFYING BOARD CODE: | EXPIRATION DATE (IF APPLICABLE): M M D D Y Y Y Y | POS: YES NO

IF NOT BOARD CERTIFIED (SELECT ONE):
- I HAVE TAKEN EXAM, RESULTS PENDING FOR: CERTIFYING BOARD CODE
- I INTEND TO SIT FOR AN EXAM ON: M M D D Y Y Y Y
- I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

Practice Interests:

Provide additional areas of professional practice interest.

4050

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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Section 4 — Practice Location Information

Primary Practice Location

If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 21-25.

NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.

TIP: Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

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 BELOW. THE REMAINDER OF SECTION 4 MAY BE LEFT BLANK. YOU MAY THEN PROCEED TO SECTION 5 ON PAGE 10.

CURRENTLY PRACTICING AT THIS ADDRESS?* ☐ YES ☐ NO

IF NO, WHAT IS YOUR EXPECTED START DATE? M M D D Y Y Y Y

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)

NUMBER* | STREET* | SUITE/BLDG.

CITY* | STATE* | ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* ☐ YES ☐ NO

TELEPHONE* | FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID | GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)*: ☐ USE INDIVIDUAL TAX ID ☐ USE GROUP TAX ID

Office Manager or Business Office Staff Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME*

FIRST NAME* | M.I.

TELEPHONE* | FAX

E-MAIL ADDRESS

Credentialing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS CREDENTIALING INFORMATION ☐

LAST NAME

FIRST NAME | M.I.

NUMBER | STREET | SUITE/BLDG

CITY | STATE | ZIP CODE

TELEPHONE | FAX

E-MAIL ADDRESS

Note:

Even if you checked the boxes above, please provide the e-mail address, if available.

4051

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information (Continued)

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION ☐

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BLDG

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

Note:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To.

ELECTRONIC BILLING CAPABILITIES?* ☐ YES ☐ NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

CHECK PAYABLE TO*

Office Hours

(USE HH:MM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY:					FRIDAY:				
TUESDAY:					SATURDAY:				
WEDNESDAY:					SUNDAY:				
THURSDAY:									

Note:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE?* ☐ YES ☐ NO

IF YES: ☐ ANSWERING SERVICE ☐ VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE ☐ VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* ☐ YES ☐ NO

ACCEPT ALL NEW PATIENTS?* ☐ YES ☐ NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* ☐ YES ☐ NO

ACCEPT NEW MEDICARE PATIENTS?* ☐ YES ☐ NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* ☐ YES ☐ NO

ACCEPT NEW MEDICAID PATIENTS?* ☐ YES ☐ NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN: (USE BOTH LINES IF REQUIRED)

ARE THERE ANY PRACTICE LIMITATIONS?* ☐ YES ☐ NO

IF YES:

GENDER LIMITATIONS: ☐ MALE ONLY ☐ NONE ☐ FEMALE ONLY

AGE LIMITATIONS: ☐☐ MINIMUM AGE ☐☐ MAXIMUM AGE

LIST OTHER LIMITATIONS:

4052

Section 4 Practice Location Information (Continued)

Mid-Level Practitioners

YES NO DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNM, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNM, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNM, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNM, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNM, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE

4053

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information (Continued)

Languages

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL: LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED: LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING:

- BUILDING?* YES NO
- PARKING?* YES NO
- RESTROOM?* YES NO

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* YES NO

- TEXT TELEPHONY (TTY)* YES NO
- AMERICAN SIGN LANGUAGE* YES NO
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* YES NO

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO

- BUS* YES NO
- SUBWAY* YES NO
- REGIONAL TRAIN* YES NO

OTHER TRANSPORTATION ACCESS

Certifications

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

			EXPIRATION DATE:															
BASIC LIFE SUPPORT?*	YES	NO	M	M	D	D	Y	Y	Y	Y	ADV LIFE SUPPORT IN OB?*	YES	NO	M	M	D	D	Y	Y	Y	Y
CPR?*	YES	NO	M	M	D	D	Y	Y	Y	Y	ADV TRAUMA LIFE SUPPORT?*	YES	NO	M	M	D	D	Y	Y	Y	Y
ADV CARDIAC LIFE SPT?*	YES	NO	M	M	D	D	Y	Y	Y	Y	PEDIATRIC ADVANCED LIFE SPT?*	YES	NO	M	M	D	D	Y	Y	Y	Y
NEONATAL ADVANCED LIFE SPT?*	YES	NO	M	M	D	D	Y	Y	Y	Y											

Services

Does this location provide any of the following services?

LABORATORY SERVICES? YES NO — IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE):

RADIOLOGY SERVICES? YES NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE:

EKGS?	YES	NO	ALLERGY INJECTIONS?	YES	NO	ALLERGY SKIN TESTING?	YES	NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)?	YES	NO
DRAWING BLOOD?	YES	NO	AGE APPROPRIATE IMMUNIZATIONS?	YES	NO	FLEXIBLE SIGMOIDOSCOPY?	YES	NO	TYMPANOMETRY/ AUDIOMETRY SCREENING?	YES	NO
ASTHMA TREATMENT?	YES	NO	OSTEOPATHIC MANIPULATION?	YES	NO	IV HYDRATION/ TREATMENT?	YES	NO	CARDIAC STRESS TEST?	YES	NO
PULMONARY FUNCTION TESTING?	YES	NO	PHYSICAL THERAPY?	YES	NO	CARE OF MINOR LACERATIONS?	YES	NO			

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT? LAST NAME | FIRST NAME

TYPE OF PRACTICE: (SELECT ONE ONLY)* SOLO PRACTICE | SINGLE SPECIALTY GROUP | MULTI-SPECIALTY GROUP

4054

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information (Continued)

Services
(Continued)

SERVICES (Continued)

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES):

Partners/ Associates

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 19. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

Covering Colleagues

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at this location, use the Covering Colleagues Supplemental Form on page 20. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | DEGREE

4055

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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 hospitals where you currently have privileges.

If you have additional hospital privileges, use the Supplemental Hospital Privileges Form on page 26.

TIP: Be certain your admission percentages add up to 100%. Otherwise, you will have to correct this error.

