Standardized

Credentialing

Application

To Be Used By Health Care Organizations

Licensed in the State of Kansas

COMPLETE EACH SECTION AS THOROUGHLY AS POSSIBLE. PLEASE TYPE OR PRINT.

I. GENERAL INFORMATION

1. _____
Name (Last, First, MI, Degree/Prof. Designation-M.D./D.O./PH.D./M.S.W./D.C./D.P.M./D.D.S./D.M.D./A.P.N./P.A./Other)

2. _____
Home Address/Street

3. _____
City/County/State/ZIP

4. _____
E-Mail Address

5. _____
Other Names You May Have Used (i.e. Maiden, etc.)

6. _____
Date of Birth (Month/Day/Year)

7. _____
Place of Birth

8. _____
Social Security Number

9. Are You a U.S. Citizen? Yes_____ No_____

10. Sex: Male_____ Female_____

If Not a Citizen of the U.S., indicate the Current Status Of Your VISA:

_____

_____

Form Authorized by the Kansas Insurance Department 1999
DO NOT *SUBMIT COMPLETED FORM TO THE INSURANCE DEPARTMENT*
This form may also be found and downloaded from www.ksinsurance.org

Last Revised 6/5/00

II. OFFICE/PRACTICE INFORMATION

If More Than Two Offices, Check Here____and Attach a Copy of Page 3, Completing Questions 22-40 for Each Office.

1. Participation Status For Which You Are Applying: (Indicate Specialty)
   Primary Care:_____ Specialty:_____ Subspecialty:_____ Both:_____ Patient Ages:_____
2. _____
   PRIMARY OFFICE Address/Street/Building/Suite
3. _____
   City/County/State/ZIP (Should this practice location be listed in provider directory? Yes_____ No_____)
4. _____
   Tax ID # Owner/Corporate Name as Appears on SS4 or W-9 Form (or Full Legal Name)
5. _____
   Business Name or Name By Which the Provider Group is Generally Known
6. _____
   Office Phone Number
7. _____
   After Hours/Emergency Number or Procedure
8. _____
   Office Fax Number
9. _____
   Office E-Mail Address
10. _____
    Office Manager
11. _____
    Federal Tax ID#
12. _____
    Billing Address/Street (If Different From Above)
13. _____
    Billing City/State/ZIP
14. List Routine Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday

15. Evening Hours Yes_____ No_____ If Yes, List Hours After 5:00 P.M.

Monday	Tuesday	Wednesday	Thursday	Friday

16. Weekend Hours: Yes_____ No_____

Saturday	Sunday

17.(a) Lab Service in Your Office:
Yes_____ No_____

17.(b)_____
If Yes, specify Waived, Physician Performed Microscopy, Moderately Complex, Highly Complex

18. Please check all of the following that you perform IN THIS OFFICE:

EKG_____ Office gynecology (Routine Pelvic/PAP)_____ Drawing Blood_____ Age appropriate immunizations_____
X-Rays_____ Minor Surgery_____ Tympanometry/audiometry screening_____ Flexible sigmoidoscopy_____
Laceration Repair_____ Pulmonary Function Studies_____ Asthma Treatment_____ Allergy Skin Testing_____
Osteopathic manipulation_____ IV Hydration/treatment_____ Other (please specify)_____

19. (a) Languages Spoken (other than English):
_____
(Health Care Provider)

(b) Are Interpreters Available? Yes_____ No_____
_____
(Staff)

20. Does Your Office: (CIRCLE ONE)

(a) Have 24-hr. Phone Coverage Service? Y N
(b) Qualify as a Minority Business Enterprise? Y N
(c) Have Capability for Electronic Billing? Y N
(d) Provide Child Care Services for Patients? Y N
(e) Meet ADA Accessibility Standards? Y N
(f) Have Public Transportation Accessibility? Y N
(g) Collaborate With an Advanced Nurse Practitioner or Physician Assistant (P.A.)? Y N
If Yes, Provide a Copy of Appropriate Collaborative Practice or P.A. Agreement(s) & the name(s) of the individual(s).
(h) Type of Practice: Solo Single Specialty Group Multispecialty Group Other
If Group Practice, Attach a List of Other Members of Your Practice, Their Specialties, and Coverage Arrangements.

