

Ohio Department of Insurance

STANDARDIZED CREDENTIALING FORM

Please complete each section thoroughly.
Attach additional sheets where necessary.
Type or print clearly in black ink.
Sign and date the application.

**YOU MUST INCLUDE THE FOLLOWING WITH THIS
COMPLETED APPLICATION
(use this checklist as a guide)**

- Copy of State License(s)
- Copy of DEA Registration
- Copy of State Controlled Dangerous Substance Certificate
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and provider's name
- Copy of Board Certification Certificate, if applicable
- Copy of certificate or letter certifying formal post-graduate training
- Copy of Curricula Vita/Resume
Include work history. **(Not accepted as a substitute for completion of application.)**
- Copy of ECFMG Certificate (if applicable)
- Copy of W-9 for verification of each tax identification number used
- Copy of certificates for conducting x-ray and/or laboratory services (if applicable)
- Copy of Workers Compensation Certificate of Coverage (if applicable)
- Copy of certificates of Advanced Nurse Practitioners employed by the office (if applicable)
- Other _____

Provider's Name _____ Date _____

Health Insuring Corporation's Name _____

Note: Submit this form directly to licensed health insuring corporations and other entities that credential providers for participation in their networks. Do not send this form to the Ohio Department of Insurance; the Department does not use the form for any reporting purposes.

Ohio Department of Insurance

STANDARDIZED CREDENTIALING FORM

Please type or print

Fill in all sections - incomplete applications will not be processed.

To be completed by MDs, DOs, DDSs, DPMs, and DCs, and other health care providers.

Date _____

SECTION I PERSONAL INFORMATION

Name (Last, First, Middle) _____ Degree _____

Home Address/Street _____

City/State/Zip _____

Home Phone Number _____ Cellular Phone Number _____

Date of Birth (for Data Bank Query) _____ Sex: Male Female

Place of Birth: (City, State & Country) _____

Languages Spoken _____

Citizenship _____

If not an American citizen, Status & Visa Number _____

SSN # _____

Beeper # _____ Digital: Yes No Answering Service # _____

SECTION II LICENSURE/CERTIFICATIONS/REGISTRATIONS

For all the questions in this section, if you do not have a number but have applied, please indicate "application in process."

Ohio License Number _____ Expiration Date _____

Other State License Number/State of License (list all past and current)

_____ Expiration Date _____

_____ Expiration Date _____

_____ Expiration Date _____

Federal DEA Number _____ Expiration Date _____

Date Issued _____

State Narcotics Registration # or CDS
Certification/State of Registration
(if applicable) _____ Expiration Date _____

CPR Certifications:

Are you certified in CPR?	<input type="checkbox"/> Yes (attach copy of certificate(s))	<input type="checkbox"/> No	Expiration Date _____
Check classification(s):	<input type="checkbox"/> Basic Life Support (BLS)	<input type="checkbox"/> No	Expiration Date _____
	<input type="checkbox"/> Advanced Cardiac Life Support (ACLS)	<input type="checkbox"/> No	Expiration Date _____
	<input type="checkbox"/> Health Care Provider (Core C)	<input type="checkbox"/> No	Expiration Date _____
	<input type="checkbox"/> Advanced Trauma Life Support (ATLS)	<input type="checkbox"/> No	Expiration Date _____
	<input type="checkbox"/> Neonatal Resuscitation Program (NRP)	<input type="checkbox"/> No	Expiration Date _____
	<input type="checkbox"/> Pediatric Advanced Life Support (PALS)	<input type="checkbox"/> No	Expiration Date _____
	<input type="checkbox"/> Pediatric Emergency Medicine Course (APLS)	<input type="checkbox"/> No	Expiration Date _____

Other professional certifications or credentials (please include description) _____

Optometrists Only:

Therapeutics Classification Number _____

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Indicate the hours that the doctor(s) is/are available:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Languages spoken by office personnel (other than English) _____

Based on your individual practice, do you currently: (check appropriate box for each item)

- Accept new patients into your practice? Yes No Accept new Medicare patients? Yes No
- Accept new patients from phys. referral only? Yes No Accept new Medicaid patients? Yes No
- Provide inpatient care? Yes No Accept new BWC patients? Yes No
- Have any age restrictions? Yes No

If YES, what are they? _____

Does the office: (check appropriate box for each item)

