



LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

DIRECTIONS

Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 10 for a list of required documents.

**** All sections must be completed in their entirety. "See C.V.", not acceptable****

GENERAL INFORMATION

Last Name		Suffix	First	Middle	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Degree: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> DC <input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> Other _____						
Any other name under which you have been known? (AKA) List			ECFMG Number		UPIN Number	
Home Street Address			City		State	Zip Code
Home Phone Number		Pager Number/Answering Service		Home Email Address (optional)		
Social Security Number		Date of Birth	Birth Place (City, State)		Race/Ethnicity (voluntary)	
NPI - Individual		Medicaid Provider Number		Medicare Provider Number		

PRIMARY PRACTICE LOCATION

Institution/Group/Clinic Name (If Applicable)				Office Manager		
Tax Identification Number		Effective Date of Provider at this Practice Location			NPI – Group	
Name to which Employer Identification Number (EIN) is registered with the IRS (IMPORTANT: must match IRS information exactly)						
Physical Address				City	State	Zip Code
Office Email			Office Website			
Main Phone Number		Appointment Phone Number		Fax Number		
Billing Address (Where you want payments sent)				Contact Person		Phone Number
City	State	Zip Code	Billing Email		Fax Number	
Correspondence Address (Where you want communications sent)				Contact Person		Phone Number
City	State	Zip Code	Correspondence Email		Fax Number	
Medical Records Address (Where you want medical record requests sent)				Contact Person		Phone Number
City	State	Zip Code	Medical Records Email		Fax Number	
Type of Practice: <input type="checkbox"/> Solo <input type="checkbox"/> Multi-specialty Group <input type="checkbox"/> Single Specialty Group <input type="checkbox"/> Hospital-based <input type="checkbox"/> Hospital-employed <input type="checkbox"/> Healthplan/Payor-owned						
If Hospital-employed or Healthplan/Payor-owned, please indicate owner name: _____						
Office Hours	Mon. _____-____	Tues. _____-____	Wed. _____-____	Thur. _____-____	Fri. _____-____	Sat. Sun. _____-____ _____-____
Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify) _____						
Languages spoken at this location (other than English): _____						<input type="checkbox"/> Provider <input type="checkbox"/> Other

PRIMARY PRACTICE LOCATION CONTINUED

Accepting Patients? <input type="checkbox"/> New <input type="checkbox"/> Only family members of existing patients		<input type="checkbox"/> Existing Only <input type="checkbox"/> Other (Specify) _____	
Age group(s) treated: <input type="checkbox"/> 0-6 years <input type="checkbox"/> 7-11 years <input type="checkbox"/> 12-18 years <input type="checkbox"/> 19-65 years		<input type="checkbox"/> Over 65 <input type="checkbox"/> All Ages <input type="checkbox"/> Other (Specify): _____	
Are PAs and/or nurse/paraprofessional practitioners used? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this facility wheelchair/ handicapped accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the office offer handicapped access for: Building: <input type="checkbox"/> Yes <input type="checkbox"/> No Parking: <input type="checkbox"/> Yes <input type="checkbox"/> No Restroom: <input type="checkbox"/> Yes <input type="checkbox"/> No		Other: _____	
Accessible by public transportation: Bus: <input type="checkbox"/> Yes <input type="checkbox"/> No Courier Service: <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____			
Offers services for the disabled: Text Telephony (TTY): <input type="checkbox"/> Yes <input type="checkbox"/> No American Sign Language: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Mental/Physical Impairment Services: <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____			
Does the office meet the Americans with Disabilities Act (ADA) accessibility requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Emergency After Hours Number		Arrangements for 24 hour / 7 day a week coverage (Specify)	
Group, Covering or Collaborating Physician(s):			
Contact Name:		Contact Phone Number:	