21. Do You Currently: (CIRCLE ONE)

(a) Accept New Patients Into Practice Y N
(b) Accept New Patients By Physician Referral Only? Y N
(c) Have Medicare Certification? Y N
(d) Accept Medicare Assignment? Y N
(e) Provide Inpatient Care? Y N
(f) Accept Medicaid Assignment? Y N

II. OFFICE/PRACTICE INFORMATION (cont'd.)

Attach Additional Copies As Necessary

22. _____
SECONDARY OFFICE Address/Street/Building/Suite

23. _____
City/County/State/ZIP (Should this practice location be listed in provider directory? Yes_____ No_____)

24. _____
Tax ID # Owner/Corporate Name as Appears on SS4 or W-9 Form (or Full Legal Name)

25. _____
Business Name or Name By Which the Provider Group is Generally Known

26. _____
Office Phone Number

27. _____
After Hours/Emergency Number or Procedure

28. _____
Office Fax Number

29. _____
Office E-Mail Address

30. _____
Office Manager

31. _____
Federal Tax ID#

32. _____
Billing Address/Street (If Different From Above)

33. _____
Billing City/State/ZIP

34. List Routine Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday

35. Evening Hours Yes_____ No_____ If Yes, List Hours After 5:00 P.M.

Monday	Tuesday	Wednesday	Thursday	Friday

36. Weekend Hours: Yes_____ No_____

Saturday	Sunday

37.(a) Lab Service in Your Office:
Yes_____ No_____

37.(b)_____
If Yes, specify Waived, Physician Performed Microscopy, Moderately Complex, Highly Complex

38. Please check all of the following that you perform IN THIS OFFICE:

EKG_____ Office Gynecology (Routine Pelvic/PAP)_____ Drawing Blood_____ Age appropriate immunizations_____
X-Rays_____ minor Surgery_____ Tympanometry/audiometry screening_____ Flexible sigmoidoscopy_____
Laceration Repair_____ Pulmonary Function Studies_____ Asthma Treatment_____ Allergy Skin Testing_____
Osteopathic Maniuplation_____ IV Hydration/treatment_____ Other (please specify)_____

39. (a) Language Spoken (other than English): _____ (Health Care Provider)

(b) Are Interpreters Available? Yes_____ No_____ _____ (Staff)

40. Does Your Office: (CIRCLE ONE)

(a) Have 24-hr. Phone Coverage Service? Y N
(b) Qualify as a Minority Business Enterprise? Y N
(c) Have Capability for Electronic Billing? Y N
(d) Provide Child Care Services for Patients? Y N
(e) Meet ADA Accessibility Standards? Y N
(f) Have Public Transportation Accessibility? Y N
(g) Collaborate With an Advanced Nurse Practitioner or Physician Assistant (P.A.)? Y N
If Yes, Provide a Copy of Appropriate Collaborative Practice or P.A. Agreement(s) & the name(s) of the individual(s).
(h) Type of Practice: Solo Single Specialty Group Multispecialty Group Other
If Group Practice, Attach a List of Other Members of Your Practice, Their Specialties, and Coverage Arrangements.

III(A). PROFESSIONAL EDUCATION

List All Medical Schools/Institutions Attended
Please Explain Any 30 Day or Greater Gap In Your Training. Attach Additional Sheets If Necessary.

1. _____
   Medical/Professional School Name
2. _____
   Address/Street
3. _____
   City/State/Zip/Country
4. From: _____ To: _____
   Dated Attended (month/year)
5. _____
   Degree(s) Awarded
6. If You Are a Graduate of a Foreign Medical School, Are You Certified by the Education Council for Foreign Medical Graduates (ECFMG)? If Yes, Please Enclose a Copy of Your Certificate With This Application.
   Yes_____ No_____

III(B). POSTGRADUATE TRAINING: INTERNSHIP

1. _____
   Institution Name
2. _____
   Address/Street
3. _____
   City/State/Zip
4. From: _____ To: _____
   Dated Attended (month/year)
5. _____
   Department Chair/Program Director
6. _____
   Type of Internship (Rotating/Straight). If Straight, Please List Specialty.

III(C). POSTGRADUATE TRAINING: FIRST RESIDENCY

1. _____
   Institution Name
2. _____
   Address/Street
3. _____
   City/State/Zip
4. From: _____ To: _____
   Dated Attended (month/year)
5. _____
   Department Chair/Program Director
6. _____
   Type of Residency

III(D). POSTGRADUATE TRAINING: SECOND RESIDENCY OR FELLOWSHIP

1. _____
   Institution Name
2. _____
   Address/Street
3. _____
   City/State/Zip
4. From: _____ To: _____
   Dated Attended (month/year)
5. _____
   Department Chair/Program Director
6. _____
   Type of Residency/Fellowship

III(E). POSTGRADUATE TRAINING: FELLOWSHIP/OTHER

1. _____
   Institution Name
2. _____
   Address/Street
3. _____
   City/State/Zip
4. From: _____ To: _____
   Dated Attended (month/year)
5. _____
   Department Chair/Program Director
6. _____
   Type of Fellowship/Other Explanation