- Make 24-hour phone coverage available? Yes No Provide childcare services? Yes No
- Have capability for electronic billing? Yes No Meet ADA accessibility standards? Yes No
- Have internet access? Yes No Communicate with health plans via the Internet? Yes No
- Offer patients internet access to obtain medical, billing, and appointment information? Yes No Have public transportation access? Yes No
- Have other services for the disabled? (TTY, American Sign Language, mental/physical impairments, etc.) Yes No Employ or contract with allied health professionals including physician assistants and Advanced Nurse Practitioners? Yes No

Please list services

If Yes, please list all names

SECTION IV
PROFESSIONAL / MEDICAL EDUCATION & TRAINING/WORK HISTORY

Provide history (since medical school) of **all** work, education and training including but not limited to medical military services, public health or business training. Provide an explanation for any gaps of more than two months.

MEDICAL EDUCATION

University _____
Address/Street _____
City/State/Zip _____ Telephone Number _____
Degree _____ Month/Year Started _____ Month/Year Completed _____

University _____
Address/Street _____
City/State/Zip _____ Telephone Number _____
Degree _____ Month/Year Started _____ Month/Year Completed _____

INTERNSHIP

Facility _____
Address/Street _____
City/State/Zip _____ Telephone Number _____
Type _____ Month/Year Started _____ Month/Year Completed _____
Name of Department Head or Chief of Service _____

Was this program successfully completed? Yes No

RESIDENCIES

Facility _____
Program Name _____
Address/Street _____
City/State/Zip _____ Telephone Number _____
Specialty _____ Month/Year Started _____ Month/Year Completed _____
Name of Department Head or Chief of Service _____

Was this program successfully completed? Yes No

Facility _____
Program Name _____
Address/Street _____
City/State/Zip _____ Telephone Number _____
Specialty _____ Month/Year Started _____ Month/Year Completed _____
Name of Department Head or Chief of Service _____

Was this program successfully completed? Yes No

FELLOWSHIPS

Facility _____
Program Name _____
Address/Street _____
City/State/Zip _____
Specialty _____ Month/Year Started _____ Month/Year Completed _____
Name of Department Head or Chief of Service _____
Was this program successfully completed? Yes No

Facility _____
Program Name _____
Address/Street _____
City/State/Zip _____ Telephone Number: _____
Specialty _____ Month/Year Started _____ Month/Year Completed _____
Name of Department Head or Chief of Service _____
Was this program successfully completed? Yes No

Other Graduate Level Education for which a degree was obtained

Degree(s) obtained _____
Institution _____
Address/Street _____
City/State/Zip _____
Telephone Number _____
Dates (from/to) _____
Program Director _____

International Medical Graduates

Are you certified by the Educational Council for Foreign Medical Graduates? Yes No
ECFMG # _____
Date Issued _____

Practice/Employer

Contact Name

Address/Street

City/State/Zip

Phone

Dates of employment

Month/Year Started

Month/Year Ended

Reason for leaving

**SECTION V
PROFESSIONAL / MEDICAL SPECIALTY INFORMATION**

For each specialty below, please indicate if you are qualified or board certified:

PRIMARY SPECIALTY

Qualified

Certified

Not certified

No board available

Certifying Board

Date

Is certification current?

Yes

No

Dates of current certification

From (month/year)

To (month/year)

Have you been recertified?

Yes

No

Date

If status is qualified, give date status expires.

Date

If qualified, date exam scheduled.

Date

Board certification results pending?

Yes

No

Do you wish to be listed in the organization directory under this specialty?

Yes

No

SECONDARY SPECIALTY

(Secondary area of practice)

Qualified

Certified

Not certified

No board available

Certifying Board

Date of initial certification

Is certification current?

Yes

No

Dates of current certification

From (month/year)

To (month/year)

Have you been recertified?

Yes

No

Date

If status is qualified, give date status expires.

Date

If qualified, date exam scheduled.

Date

Board certification results pending?

Yes

No

Do you wish to be listed in the organization directory under this specialty?

Yes

No

If you have applied to a specialty board for examination, give the name of the board and the date of application.

Board _____	Date _____
Board _____	Date _____
Board _____	Date _____

**Note: Submit copies of all certificates with application including copies of letters attesting to board eligibility.*

PROFESSIONAL AFFILIATIONS (e.g. AMA, AOA) _____

**SECTION VI
HEALTH CARE AFFILIATIONS**

List all health care facilities at which you have privileges. (Copy this page for additional facilities.)