PRIMARY HOSPITAL

HOSPITAL NAME

NUMBER STREET SUITE/BLDG

CITY STATE ZIP CODE

TELEPHONE

FULL, UNRESTRICTED PRIVILEGES? YES NO

ARE PRIVILEGES TEMPORARY? YES NO

TYPE OF ADMITTING PRIVILEGES (E.G., ATTENDING, EMERITUS, ETC.)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

OTHER HOSPITAL

HOSPITAL NAME

NUMBER STREET SUITE/BLDG

CITY STATE ZIP CODE

TELEPHONE

FULL, UNRESTRICTED PRIVILEGES? YES NO

ARE PRIVILEGES TEMPORARY? YES NO

TYPE OF ADMITTING PRIVILEGES (E.G., ATTENDING, EMERITUS, ETC.)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

OTHER HOSPITAL

HOSPITAL NAME

NUMBER STREET SUITE/BLDG

CITY STATE ZIP CODE

TELEPHONE

FULL, UNRESTRICTED PRIVILEGES? YES NO

ARE PRIVILEGES TEMPORARY? YES NO

TYPE OF ADMITTING PRIVILEGES (E.G., ATTENDING, EMERITUS, ETC.)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6 — Professional Liability Insurance Coverage

Current Malpractice Insurance Carrier

IMPORTANT: IF YOU DO NOT CARRY MALPRACTICE INSURANCE, CHECK THIS BOX AND SKIP THIS SECTION. ☐

SELF-INSURED?* ☐ YES ☐ NO

CARRIER OR SELF-INSURED NAME (USE BOTH LINES IF NECESSARY)*

NUMBER* STREET* SUITE/BLDG

CITY* STATE* ZIP CODE*

ORIGINAL EFFECTIVE DATE* (MMYYYY) EFFECTIVE DATE* (MMYYYY) EXPIRATION DATE (MMYYYY) TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?* ☐ YES ☐ NO

$ AMOUNT OF COVERAGE PER OCCURRENCE $ AMOUNT OF COVERAGE AGGREGATE

POLICY NUMBER*

Previous Malpractice Insurance Carrier

Required only if with current carrier less than five (5) years.

SELF-INSURED? ☐ YES ☐ NO

CARRIER OR SELF-INSURED NAME (USE BOTH LINES IF NECESSARY)

NUMBER* STREET* SUITE/BLDG

CITY* STATE* ZIP CODE*

ORIGINAL EFFECTIVE DATE* (MMYYYY) EFFECTIVE DATE* (MMYYYY) EXPIRATION DATE (MMYYYY) TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

$ AMOUNT OF COVERAGE PER OCCURRENCE $ AMOUNT OF COVERAGE AGGREGATE

POLICY NUMBER*

Section 7 — Work History and References

Military Duty

☐ YES ☐ NO Are you currently on active military duty or military reserve?*

Work History

Include a chronological work history for the past 5 years.

If you have additional work history, use the Supplemental Work History Form on page 27.

Note: Leave End Date blank to indicate "present"

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER STREET SUITE/BLDG.

CITY STATE POSTAL CODE

COUNTRY CODE START DATE (MMYYYY) END DATE (MMYYYY)

4057

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7 Work History and References (Continued)

Work History

Include a chronological work history for the past 5 years. This information must be complete if applicable.

If you have additional work history, use the Supplemental Work History Form on page 27.

Note: Leave End Date blank to indicate "present"

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER STREET SUITE/BLDG.

CITY STATE POSTAL CODE

COUNTRY CODE START DATE M M Y Y Y Y END DATE M M Y Y Y Y

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER STREET SUITE/BLDG.

CITY STATE POSTAL CODE

COUNTRY CODE START DATE M M Y Y Y Y END DATE M M Y Y Y Y

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER STREET SUITE/BLDG.

CITY STATE POSTAL CODE

COUNTRY CODE START DATE M M Y Y Y Y END DATE M M Y Y Y Y

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER STREET SUITE/BLDG.

CITY STATE POSTAL CODE

COUNTRY CODE START DATE M M Y Y Y Y END DATE M M Y Y Y Y

4058

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7 — Work History and References (Continued)

Gaps in Work History

Include an explanation of any gap(s) six (6) months or greater.

YES NO DO YOU HAVE ANY WORK HISTORY GAPS GREATER THAN 6 MONTHS?:*

GAP START DATE: M M Y Y Y Y GAP END DATE: M M Y Y Y Y

GAP START DATE: M M Y Y Y Y GAP END DATE: M M Y Y Y Y

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.

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

LAST NAME*

FIRST NAME* PROVIDER TYPE CODE

NUMBER* STREET* APT/SUITE/BLDG

CITY* STATE* ZIP CODE*

LAST NAME*

FIRST NAME* PROVIDER TYPE CODE

NUMBER* STREET* APT/SUITE/BLDG

CITY* STATE* ZIP CODE*

LAST NAME*

FIRST NAME* PROVIDER TYPE CODE

NUMBER* STREET* APT/SUITE/BLDG

CITY* STATE* ZIP CODE*

4059

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8 — Disclosure Questions

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 28.

For the questions that have Not Applicable as a possible answer, select the Not Applicable option if the question truly does not pertain to you. For example, disclosure questions relating to hospital privileges are not applicable if you do not have hospital privileges. In this example, it would be appropriate to select Not Applicable.

LICENSURE

1. ☐ YES ☐ NO — Has your license to practice in your profession ever been denied, suspended, revoked, restricted, voluntarily surrendered or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?*

2. ☐ YES ☐ NO — Have you ever received a reprimand or been fined by any state licensing board?*

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. ☐ YES ☐ NO ☐ N/A — Have your clinical privileges at any hospital or healthcare institution 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 records 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?*

4. ☐ YES ☐ NO ☐ N/A — Have you voluntarily surrendered, limited your privileges or not reapplied for privileges?*

5. ☐ YES ☐ NO — 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)?*

EDUCATION, TRAINING AND BOARD CERTIFICATION

6. ☐ YES ☐ NO — 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?*

7. ☐ YES ☐ NO — Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*

8. ☐ YES ☐ NO ☐ N/A — Have any of your board certifications or eligibility ever been revoked?*

9. ☐ YES ☐ NO ☐ N/A — Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

10. ☐ YES ☐ NO ☐ N/A — Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?*

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

11. ☐ YES ☐ NO — 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?*

OTHER SANCTIONS OR INVESTIGATIONS

12. ☐ YES ☐ NO — Are you currently or have you ever been the subject of an investigation within the last ten years 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?*

13. ☐ YES ☐ NO — To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*

14. ☐ YES ☐ NO — Have you ever received sanctions from or been the subject of investigation within the last ten years by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*

15. ☐ YES ☐ NO — 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?*

16. ☐ YES ☐ NO — Have you ever been investigated, sanctioned, reprimanded or cautioned within the last ten years by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation within the last ten years by a hospital or healthcare facility of any military agency?*

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. ☐ YES ☐ NO — Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*

18. ☐ YES ☐ NO — 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?*

Section 8 — Disclosure Questions (Continued)

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 28.