IV(A). HOSPITAL AFFILIATIONS: PRIMARY

1. _____
   CURRENT PRIMARY HOSPITAL NAME
2. _____
   Address/Street
3. _____
   City/State/Zip

Status of Privileges Key

1. Active	4. Associate	7. Courtesy	10. Senior Staff	13. Consulting
2. Courtesy Provisional Staff	5. Visiting	8. Admitting	11. Provisional	14. Pending
3. Active Provisional Staff	6. Temporary	9. Co-Admitting	12. Suspended	15. Other _____

4. _____
   Status of Privileges *(INDICATE BY USING KEY)*
5. From: _____ To: _____.
   Dates Affiliated (month/year)

If Co-Admitting Status, List Other Admitting Physician(s)_____

6. Any past or present restriction of privileges? Yes_____ No_____ (If Yes, explain) _____

_____

IV(B). HOSPITAL AFFILIATIONS: OTHER

List All Other Hospitals At Which You Have Or Have Had Privileges.

1a. _____
HOSPITAL NAME

2a. _____
Address/Street

3a. _____
City/State/Zip

4a. _____
Status of Privileges *(INDICATE BY USING KEY)*

5a. From: _____ To: _____.
Dates Affiliated (month/year)

If Co-Admitting Status, List Other Admitting Physician(s)_____

6a. Any past or present restriction of privileges? Yes_____ No_____ (If Yes, explain) _____

_____

1b. _____
HOSPITAL NAME

2b. _____
Address/Street

3b. _____
City/State/Zip

4b. _____
Status of Privileges *(INDICATE BY USING KEY)*

5b. From: _____ To: _____.
Dates Affiliated (month/year)

If Co-Admitting Status, List Other Admitting Physician(s)_____

6b. Any past or present restriction of privileges? Yes_____ No_____ (If Yes, explain) _____

_____

IV(B). HOSPITAL AFFILIATIONS: OTHER (cont'd.)

1c. _____
HOSPITAL NAME
2c. _____
Address/Street
3c. _____
City/State/Zip
4c. _____ 5c. From: _____ To: _____.
Status of Privileges *(INDICATE BY USING KEY)* Dates Affiliated (month/year)
If Co-Admitting Status, List Other Admitting Physician(s)_____

6c. Any past or present restriction of privileges? Yes_____ No_____ (If Yes, explain) _____

_____

IV(C). OTHER PRACTICE AFFILIATIONS (e.g. HMOs, PPOs, IPAs,PHOs, etc.)

Attach Additional Pages If Necessary

1a. _____
Institution/Organization Name
2a. _____
Address/Street
3a. _____
City/State/Zip
4a. _____ 5a. From: _____ To: _____.
Type of Affiliation Dates Affiliated (month/year)

1b. _____
Institution/Organization Name
2b. _____
Address/Street
3b. _____
City/State/Zip
4b. _____ 5b. From: _____ To: _____.
Type of Affiliation Dates Affiliated (month/year)

1c. _____
Institution/Organization Name
2c. _____
Address/Street
3c. _____
City/State/Zip
4c. _____ 5c. From: _____ To: _____.
Type of Affiliation Dates Affiliated (month/year)

1d. _____
Institution/Organization Name
2d. _____
Address/Street
3d. _____
City/State/Zip
4d. _____ 5d. From: _____ To: _____.
Type of Affiliation Dates Affiliated (month/year)

1e. _____
Institution/Organization Name
2e. _____
Address/Street
3e. _____
City/State/Zip
4e. _____ 5e. From: _____ To: _____.
Type of Affiliation Dates Affiliated (month/year)

V. PRACTICE SPECIALTY

Attach Copy of Certificate(s). If Not Applicable to Your Profession/Specialty, Complete With N/A.

1. _____ PRIMARY SPECIALTY/BOARD CERTIFICATION
2. _____ Certification Number
3. _____ Name of Board
4. _____ Date of Certification
5. _____ Expiration Date
6. _____ Date of Recertification (If Applicable)
7. _____ If Not Certified, Indicate Current Status and/or Date Intending to Sit For Boards
8. _____ SECONDARY SPECIALTY/BOARD CERTIFICATION
9. _____ Certification Number
10. _____ Name of Board
11. _____ Date of Certification
12. _____ Expiration Date
13. _____ Date of Recertification (If Applicable)
14. _____ If Not Certified, Indicate Current Status and/or Date Intending to Sit For Boards

VI. WORK/PRACTICE HISTORY

List Chronologically All Employment, Including Self Employment, For the Last Ten (10) Years, For Any Gap in Chronology, Explain On a Separate Sheet. Leave no Time Period Unaccounted For Within the Last Ten (10) Years, Excluding Previously Stated Training. Attach Additional Sheets If Necessary.