Status of Privileges Key

1 Active	4 Associate	7 Courtesy	10 Provisional	13 Pending
2 Courtesy Provisional Staff	5 Visiting	8 Admitting	11 Suspended	14 Other
3 Active Provisional Staff	6 Temporary	9 Senior Staff	12 Consulting	

PRIMARY FACILITY

Date affiliation started _____ Date affiliation ended (if applicable) _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Status of privileges (*indicate by using key*); explain coverage arrangements. _____

Any past or present restriction of privileges? Yes No
(If Yes, explain. Attach additional pages if necessary.)

SECONDARY FACILITY

Date affiliation started _____ Date affiliation ended (if applicable) _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Status of privileges (*indicate by using key*); explain coverage arrangements. _____

Any past or present restriction of privileges? Yes No
(If Yes, explain. Attach additional pages if necessary.)

SECONDARY FACILITY

Date affiliation started _____ Date affiliation ended (if applicable) _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Status of privileges (*indicate by using key*); explain coverage arrangements. _____

Any past or present restriction of privileges? Yes No
(If Yes, explain. Attach additional pages if necessary.)

OTHER FACILITIES

List all other health care facilities or practices where you have had privileges and indicate whether your privileges were restricted in any way at any of the facilities. (*Attach additional pages if necessary*)

OTHER FACILITY

Date affiliation started _____ Date affiliation ended (if applicable) _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Status of privileges (*indicate by using key*); explain coverage arrangements. _____

Any past or present restriction of privileges? Yes No
(*If Yes, explain. Attach additional pages if necessary.*)

**SECTION VII
PROFESSIONAL REFERENCES**

List three (3) professional/medical references from individuals who have worked extensively with you or who have been responsible for professional observation of your work within the past three years. Only one reference can be a current partner or associate. Do not include relatives.

Name _____
Address/Street _____
City/State/Zip _____
Phone _____ Fax _____
Relationship _____

Name _____
Address/Street _____
City/State/Zip _____
Phone _____ Fax _____
Relationship _____

Name _____
Address/Street _____
City/State/Zip _____
Phone _____ Fax _____
Relationship _____

**SECTION VIII
PROFESSIONAL LIABILITY INSURANCE COVERAGE**

Provide professional liability insurance coverage information for the previous ten (10) years.

Not Applicable Reason _____

MALPRACTICE CARRIER

Carrier Name _____
Address/Street _____
City/State/Zip _____
Phone _____ Fax _____ Website _____
Policy number _____
Length of time with this carrier _____

If coverage with this carrier is less than ten (10) years, please list your previous carrier(s). (Attach additional pages if necessary)

Amount of coverage
(Per claim/Aggregate)

Type of coverage

Occurrence Claims made

Effective dates (from/to)

Renewal date

Agent Name

Address/Street

City/State/Zip

PREVIOUS CARRIER

Carrier Name

Address/Street

City/State/Zip

Phone

Fax

Website

Policy number

Amount of coverage
(Per claim/Aggregate)

Type of coverage

Occurrence Claims made

Effective dates (from/to)

Agent Name

Address/Street

City/State/Zip

**SECTION IX
MALPRACTICE CLAIMS HISTORY**

Provide information for all cases occurring in previous ten (10) years. Attach additional sheets if necessary. This sheet may be photocopied. No claims to date

Date of occurrence _____ Date claim was filed with malpractice carrier _____

Professional liability carrier involved _____

Address (if different from Section VII) _____

Patient name _____ Age _____ Sex _____

Name of Plaintiff, if other than patient _____

You were (Check one): Primary Defendant Co-Defendant

Other Defendants (if any) _____

Describe the allegations against you _____

Describe the alleged injury to the patient _____

Claimant/Plaintiff filed suit in court Yes No If yes, date filed _____

State Court Case Number _____ State _____ County/Parish _____

Federal Court (U.S. District Court) Case Number _____ District _____

Present status of the Claim/Case (Include amount awarded/attribution/settlement)

Pending Settled Arbitrated Award

In Appeal Adjudicated Withdrawn Date _____

Other, please specify _____

If pending, amount being sought \$ _____

Amount of award or settlement \$ _____

Amount paid on your behalf \$ _____

Amount paid by all parties \$ _____

Additional information/explanation (e.g. the condition/diagnosis of the patient at the time of the incident, treatment rendered, and the condition of the patient subsequent to treatment)

**SECTION X
DISCLOSURE INFORMATION**

Please answer the following questions "yes" or "no". If your answer to questions 1-18 is "yes" or if your answer to question 19 is "no", please provide a written explanation on a separate sheet.