IMPORTANT:
If you answered "Yes" to **question #19**, you must complete the Supplemental Malpractice Claims Explanation Form on page 29 for each malpractice claim.

MALPRACTICE CLAIMS HISTORY

19. ☐ YES ☐ NO Have you ever had any malpractice actions (pending, settled, dropped, dismissed, arbitrated, mediated or litigated)?* If yes, you must complete a Supplemental Malpractice Claims History Explanation Form that was included with your application materials. Use one form for each malpractice case.

CRIMINAL/CIVIL HISTORY

20. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony in the last ten years or been found liable or responsible for or named as a defendant in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional?*

21. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony in the last ten years or been found liable or responsible for or been named as a defendant in any civil offense that alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*

22. ☐ YES ☐ NO Have you ever been court-martialed for actions related to your duties as a medical professional?*

Note: A criminal record will not necessarily be a 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.

ABILITY TO PERFORM JOB

23. ☐ YES ☐ NO Are you currently engaged in the illegal use of drugs?* ("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 it 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.)

24. ☐ YES ☐ NO 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?*

25. ☐ YES ☐ NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*

26. ☐ YES ☐ NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

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 and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Plans" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Plans" 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 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.

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 without 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 true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information 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 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. 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)*

M M D D Y Y Y Y

DATE SIGNED*

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Professional IDs Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1 — Personal Information and Professional IDs

Professional IDs

Include all additional state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/ certifications.

If you need to report additional Professional IDs, photocopy this page as needed and submit as instructed.

FEDERAL DEA NUMBER | DEA STATE OF REGISTRATION | DEA EXPIRATION DATE: MMDDYYYY

FEDERAL DEA NUMBER | DEA STATE OF REGISTRATION | DEA EXPIRATION DATE: MMDDYYYY

FEDERAL DEA NUMBER | DEA STATE OF REGISTRATION | DEA EXPIRATION DATE: MMDDYYYY

CDS CERTIFICATE NUMBER | CDS STATE OF REGISTRATION | CDS EXPIRATION DATE: MMDDYYYY

CDS CERTIFICATE NUMBER | CDS STATE OF REGISTRATION | CDS EXPIRATION DATE: MMDDYYYY

CDS CERTIFICATE NUMBER | CDS STATE OF REGISTRATION | CDS EXPIRATION DATE: MMDDYYYY

STATE LICENSE NUMBER | LICENSE ISSUING STATE | LICENSE EXPIRATION DATE: MMDDYYYY

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

STATE LICENSE NUMBER | LICENSE ISSUING STATE | LICENSE EXPIRATION DATE: MMDDYYYY

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

STATE LICENSE NUMBER | LICENSE ISSUING STATE | LICENSE EXPIRATION DATE: MMDDYYYY

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

STATE LICENSE NUMBER | LICENSE ISSUING STATE | LICENSE EXPIRATION DATE: MMDDYYYY

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

STATE LICENSE NUMBER | LICENSE ISSUING STATE | LICENSE EXPIRATION DATE: MMDDYYYY

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

MEDICARE NUMBER

MEDICAID NUMBER

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Other Relevant Education and Training
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2 **Education and Training**

Other Relevant Education

List any other relevant degrees you have earned.

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)

NUMBER | STREET | SUITE/BLDG.

CITY | STATE | POSTAL CODE

COUNTRY CODE | START DATE (M M Y Y Y Y) | END DATE (I.E., GRADUATION DATE) (M M Y Y Y Y) | DEGREE AWARDED

Training

List all postgraduate training programs you attended. Use one section per institution.

If you need to report additional Training, photocopy this page as needed and submit as instructed.

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

INSTITUTION / HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

NUMBER | STREET | SUITE/BLDG

CITY | STATE | POSTAL CODE

COUNTRY CODE

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

INTERNSHIP/ RESIDENCY | FELLOWSHIP | OTHER | START DATE (M M Y Y Y Y) | END DATE (M M Y Y Y Y)

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

INTERNSHIP/ RESIDENCY | FELLOWSHIP | OTHER | START DATE (M M Y Y Y Y) | END DATE (M M Y Y Y Y)

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

INTERNSHIP/ RESIDENCY | FELLOWSHIP | OTHER | START DATE (M M Y Y Y Y) | END DATE (M M Y Y Y Y)

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Partners/Associates Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information

Partner/ Associates

Use this page to report additional partners/associates at the designated practice location.

IMPORTANT:

In the box provided, indicate to which practice location this page belongs.

Check "Covering Colleague?" if he/she provides coverage for you at THIS location.

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

If you need to report additional partners/associates, photocopy this page as needed and submit as instructed.

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION #: ☐☐ ☐ PRIMARY PRACTICE

PRACTICE NAME

PRACTICE ADDRESS

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

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Covering Colleagues
Supplemental Form

★ REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 **Practice Location Information**

Covering Colleagues

Include all colleagues providing regular coverage and his/her specialty, including if he/she is a partner in one or more of your practice locations.

IMPORTANT:

In the box provided, indicate to which practice location this page belongs.

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

If you need to report additional Covering Colleagues, photocopy this page as needed and submit as instructed.