SECOND PRACTICE LOCATION

Institution/Group/Clinic Name <i>(If Applicable)</i>			Office Manager				
Tax Identification Number		Effective Date of Provider at this Practice Location		NPI – Group			
Name to which Employer Identification Number (EIN) is registered with the IRS (IMPORTANT: must match IRS information exactly)							
Physical Address			City		State	Zip Code	
Office Email			Office Website				
Main Phone Number		Appointment Phone Number		Fax Number			
Billing Address <i>(Where you want payments sent)</i>			Contact Person		Phone Number		
City	State	Zip Code	Billing Email		Fax Number		
Correspondence Address <i>(Where you want communications sent)</i>			Contact Person		Phone Number		
City	State	Zip Code	Correspondence Email		Fax Number		
Medical Records Address <i>(Where you want medical record requests sent)</i>			Contact Person		Phone Number		
City	State	Zip Code	Medical Records Email		Fax Number		
Type of Practice: <input type="checkbox"/> Solo <input type="checkbox"/> Multi-specialty Group <input type="checkbox"/> Single Specialty Group <input type="checkbox"/> Hospital-based							
<input type="checkbox"/> Hospital-employed <input type="checkbox"/> Healthplan/Payor-owned							
If Hospital-employed or Healthplan/Payor-owned, please indicate owner name: _____							
Office Hours	Mon. _____	Tues. _____	Wed. _____	Thur. _____	Fri. _____	Sat. _____	Sun. _____
Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify) _____							
Languages spoken at this location <i>(other than English)</i> : _____							
<input type="checkbox"/> Provider <input type="checkbox"/> Other							

SECOND PRACTICE LOCATION CONTINUED

Accepting Patients?	<input type="checkbox"/> New	<input type="checkbox"/> Only family members of existing patients
	<input type="checkbox"/> Existing Only	<input type="checkbox"/> Other (Specify) _____
Age group(s) treated:	<input type="checkbox"/> 0-6 years	<input type="checkbox"/> 7-11 years
	<input type="checkbox"/> Over 65	<input type="checkbox"/> All Ages
	<input type="checkbox"/> 12-18 years	<input type="checkbox"/> 19-65 years
	<input type="checkbox"/> Other (Specify): _____	
Are PAs and/or nurse/paraprofessional practitioners used?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this facility wheelchair/ handicapped accessible?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the office offer handicapped access for:	Building: <input type="checkbox"/> Yes <input type="checkbox"/> No	Parking: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Other: _____	Restroom: <input type="checkbox"/> Yes <input type="checkbox"/> No
Accessible by public transportation:	Bus: <input type="checkbox"/> Yes <input type="checkbox"/> No	Courier Service: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Other: _____	
Offers services for the disabled:	Text Telephony (TTY): <input type="checkbox"/> Yes <input type="checkbox"/> No	American Sign Language: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Mental/Physical Impairment Services: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____
Does the office meet the Americans with Disabilities Act (ADA) accessibility requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Emergency After Hours Number	Arrangements for 24 hour / 7 day a week coverage (Specify)	
Group, Covering or Collaborating Physician(s):		
Contact Name:	Contact Phone Number:	

THIRD PRACTICE LOCATION

Institution/Group/Clinic Name <i>(If Applicable)</i>				Office Manager			
Tax Identification Number		Effective Date of Provider at this Practice Location			NPI – Group		
Name to which Employer Identification Number (EIN) is registered with the IRS (IMPORTANT: must match IRS information exactly)							
Physical Address				City		State	Zip Code
Office Email				Office Website			
Main Phone Number		Appointment Phone Number			Fax Number		
Billing Address <i>(Where you want payments sent)</i>				Contact Person		Phone Number	
City	State	Zip Code	Billing Email			Fax Number	
Correspondence Address <i>(Where you want communications sent)</i>				Contact Person		Phone Number	
City	State	Zip Code	Correspondence Email			Fax Number	
Medical Records Address <i>(Where you want medical record requests sent)</i>				Contact Person		Phone Number	
City	State	Zip Code	Medical Records Email			Fax Number	
Type of Practice:	<input type="checkbox"/> Solo	<input type="checkbox"/> Multi-specialty Group	<input type="checkbox"/> Single Specialty Group	<input type="checkbox"/> Hospital-based			
	<input type="checkbox"/> Hospital-employed		<input type="checkbox"/> Healthplan/Payor-owned				
If Hospital-employed or Healthplan/Payor-owned, please indicate owner name: _____							
Office Hours	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.
	_____	_____	_____	_____	_____	_____	_____
Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify) _____							
Languages spoken at this location <i>(other than English)</i> : _____							<input type="checkbox"/> Provider
							<input type="checkbox"/> Other
Accepting Patients?	<input type="checkbox"/> New	<input type="checkbox"/> Only family members of existing patients					
	<input type="checkbox"/> Existing Only	<input type="checkbox"/> Other (Specify) _____					