INSTRUCTION NOTE: A voluntary surrender or non-renewal is for reasons related to professional competence or conduct when the surrender or non-renewal is done to avoid an adverse action, preclude an investigation or is done while the licensee is under investigation related to professional competence or conduct.

- | | | | | | |
|-----|---|--------------------------|-----|--------------------------|----|
| 1. | Have any of your board certifications or equivalents ever been suspended, revoked, voluntarily surrendered or have you failed to recertify? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 2. | Has your professional license, in any jurisdiction, ever been voluntarily or involuntarily suspended, limited, revoked, denied, or surrendered or subjected to probationary conditions or are any such actions pending? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 3. | Has your DEA license or state narcotics registration ever been voluntarily or involuntarily suspended, limited, revoked, denied, or restricted for reasons other than non-completion of medical records or are any such actions pending? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 4. | Has your hospital or facility medical staff membership or have your hospital or facility professional privileges ever been voluntarily or involuntarily suspended, limited, revoked, denied or surrendered for reasons related to professional competence or conduct, other than non-completion of medical records or are any such actions pending? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 5. | Have you ever been placed on probation or asked to resign an internship or residency training program? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 6. | Has Medicare, Medicaid, or any other medical reimbursement plan ever voluntarily or involuntarily suspended, limited, revoked, denied, not renewed or terminated your participation for reasons related to professional competence or conduct? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 7. | Have you ever been or are you currently excluded from participation with Medicare or any other federally funded health care program? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 8. | Has your professional liability coverage ever been restricted, limited, denied, not renewed, or special rated (for reasons other than the carrier's termination of operations in your state)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 9. | Have you ever been named as a defendant in any criminal case? (excluding minor traffic infractions, but not DUIs) | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 10. | Have you ever been convicted of a felony? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 11. | Have you ever been disciplined for a violation of ethical standards by a professional organization? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

12. To your knowledge has information pertaining to you ever been reported to the National Practitioner Data Bank? Yes No
13. Do you have a history of engaging in the illegal use of drugs? (“Illegal use of drugs” means the use of any controlled substances illegally obtained, i.e. not obtained pursuant to a valid prescription and not taken in accordance with the direction of a licensed health care practitioner.) Yes No
14. Are you currently engaged in the illegal use of drugs? (“Currently” does not mean on the day of or even the weeks preceding the completion of this application. Rather, it means recently enough so that the illegal use may have an impact on one’s ability to practice.) Yes No
15. Are you currently in treatment for addiction to drugs or alcohol? Yes No
16. Within the last five years, have you been reprimanded or disciplined in any manner by any state licensing authority or other professional board for conduct related to the use of alcohol or the use of any drug? Yes No
17. Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital, ambulatory surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies? Yes No
18. Do you have any emotional or physical disabilities that may limit your ability to practice? Yes No
19. Are you able to perform the procedures and the essential functions of the position for which you have applied or requested privileges, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients? Yes No

**SECTION XI
AFFIRMATION OF INFORMATION**

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I understand that this application does not entitle me to participation in the network of any health plan using this application.

I release _____ "the Health Plan," its representatives, and any individuals or entities providing information to the Health Plan from liability for any act or omission related to the evaluation or verification contained in this application provided the Health Plan, its representatives and individuals providing information to the Health Plan act in good faith and without malice. I further agree to notify the Health Plan of any change to the information provided in this application within 30 days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by the Health Plan.

I authorize _____ and its agents and any individual or entity providing information to the Health Plan to investigate and evaluate my provider application, and consult with any person, organization, or entity that has, or could have any information, data, or documents regarding my background, competence, and credentials.

Applicant Signature

Print Name

Print Degree

Date

Note: Providers submitting completed credentialing forms to a health plan must complete and submit Section XI as shown. Health plans may, however, substitute their own release and affirmation page in place of this form.