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION #: ☐☐ ☐ PRIMARY PRACTICE

PRACTICE NAME

PRACTICE ADDRESS

LAST NAME SPECIALTY CODE

FIRST NAME M.I. DEGREE

LAST NAME SPECIALTY CODE

FIRST NAME M.I. DEGREE

LAST NAME SPECIALTY CODE

FIRST NAME M.I. DEGREE

LAST NAME SPECIALTY CODE

FIRST NAME M.I. DEGREE

LAST NAME SPECIALTY CODE

FIRST NAME M.I. DEGREE

LAST NAME SPECIALTY CODE

FIRST NAME M.I. DEGREE

LAST NAME SPECIALTY CODE

FIRST NAME M.I. DEGREE

LAST NAME SPECIALTY CODE

FIRST NAME M.I. DEGREE

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Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information**

Additional Practice Location

IMPORTANT:

In the box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

TIP: Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

LOCATION* #

CURRENTLY PRACTICING AT THIS ADDRESS?* YES NO

IF NO, WHAT IS YOUR EXPECTED START DATE? M M D D Y Y Y Y

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)

NUMBER* STREET* SUITE/BLDG.

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPON-DENCE HERE?* YES NO

TELEPHONE* FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)*: USE INDIVIDUAL TAX ID USE GROUP TAX ID

Office Manager or Business Office Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Credentialing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS CREDENTIALING INFORMATION

LAST NAME

FIRST NAME M.I.

NUMBER STREET SUITE/BLDG

CITY STATE ZIP CODE

TELEPHONE FAX

E-MAIL ADDRESS

Note:

Even if you checked the boxes above, please provide the e-mail address, if available.

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 2 of 5**

Additional Practice Location (Continued)

IMPORTANT:

In the box provided, indicate to which practice location this page belongs.

LOCATION* #

BILLING CONTACT

LAST NAME*

FIRST NAME* **M.I.**

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

NUMBER* **STREET*** **SUITE/BLDG**

CITY* **STATE*** **ZIP CODE***

TELEPHONE* **FAX**

E-MAIL ADDRESS

Note:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

BILLING DEPARTMENT (IF HOSPITAL-BASED)

ELECTRONIC BILLING CAPABILITIES?* YES NO

CHECK PAYABLE TO

Office Hours

(USE HH:MM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY:					FRIDAY:				
TUESDAY:					SATURDAY:				
WEDNESDAY:					SUNDAY:				
THURSDAY:									

Note:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE?* YES NO

IF YES: ANSWERING SERVICE; VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE; VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* YES NO

ACCEPT ALL NEW PATIENTS?* YES NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* YES NO

ACCEPT NEW MEDICARE PATIENTS?* YES NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* YES NO

ACCEPT NEW MEDICAID PATIENTS?* YES NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN: (USE BOTH LINES IF REQUIRED)

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information - Page 3 of 5

Additional Practice Location
(Continued)

IMPORTANT: In the box provided, indicate to which practice location this page belongs.

LOCATION* #

OPEN PRACTICE STATUS (CONTINUED)

ARE THERE ANY PRACTICE LIMITATIONS?* YES NO

IF YES:

GENDER LIMITATIONS: MALE ONLY / NONE / FEMALE ONLY

AGE LIMITATIONS: MINIMUM AGE / MAXIMUM AGE

LIST OTHER LIMITATIONS:

TYPE OF PRACTICE: (SELECT ONE ONLY)* SOLO PRACTICE / SINGLE SPECIALTY GROUP / MULTI-SPECIALTY GROUP

Mid-Level Practitioners

YES NO DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME — M.I. — PRACTITIONER TYPE (E.G., PA, CNM, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER — PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME — M.I. — PRACTITIONER TYPE (E.G., PA, CNM, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER — PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME — M.I. — PRACTITIONER TYPE (E.G., PA, CNM, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER — PRACTITIONER STATE

Languages

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL: LANGUAGE CODE / LANGUAGE CODE / LANGUAGE CODE / LANGUAGE CODE / LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED: LANGUAGE CODE / LANGUAGE CODE / LANGUAGE CODE / LANGUAGE CODE

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Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 4 of 5**

Additional Practice Location (Continued)

IMPORTANT:

In the box provided, indicate to which practice location this page belongs.

LOCATION* #

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING:

- BUILDING?* YES NO
- PARKING?* YES NO
- RESTROOM?* YES NO

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* YES NO

- TEXT TELEPHONY (TTY)* YES NO
- AMERICAN SIGN LANGUAGE* YES NO
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* YES NO

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO

- BUS* YES NO
- SUBWAY* YES NO
- REGIONAL TRAIN* YES NO

OTHER TRANSPORTATION ACCESS

Certifications

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

		EXPIRATION DATE:
BASIC LIFE SUPPORT?*	YES NO	MM DD YYYY
CPR?*	YES NO	MM DD YYYY
ADV CARDIAC LIFE SPT?*	YES NO	MM DD YYYY
NEONATAL ADVANCED LIFE SPT?*	YES NO	MM DD YYYY
ADV LIFE SUPPORT IN OB?*	YES NO	MM DD YYYY
ADV TRAUMA LIFE SUPPORT?*	YES NO	MM DD YYYY
PEDIATRIC ADVANCED LIFE SPT?*	YES NO	MM DD YYYY

Services

Does this location provide any of the following services?

LABORATORY SERVICES? YES NO — **IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE):**

RADIOLOGY SERVICES? YES NO — **IF YES, PROVIDE X-RAY CERTIFICATION TYPE:**

- EKGS? YES NO
- DRAWING BLOOD? YES NO
- ASTHMA TREATMENT? YES NO
- PULMONARY FUNCTION TESTING? YES NO
- ALLERGY INJECTIONS? YES NO
- AGE APPROPRIATE IMMUNIZATIONS? YES NO
- OSTEOPATHIC MANIPULATION? YES NO
- PHYSICAL THERAPY? YES NO
- ALLERGY SKIN TESTING? YES NO
- FLEXIBLE SIGMOIDOSCOPY? YES NO
- IV HYDRATION/ TREATMENT? YES NO
- CARE OF MINOR LACERATIONS? YES NO
- ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? YES NO
- TYMPANOMETRY/ AUDIOMETRY SCREENING? YES NO
- CARDIAC STRESS TEST? YES NO

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO — **IF YES, WHAT CLASS/CATEGORY DO YOU USE?**

IF YES, WHO ADMINISTERS IT?