THIRD PRACTICE LOCATION CONTINUED

Age group(s) treated:				<input type="checkbox"/> 0-6 years	<input type="checkbox"/> 7-11 years	<input type="checkbox"/> 12-18 years	<input type="checkbox"/> 19-65 years
				<input type="checkbox"/> Over 65	<input type="checkbox"/> All Ages	<input type="checkbox"/> Other (Specify): _____	
Are PAs and/or nurse/paraprofessional practitioners used?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is this facility wheelchair/ handicapped accessible?	
				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the office offer handicapped access for:				Building:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parking: <input type="checkbox"/> Yes <input type="checkbox"/> No
				Other: _____		Restroom:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Accessible by public transportation:				Bus:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Courier Service: <input type="checkbox"/> Yes <input type="checkbox"/> No
				Other: _____			
Offers services for the disabled:				Text Telephony (TTY):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	American Sign Language: <input type="checkbox"/> Yes <input type="checkbox"/> No
				Mental/Physical Impairment Services:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other: _____
Does the office meet the Americans with Disabilities Act (ADA) accessibility requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Emergency After Hours Number				Arrangements for 24 hour / 7 day a week coverage (Specify)			
Group, Covering or Collaborating Physician(s):							
Contact Name:				Contact Phone Number:			

FOURTH PRACTICE LOCATION

(If you have more than four locations, attach additional sheets with the following information.)

Institution/Group/Clinic Name (If Applicable)						Office Manager		
Tax Identification Number		Effective Date of Provider at this Practice Location			NPI – Group			
Name to which Employer Identification Number (EIN) is registered with the IRS (IMPORTANT: must match IRS information exactly)								
Physical Address					City		State	Zip Code
Office Email				Office Website				
Main Phone Number			Appointment Phone Number		Fax Number			
Billing Address (Where you want payments sent)					Contact Person		Phone Number	
City		State	Zip Code	Billing Email		Fax Number		
Correspondence Address (Where you want communications sent)					Contact Person		Phone Number	
City		State	Zip Code	Correspondence Email		Fax Number		
Medical Records Address (Where you want medical record requests sent)					Contact Person		Phone Number	
City		State	Zip Code	Medical Records Email		Fax Number		
Type of Practice: <input type="checkbox"/> Solo <input type="checkbox"/> Multi-specialty Group <input type="checkbox"/> Single Specialty Group <input type="checkbox"/> Hospital-based								
<input type="checkbox"/> Hospital-employed <input type="checkbox"/> Healthplan/Payor-owned								
If Hospital-employed or Healthplan/Payor-owned, please indicate owner name: _____								
Office Hours		Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.
		_____	_____	_____	_____	_____	_____	_____
Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify) _____								
Languages spoken at this location (other than English): _____							<input type="checkbox"/> Provider	
							<input type="checkbox"/> Other	
Accepting Patients? <input type="checkbox"/> New <input type="checkbox"/> Existing Only <input type="checkbox"/> Only family members of existing patients <input type="checkbox"/> Other (Specify) _____								

CURRENT HOSPITAL AFFILIATION

List the hospital to which you primarily admit your patients: _____

List in **chronological** order from oldest to most current all hospitals at which you currently have privileges:

Hospital	Location/Address	Type of Privileges	Effective Date MO/YR
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If you do not have admitting privileges, who admits for you and to what hospital? Please list provider's name, specialty and hospital.

EDUCATION

If additional training to what is requested below has been completed, please attach on a separate form.