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES):

4070

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 **Practice Location Information - Page 5 of 5**

Additional Practice Location
(Continued)

IMPORTANT:
In the box provided, indicate to which practice location this page belongs.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 19. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

LOCATION* #

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | DEGREE

Covering Colleagues

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at this location, use the Covering Colleagues Supplemental Form on page 20. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | DEGREE

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | DEGREE

4071

Hospital Privileges (Current) Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 5 Hospital Affiliations

Hospital Privileges

Use this form to continue listing hospitals where you currently have privileges.

If you need to report additional Hospital Privileges, photocopy this page as needed and submit as instructed.

TIP: Be certain your admission percentages add up to 100%. Otherwise, you will have to correct this error.

OTHER HOSPITAL

HOSPITAL NAME

NUMBER STREET SUITE/BLDG

CITY STATE ZIP CODE

TELEPHONE - -

FULL, UNRESTRICTED PRIVILEGES? YES NO

ARE PRIVILEGES TEMPORARY? YES NO

TYPE OF ADMITTING PRIVILEGES (E.G., ATTENDING, EMERITUS, ETC.)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

OTHER HOSPITAL

HOSPITAL NAME

NUMBER STREET SUITE/BLDG

CITY STATE ZIP CODE

TELEPHONE - -

FULL, UNRESTRICTED PRIVILEGES? YES NO

ARE PRIVILEGES TEMPORARY? YES NO

TYPE OF ADMITTING PRIVILEGES (E.G., ATTENDING, EMERITUS, ETC.)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

OTHER HOSPITAL

HOSPITAL NAME

NUMBER STREET SUITE/BLDG

CITY STATE ZIP CODE

TELEPHONE - -

FULL, UNRESTRICTED PRIVILEGES? YES NO

ARE PRIVILEGES TEMPORARY? YES NO

TYPE OF ADMITTING PRIVILEGES (E.G., ATTENDING, EMERITUS, ETC.)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

4072

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Work History
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7 Work History and References

Work History

Use this form to continue listing work history.

Include a chronological work history for the past 5 years. This information must be complete if applicable.

If you need to report additional Work History, photocopy this page as needed and submit as instructed.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER STREET SUITE/BLDG

CITY STATE POSTAL CODE

COUNTRY CODE START DATE M M Y Y Y Y END DATE M M Y Y Y Y

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER STREET SUITE/BLDG

CITY STATE POSTAL CODE

COUNTRY CODE START DATE M M Y Y Y Y END DATE M M Y Y Y Y

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER STREET SUITE/BLDG

CITY STATE POSTAL CODE

COUNTRY CODE START DATE M M Y Y Y Y END DATE M M Y Y Y Y

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER STREET SUITE/BLDG

CITY STATE POSTAL CODE

COUNTRY CODE START DATE M M Y Y Y Y END DATE M M Y Y Y Y

4073

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Disclosure Questions
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8 | **Disclosure Questions**

Disclosure Questions

Use this form to report any "Yes" response to one or more of the Disclosure Questions in Section 8. Your response should not exceed the spaces provided.

Record the question number in the first column, then your explanation in the second column.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

QUESTION #:	EXPLANATION:

QUESTION #:	EXPLANATION:

QUESTION #:	EXPLANATION:

4074

Malpractice Claims Explanation
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8 | **Malpractice Claims Explanation**

Malpractice Claims Explanation

Use this form to report any "Yes" response to Disclosure Question #19.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

DATE OF OCCURRENCE*: M M D D Y Y Y Y

DATE CLAIM WAS FILED*: M M D D Y Y Y Y

STATUS OF CLAIM* (NOTE: IF CASE IS PENDING, SELECT OPEN):

☐ OPEN ☐ CLOSED

PROFESSIONAL LIABILITY CARRIER INVOLVED (USE BOTH LINES IF NECESSARY)

NUMBER | STREET | SUITE/BLDG

CITY | STATE | ZIP CODE

TELEPHONE | POLICY NUMBER

$ AMOUNT OF AWARD OR SETTLEMENT

METHOD OF RESOLUTION?

☐ DISMISSED ☐ SETTLED WITH PREJUDICE ☐ MEDIATION ☐ ARBITRATION

☐ JUDGMENT FOR DEFENDANT(S) ☐ JUDGMENT FOR PLAINTIFF(S) ☐ SETTLED WITHOUT PREJUDICE

DESCRIPTION OF ALLEGATIONS* (USE ALL FOUR LINES BELOW, IF NECESSARY):

WERE YOU THE PRIMARY DEFENDANT OR CO-DEFENDANT?* ☐ PRIMARY DEFENDANT ☐ CO-DEFENDANT

NUMBER OF OTHER CO-DEFENDANTS (IF ANY):

YOUR INVOLVEMENT IN CASE* (ATTENDING, CONSULTING, ETC)

DESCRIPTION OF ALLEGED INJURY TO THE PATIENT* (USE ALL FOUR LINES BELOW, IF NECESSARY):

TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?* ☐ YES ☐ NO

4075

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Code Lists

Provider Type Codes

020 Acupuncturist
021 Alcohol/Drug Counselor
022 Audiologist
023 Biofeedback Technician
024 Certified Registered Nurse Anesthetist
025 Christian Science Practitioner
026 Clinical Nurse Specialist
027 Clinical Psychologist
028 Clinical Social Worker
029 Dietician
030 Licensed Practical Nurse
031 Marriage/Family Therapist
032 Massage Therapist
033 Naturopath
034 Neuropsychologist
035 Midwife
036 Nurse Midwife
037 Nurse Practitioner
038 Nutritionist
039 Occupational Therapist
040 Optician
041 Optometrist
042 Pharmacist
043 Physical Therapist
044 Physician Assistant
045 Professional Counselor
046 Registered Nurse
047 Registered Nurse First Assistant
048 Respiratory Therapist
049 Speech Pathologist

*Codes 001-007 for use only on Professional References section.

001 Medical Doctor (MD)
002 Doctor of Dental Surgery (DDS)
003 Doctor of Dental Medicine (DMD)
004 Doctor of Podiatric Medicine (DPM)
005 Doctor of Chiropractic (DC)
007 Osteopathic Doctor (DO)

Country Codes

004 Afghanistan
008 Albania
012 Algeria
016 American Samoa
020 Andorra
024 Angola
660 Anguilla
010 Antarctica
028 Antigua and Barbuda
032 Argentina
051 Armenia
533 Aruba
036 Australia
040 Austria
031 Azerbaijan
044 Bahamas
048 Bahrain
050 Bangladesh
052 Barbados
112 Belarus
056 Belgium
084 Belize
204 Benin
060 Bermuda
064 Bhutan
068 Bolivia
070 Bosnia and Herzegovina
072 Botswana
074 Bouvet Island
076 Brazil
086 British Indian Ocean Territory
096 Brunei Darussalam
100 Bulgaria
854 Burkina Faso
108 Burundi
116 Cambodia
120 Cameroon
124 Canada
132 Cape Verde
136 Cayman Islands
140 Central African Republic
148 Chad
152 Chile
156 China
162 Christmas Island
166 Cocos (Keeling) Islands
170 Colombia
174 Comoros
178 Congo
180 Congo, Democratic Republic of the
184 Cook Islands
188 Costa Rica
384 Cote d'Ivoire
191 Croatia
192 Cuba
196 Cyprus
203 Czech Republic
208 Denmark
262 Djibouti
212 Dominica
214 Dominican Republic
626 East Timor (provisional)
218 Ecuador
818 Egypt
222 El Salvador
226 Equatorial Guinea
232 Eritrea
233 Estonia
231 Ethiopia
238 Falkland Islands (Malvinas)
234 Faroe Islands
242 Fiji
246 Finland
250 France
249 France, Metropolitan
254 French Guiana
258 French Polynesia
260 French Southern Territories
266 Gabon
270 Gambia
268 Georgia
276 Germany
288 Ghana
292 Gibraltar
300 Greece
304 Greenland
308 Grenada
312 Guadaloupe
316 Guam
320 Guatemala
324 Guinea
624 Guinea-Bissau
328 Guyana
332 Haiti
334 Heard Island and McDonald Islands
340 Honduras
344 Hong Kong
348 Hungary
352 Iceland
356 India
360 Indonesia
364 Iran
368 Iraq
372 Ireland
376 Israel
380 Italy
388 Jamaica
392 Japan
400 Jordan
398 Kazakhstan
404 Kenya
296 Kiribati
408 Korea, North
410 Korea, South
414 Kuwait
417 Kyrgyzstan
418 Laos
428 Latvia
422 Lebanon
426 Lesotho
430 Liberia
434 Libya
438 Liechtenstein
440 Lithuania
442 Luxembourg
446 Macau
807 Macedonia
450 Madagascar
454 Malawi
458 Malaysia
462 Maldives
466 Mali
470 Malta
584 Marshall Islands
474 Martinique
478 Mauritania
480 Mauritius
175 Mayotte
484 Mexico
583 Micronesia
498 Moldova
492 Monaco
496 Mongolia
500 Montserrat
504 Morocco
508 Mozambique
104 Myanmar
516 Namibia
520 Nauru
524 Nepal
528 Netherlands
530 Netherlands Antilles
540 New Caledonia
554 New Zealand
558 Nicaragua
562 Niger
566 Nigeria
570 Niue
574 Norfolk Island
580 Northern Mariana Islands
578 Norway
512 Oman
586 Pakistan
585 Palau
591 Panama
598 Papua New Guinea
600 Paraguay
604 Peru
608 Philippines
612 Pitcairn
616 Poland
620 Portugal
630 Puerto Rico
634 Qatar
638 Réunion
642 Romania
643 Russian Federation
646 Rwanda
654 Saint Helena
659 Saint Kitts and Nevis
662 Saint Lucia
666 Saint Pierre and Miquelon
670 Saint Vincent and the Grenadines
882 Samoa
674 San Marino
678 São Tomé and Príncipe
682 Saudi Arabia
683 Scotland
686 Senegal
690 Seychelles
694 Sierra Leone
702 Singapore
703 Slovakia
705 Slovenia
090 Solomon Islands
706 Somalia
710 South Africa
239 South Georgia and the South Sandwich Islands
724 Spain
144 Sri Lanka
736 Sudan
740 Suriname
744 Svalbard and Jan Mayen
748 Swaziland
752 Sweden
756 Switzerland
760 Syria
158 Taiwan
762 Tajikistan
834 Tanzania
764 Thailand
768 Togo
772 Tokelau
776 Tonga
780 Trinidad and Tobago
788 Tunisia
792 Turkey
795 Turkmenistan
796 Turks and Caicos Islands
798 Tuvalu
800 Uganda
804 Ukraine
784 United Arab Emirates
826 United Kingdom
840 United States
581 U.S. Minor Outlying Islands
858 Uruguay
860 Uzbekistan
548 Vanuatu
336 Vatican City State (Holy See)
862 Venezuela
704 Viet Nam
092 Virgin Islands, British
850 Virgin Islands, U.S.
876 Wallis and Fortuna Islands
732 Western Sahara (provisional)
887 Yemen
891 Yugoslavia
894 Zambia
716 Zimbabwe

Code Lists

Language Codes

001 Abkhazian
002 Afan (Oromo)
003 Afar
004 Afrikaans
005 Albanian
006 Amharic
007 Arabic
008 Armenian
009 Assamese
010 Zerbaijani
011 Bashkir
012 Basque
013 Bengali;Bangla
014 Bhutani
015 Bihari
016 Bislama
017 Breton
018 Bulgarian
019 Burmese
020 Byelorussian
021 Cambodian
022 Catalan
023 Chinese
024 Corsican
025 Croatian
026 Czech
027 Danish
028 Dutch
140 English
030 Esperonto
031 Estonian
032 Faroese
033 Fiji
034 Finnish
035 French
036 Frisian
037 Galican
038 Georgian
039 German
040 Greek
041 Greenlandic
042 Guarani
043 Gujarati
044 Hausa
045 Hebrew
046 Hindi
047 Hungarian
048 Icelandic
049 Indonesian
050 Interlingua
051 Interlingue
052 Inuktitut
053 Inupiak
054 Irish
055 Italian
056 Japanese
057 Javanese
058 Kannada
059 Kashmiri
060 Kazakh
061 Kinyarwanda
062 Kirghiz
063 Kurundi
064 Korean
065 Kurdish
066 Laothian
067 Latin
068 Latvian;Lettish
069 Lingala
070 Lithuanian
071 Macedonian
072 Malagasy
073 Malay
074 Malayalam
075 Maltese
076 Maori
077 Marathi
078 Moldavian
079 Mongolian
080 Nauru
081 Nepali
082 Norwegian
083 Occitan
084 Oriya
085 Pashto;Pushto
086 Persian (Farsi)
087 Polish
088 Portuguese
089 Punjabi
090 Quechua
091 Rhaeto-Romance
092 Romanian
093 Russian
094 Samoan
095 Sangho
096 Sanskrit
097 Scot Gaelic
098 Serbian
099 Serbo-Croatian
100 Sesotho
101 Setswana
102 Shona
103 Sindhi
104 Singhalese
105 Siswati
106 Slovak
107 Slovenian
108 Somali
109 Spanish
110 Sundanese
111 Swahili
112 Swedish
113 Tagalog
114 Tajik
115 Tamil
116 Tatar
117 Telugu
118 Thai
119 Tibetan
120 Tigrinya
121 Tonga
122 Tsonga
123 Turkish
124 Turkmen
125 Twi
126 Uigur
127 Ukrainian
128 Urdu
129 Uzbek
130 Vietnamese
131 Volapuk
132 Welsh
133 Wolof
134 Xhosa
135 Yiddish
136 Yoruba
10 Zerbaijani
137 Zhuang
138 Zulu