Medical/Professional School:

City	State	Zip
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Degree	Year of Graduation	Dates Attended (MO/YR): From: _____ to _____
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Internship: Institution Name	Type of Training
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City	State
------	-------

University Affiliation	Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates Attended (MO/YR): From: _____ to _____
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Residency: Institution Name	Type of Residency	<input type="checkbox"/> Clinical <input type="checkbox"/> Research
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City	State	Dates Attended (MO/YR): From: _____ to _____
------	-------	---

University Affiliation	Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Residency: Institution Name	Type of Residency	<input type="checkbox"/> Clinical <input type="checkbox"/> Research
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City	State	Dates Attended (MO/YR): From: _____ to _____
------	-------	---

University Affiliation	Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Fellowship: Institution Name	Specialty Field	Dates Attended (MO/YR): From: _____ to _____
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City	State	Completed <input type="checkbox"/> Yes <input type="checkbox"/> No
------	-------	---

	Type of Fellowship	<input type="checkbox"/> Clinical <input type="checkbox"/> Research
--	--------------------	--

Fellowship: Institution Name	Subspecialty Fields	Dates Attended (MO/YR): From: _____ to _____
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City	State	Completed <input type="checkbox"/> Yes <input type="checkbox"/> No
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	Type of Fellowship	<input type="checkbox"/> Clinical <input type="checkbox"/> Research
--	--------------------	--

WORK HISTORY

Using the following codes, please list in **chronological order** from oldest to most current your work history from the time you completed your medical training to the present. **It is very important that you use the MONTH and YEAR for each entity listed. Work history is critical. Failure to provide this information may delay your credentialing.**

Code:
C = Clinic/Group **S** = Solo Practice **A** = Academic (Paid Teaching Appointments)
H = Civilian Hospital Medical Staff Appointment **M** = Military Service (Including Hospital Staff Appointments) **O** = Other

CODE	NAME AND ADDRESS OF ENTITY	DATE (From MO/YR to MO/YR)
_____	_____	____ / ____ to ____ / ____
_____	_____	____ / ____ to ____ / ____
_____	_____	____ / ____ to ____ / ____
_____	_____	____ / ____ to ____ / ____
_____	_____	____ / ____ to ____ / ____
_____	_____	____ / ____ to ____ / ____
_____	_____	____ / ____ to ____ / ____
_____	_____	____ / ____ to ____ / ____
_____	_____	____ / ____ to ____ / ____
_____	_____	____ / ____ to ____ / ____

WORK HISTORY GAP

In the following section, please explain any gaps of two months or more in your education, post-graduate training or work history.

Failure to provide this information may delay your credentialing

PROFESSIONAL LICENSES

Professional Licenses	License Number	Date Obtained	Expiration Date
State License			
Federal DEA Reg Number			
State CDS License Number			
CLIA Certificate			

Are laboratory testing procedures (as covered by the Clinical Improvement Act – CLIA) currently being performed at your office site where members are seen?

Yes No **If yes, a current copy of your CLIA Registration must accompany this application.**

For Dentists Only - Do you perform any procedures in the office setting utilizing conscious sedation or any anesthesia (other than oral analgesic)?

Yes No **If yes, a copy of your Anesthesia Permit must accompany this application.**

Have you been or are you currently licensed in any other state? If YES, please complete the following:

License Number	State	Date Obtained	Expiration Date
License Number	State	Date Obtained	Expiration Date
License Number	State	Date Obtained	Expiration Date

(Please attach a copy of all licenses listed above and additional ones in other states not listed.)

REFERENCES

List, as professional references, three or more peers (Physicians of the same or similar specialty) who are familiar with your work effort and skills during the past two years.
(References should not be relatives or current partners.)