Specialty Codes - Allied Providers

501 Acupuncturist
503 Audiologist
504 Audiologist, Assistive Technology Practitioner
505 Audiologist, Assistive Technology Supplier
531 Christian Science Practitioner
727 Clinical Nurse Specialist
728 Clinical Nurse Specialist, Acute Care
729 Clinical Nurse Specialist, Adult Health
730 Clinical Nurse Specialist, Chronic Care
731 Clinical Nurse Specialist, Community Health/Public Health
732 Clinical Nurse Specialist, Critical Care Medicine
733 Clinical Nurse Specialist, Emergency
734 Clinical Nurse Specialist, Ethics
735 Clinical Nurse Specialist, Family Health
736 Clinical Nurse Specialist, Gerontology
737 Clinical Nurse Specialist, Holistic
738 Clinical Nurse Specialist, Home Health
739 Clinical Nurse Specialist, Informatics
740 Clinical Nurse Specialist, Long-Term Care
741 Clinical Nurse Specialist, Medical-Surgical
742 Clinical Nurse Specialist, Neonatal
743 Clinical Nurse Specialist, Neuroscience
744 Clinical Nurse Specialist, Occupational Health
745 Clinical Nurse Specialist, Oncology
746 Clinical Nurse Specialist, Oncology, Pediatrics
747 Clinical Nurse Specialist, Pediatrics
748 Clinical Nurse Specialist, Perinatal
749 Clinical Nurse Specialist, Perioperative
750 Clinical Nurse Specialist, Psychiatric/Mental Health
751 Clinical Nurse Specialist, Psychiatric/Mental Health, Adult
752 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent
753 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family
754 Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill
755 Clinical Nurse Specialist, Psychiatric/Mental Health, Community
756 Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric
757 Clinical Nurse Specialist, Rehabilitation
759 Clinical Nurse Specialist, School
758 Clinical Nurse Specialist, Transplantation
760 Clinical Nurse Specialist, Women's Health
513 Counselor
514 Counselor, Addiction (Substance Use Disorder)
515 Counselor, Mental Health
516 Counselor, Professional
533 Dietician, Registered
536 Dietician, Registered, Nutrition, Metabolic
534 Dietician, Registered, Nutrition, Pediatric
535 Dietician, Registered, Nutrition, Renal
651 Licensed Practical Nurse
517 Marriage & Family Therapist
547 Massage Therapist
549 Midwife, Certified
652 Midwife, Certified Nurse
551 Naturopath
553 Neuropsychologist
653 Nurse Anesthetist, Certified Registered
654 Nurse Practitioner
655 Nurse Practitioner, Acute Care
656 Nurse Practitioner, Adult Health
658 Nurse Practitioner, Community Health
657 Nurse Practitioner, Critical Care Medicine
659 Nurse Practitioner, Family
660 Nurse Practitioner, Gerontology
661 Nurse Practitioner, Neonatal
662 Nurse Practitioner, Neonatal, Critical Care
670 Nurse Practitioner, Obstetrics & Gynecology
671 Nurse Practitioner, Occupational Health

Code Lists

Specialty Codes - Allied Providers (continued)

663 Nurse Practitioner, Pediatrics
664 Nurse Practitioner, Pediatrics, Critical Care
666 Nurse Practitioner, Perinatal
667 Nurse Practitioner, Primary Care
665 Nurse Practitioner, Psych/Mental Health
668 Nurse Practitioner, School
669 Nurse Practitioner, Women's Health
537 Nutritionist
538 Nutritionist, Nutrition, Education
555 Occupational Therapist
556 Occupational Therapist, Ergonomics
557 Occupational Therapist, Hand
558 Occupational Therapist, Human Factors
559 Occupational Therapist, Neurorehabilitation
560 Occupational Therapist, Pediatrics
561 Occupational Therapist, Rehabilitation, Driver
563 Optician
565 Optometrist
566 Optometrist, Corneal and Contact Management
567 Optometrist, Low Vision Rehabilitation
571 Optometrist, Occupational Vision
568 Optometrist, Pediatrics
569 Optometrist, Sports Vision
570 Optometrist, Vision Therapy
573 Pharmacist
574 Pharmacist, General Practice
575 Pharmacist, Nuclear Pharmacy
576 Pharmacist, Nutrition Support
577 Pharmacist, Pharmacotherapy
578 Pharmacist, Psychopharmacy
580 Physical Therapist
581 Physical Therapist, Cardiopulmonary
583 Physical Therapist, Electrophysiology, Clinical
582 Physical Therapist, Ergonomics
584 Physical Therapist, Geriatrics
585 Physical Therapist, Hand
586 Physical Therapist, Human Factors
587 Physical Therapist, Neurology
590 Physical Therapist, Orthopedic
588 Physical Therapist, Pediatrics
589 Physical Therapist, Sports
592 Physician Assistant
593 Physician Assistant, Medical
594 Physician Assistant, Surgical
596 Psychologist
597 Psychologist, Addiction (Substance Use Disorder)
598 Psychologist, Adult Development & Aging
599 Psychologist, Behavioral
602 Psychologist, Child, Youth & Family
600 Psychologist, Clinical
601 Psychologist, Counseling
603 Psychologist, Educational
604 Psychologist, Exercise & Sports
605 Psychologist, Family
606 Psychologist, Forensic
607 Psychologist, Health
608 Psychologist, Men & Masculinity
609 Psychologist, Mental Retardation & Developmental Disabilities
610 Psychologist, Psychoanalysis
611 Psychologist, Psychotherapy
612 Psychologist, Psychotherapy, Group
613 Psychologist, Rehabilitation
614 Psychologist, School
615 Psychologist, Women
672 Registered Nurse
673 Registered Nurse, Addiction (Substance Use Disorder)
674 Registered Nurse, Administrator
711 Registered Nurse, Ambulatory Care
681 Registered Nurse, Cardiac Rehabilitation
676 Registered Nurse, Case Management
677 Registered Nurse, College Health
678 Registered Nurse, Community Health
680 Registered Nurse, Continence Care
679 Registered Nurse, Continuing Education/Staff Development
675 Registered Nurse, Critical Care Medicine
682 Registered Nurse, Diabetes Educator
683 Registered Nurse, Dialysis, Peritoneal
684 Registered Nurse, Emergency
685 Registered Nurse, Enterostomal Therapy
686 Registered Nurse, Flight
688 Registered Nurse, Gastroenterology
687 Registered Nurse, General Practice
689 Registered Nurse, Gerontology
691 Registered Nurse, Hemodialysis
690 Registered Nurse, Home Health
692 Registered Nurse, Hospice
694 Registered Nurse, Infection Control
693 Registered Nurse, Infusion Therapy
695 Registered Nurse, Lactation Consultant
696 Registered Nurse, Maternal Newborn
697 Registered Nurse, Medical-Surgical
699 Registered Nurse, Neonatal Intensive Care
700 Registered Nurse, Neonatal, Low-Risk
701 Registered Nurse, Nephrology
702 Registered Nurse, Neuroscience
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
722 Registered Nurse, Oncology
725 Registered Nurse, Ophthalmic
724 Registered Nurse, Orthopedic
726 Registered Nurse, Ostomy Care
723 Registered Nurse, Otorhinolaryngology & Head-Neck
704 Registered Nurse, Pain Management
706 Registered Nurse, Pediatric Oncology
705 Registered Nurse, Pediatrics
710 Registered Nurse, Perinatal
714 Registered Nurse, Plastic Surgery
708 Registered Nurse, Psych/Mental Health
709 Registered Nurse, Psych/Mental Health, Adult
707 Registered Nurse, Psych/Mental Health, Child & Adolescent
712 Registered Nurse, Rehabilitation
713 Registered Nurse, Reproductive Endocrinology/Infertility
715 Registered Nurse, School
716 Registered Nurse, Urology
718 Registered Nurse, Women's Health Care, Ambulatory
717 Registered Nurse, Wound Care
617 Respiratory Therapist, Certified
618 Respiratory Therapist, Certified, Critical Care
620 Respiratory Therapist, Certified, Educational
619 Respiratory Therapist, Certified, Emergency Care
622 Respiratory Therapist, Certified, General Care
621 Respiratory Therapist, Certified, Geriatric Care
623 Respiratory Therapist, Certified, Home Health
628 Respiratory Therapist, Certified, Neonatal/Pediatrics
627 Respiratory Therapist, Certified, Palliative/Hospice
629 Respiratory Therapist, Certified, Patient Transport
624 Respiratory Therapist, Certified, Pulmonary Diagnostics
626 Respiratory Therapist, Certified, Pulmonary Function Technologist
625 Respiratory Therapist, Certified, Pulmonary Rehabilitation
630 Respiratory Therapist, Certified, SNF/Subacute Care
631 Respiratory Therapist, Registered
632 Respiratory Therapist, Registered, Critical Care
634 Respiratory Therapist, Registered, Educational
633 Respiratory Therapist, Registered, Emergency Care
636 Respiratory Therapist, Registered, General Care
635 Respiratory Therapist, Registered, Geriatric Care
637 Respiratory Therapist, Registered, Home Health
642 Respiratory Therapist, Registered, Neonatal/Pediatrics
641 Respiratory Therapist, Registered, Palliative/Hospice
643 Respiratory Therapist, Registered, Patient Transport
638 Respiratory Therapist, Registered, Pulmonary Diagnostics
640 Respiratory Therapist, Registered, Pulmonary Function Technologist
639 Respiratory Therapist, Registered, Pulmonary Rehabilitation
644 Respiratory Therapist, Registered, SNF/Subacute Care
646 Social Worker, Clinical
648 Specialist/Technologist, Other, Biomedical Engineering
506 Speech-Language Pathologist
649 Technician, Other, Biomedical Engineering
502 Other, Not Listed

Code Lists

Specialty Boards - 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 Psyhotherapists & Psychodiagnosticians
400 American Board of Nursing Specialties
1240 American Board of Nutrition
1300 American Board of Occupational Medicine
055 American Board of Ophthalmology
1340 American Board of Optometry
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
780 National Association for the Advancement of Psychoanalysis
1450 National Association of Boards of Pharmacy
1600 National Association of Nurse Anesthetists
770 National Association of School Psychologists
980 National Association of Social Workers
1310 National Board for Certification in Occupational Therapy
1490 National Board for Certification of Orthopaedic Physician Assistants
790 National Board for Certified Clinical Hypnotherapists
310 National Board for Certified Counselors
1630 National Board for Respiratory Care
300 National Board of Addiction Examiners
800 National Board of Cognitive Behavioral Therapists
1350 National Board of Examiners in Optometry
1090 National Certification Board for Therapeutic Massage and Bodywork
210 National Certification Commission for Acupuncture and Oriental Medicine
1440 National Institute for Standards in Pharmacist Credentialing
220 Other - Not Listed

Specialty Codes - MD/DO Only

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

Code Lists

Specialty Codes - MD/DO Only (Continued)

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
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

Specialty Codes - DDS / DMD, DPM, DC

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

LIST OF AUTHORIZED ORGANIZATIONS

The following is the list of Authorized Organizations referenced in my Standard Authorization, Attestation, & Release Form dated _____:

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Provider Name:_____

Provider SS#: _____