Name	Specialty	Phone Number
Street Address	City	State Zip
Name	Specialty	Phone Number
Street Address	City	State Zip
Name	Specialty	Phone Number
Street Address	City	State Zip
Name	Specialty	Phone Number
Street Address	City	State Zip

PROFESSIONAL LIABILITY INSURANCE COVERAGE

Name of Carrier:	Policy Number:
Address of Carrier:	Phone Number:
Amounts Per Occurrence/Aggregate:	Dates of Coverage:
Do you participate in the Louisiana Patients' Compensation Fund?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you self-insured in accordance with the Louisiana Medical Malpractice Act?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has current liability insurance carrier required exclusion of any procedures from insurance coverage? (If yes, attach explanation)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please attach a copy of the current Certificates of Insurance.

GENERAL QUESTIONS

Please check the appropriate response to the following questions:

If you answered YES to any of the questions below, please attach a full explanation on a separate page.

	YES	NO	N/A
1. Has any disciplinary action ever been instituted against your license to practice in your profession in any state or country, or is any such action currently pending against you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has any disciplinary action ever been instituted against your DEA registration or CDS license, or have you voluntarily surrendered or limited your registration, or is any such action pending?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been convicted of, or pleaded nolo contendere to, or are you currently under investigation for federal or state felony or other criminal charge or have you ever served a prison sentence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have your clinical privileges at any hospital or healthcare institutions been voluntarily or involuntarily revoked, not renewed, or subjected to probationary or other disciplinary conditions, or has any proceeding been instituted or recommended by a hospital administration, medical staff committee or governing board?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever received a sanction from any regulatory agency (e.g., CLIA, OSHA, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you engaged in the illegal use of drugs within the past two years? "Illegal use of drugs" means the use of controlled substances obtained illegally, not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you currently have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you, your business entity or any family member have an ownership greater than 5% in any medical enterprise or business? If YES, please enter the ownership percentage _____ and attach a full explanation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you presently a named defendant in a pending professional liability lawsuit? If YES, please enter the number of cases _____ and attach a full explanation of each.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. During the past 5 years has any adverse medical review panel opinion been rendered, has any settlement or judgment been made, or has any payment been made by you or on your behalf in a professional liability action or potential action? If YES, please enter the number of cases _____ and attach a full explanation of each.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REQUIRED ATTACHMENTS

- ✓ State Licenses including current licenses held in other states, State CDS license and Federal DEA Registration
- ✓ Curriculum Vitae
- ✓ Certificate(s) of Professional Liability Insurance
- ✓ History of Malpractice suits in past 5 years, regardless of whether judgments or settlements paid.
- ✓ Explanation of any "Yes" Answer(s) from General Questions Section on page 9.
- ✓ Current Employer Identification Number (EIN) **and** W-9 Form or Federal Tax Deposit Coupon
- ✓ Education Certificate for Foreign Medical Graduates (ECFMG) (If applicable)
- ✓ Health Plan Agreement (If applicable)

STATEMENT TO APPLICANTS

All providers applying for network participation have the right to review the credentialing application and supporting documents. Exceptions may vary as prohibited by law or health plan policy.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have the opportunity to submit additional information to correct the discrepancy or provide clarification that might positively impact the credentialing decision.

According to La. R.S. 22:1009 (A) (8) an adverse medical review panel opinion is included in the type of information a health plan may require you to submit on a credentialing or re-credentialing application.

According to La. R.S. 22:1009, a health insurance issuer is required to complete the credentialing process within 90 days from the date of receipt of all information needed. The issuer is required to inform you within 30 days of receipt all defects and reasons known at the time in the event an application is deemed to be not correctly completed. The issuer is also required to inform you in the event that any needed verification or verification supporting statement has not been received from a third party within 60 days of the date of such a request.

PROVIDER STATEMENT TO RELEASE INFORMATION

All information and documentation submitted by me in this application is correct and complete to my best knowledge and belief.

I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for network participation.

I consent to the release of all information that may be relevant to an evaluation of my credentials, including information about disciplinary actions or other confidential or privileged information, to Plan or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which I am Plan provider. I release Plan, its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials. Plan is defined as the Health Plan that is requesting the credentialing information.

X

Name *(Please Print)*

Signature

Original Attestation Date

Second Attestation Date

Third Attestation Date

Plan accreditation guidelines may require this application signature date to be no more than 180 days old at the time of credentialing.