1a. _____ NAME OF PREVIOUS PRACTICE
2a. _____ Address/Street
3a. _____ City/State/Zip
4a. _____ Phone Number
5a. _____ Title or Professional Occupation
6a. From: _____ To: _____ Dates of Employment (month/year)

1b. _____ NAME OF PREVIOUS PRACTICE
2b. _____ Address/Street
3b. _____ City/State/Zip
4b. _____ Phone Number
5b. _____ Title or Professional Occupation
6b. From: _____ To: _____ Dates of Employment (month/year)

1c. _____ NAME OF PREVIOUS PRACTICE
2c. _____ Address/Street
3c. _____ City/State/Zip
4c. _____ Phone Number
5c. _____ Title or Professional Occupation
6c. From: _____ To: _____ Dates of Employment (month/year)

1d. _____ NAME OF PREVIOUS PRACTICE
2d. _____ Address/Street
3d. _____ City/State/Zip
4d. _____ Phone Number
5d. _____ Title or Professional Occupation
6d. From: _____ To: _____ Dates of Employment (month/year)

VII. PROFESSIONAL CERTIFICATES/LICENSE NUMBERS

List All States in Which You Have Held, or Currently Hold, a License to Practice Your Profession. Please Attach Copies.

1. _____ License/Certification/Registration Number; Licensing State
2. _____ Expiration Date
3. _____ Other License/Certification/Registration Number; Licensing State
4. _____ Expiration Date
5. _____ Other License/Certification/RegistrationNumber; Licensing State
6. _____ Expiration Date
7. _____ Federal Drug Enforcement Agency (DEA) Number(s)
8. _____ Expiration Date(s)
9. _____ CDS Certification Number (BNDD Number for Missouri
10. _____ Expiration Date
11. _____ Medicare/Unique Provider ID Number (UPIN)
12. _____ National Provider ID Number (NPI)
13. _____ State Medicaid Number(s); Licensing State
14. _____ ECFMG Number

VIII. PROFESSIONAL LIABILITY INSURANCE INFORMATION

Please Attach a Copy of Your Current Certificate(s) or Declaration(s) of Insurance, Including HCSF for Kansas Practitioners.

1a. _____ CURRENT CARRIER NAME

2a. _____ Address/Street

3a. _____ City/State/Zip

4a. _____ Phone Number

5a. _____ Policy Number

6a. From: _____ To: _____ Dates of Coverage (month/year)

7. Indicate Coverage Type: Claims Based _____ Occurrence Based _____

8. Policy Limits: Per Occurrence $_____ Aggregate $_____

Prior Carriers Within the Last Ten (10) Years. Attach Additional Sheets If Necessary.

1b. _____ PREVIOUS CARRIER NAME

2b. _____ Address/Street

3b. _____ City/State/Zip

4b. _____ Phone Number

5b. _____ Policy Number

6b. From: _____ To: _____ Dates of Coverage (month/year)

1c. _____ PREVIOUS CARRIER NAME

2c. _____ Address/Street

3c. _____ City/State/Zip

4c. _____ Phone Number

5c. _____ Policy Number

6c. From: _____ To: _____ Dates of Coverage (month/year)

1d. _____ PREVIOUS CARRIER NAME

2d. _____ Address/Street

3d. _____ City/State/Zip

4d. _____ Phone Number

5d. _____ Policy Number

6d. From: _____ To: _____ Dates of Coverage (month/year)

IX. MALPRACTICE CLAIMS HISTORY

Are You Currently or Have You Within The Last Ten (10) Years Been Involved in a Malpractice Suit or Other Suit or Claim In Which Your Care and Treatment of a Patient Was At Issue, Including Pending or Dismissed Cases or Claims Settled Before or During Trial, or Settled to Avoid a Lawsuit? Yes_____ No _____ If Yes, Answer the Following Questions For EACH Such Claim. Duplicate This Page As Necessary.

1. _____ Patient Name

2. _____ Plaintiff Name, If Other Than Patient

3. _____ Your Involvement in the Case (Attending, Consulting, Etc.)

4. _____ Date of Occurrence (month/day/year)

5. _____ Your Status in the Case (Primary Defendant, Co-Defendant, Etc.)

6. _____ Date Claim Was Filed (month/day/year)

7. _____ Professional Liability Insurance Carrier Involved

8. _____ Carrier's Phone Number

9. _____ Policy Number

10. _____ Additional Defendants

11. Describe the Allegations Against You:_____

_____

_____

12. Describe the Alleged Injury to the Patient:_____

_____

_____

13. Claimant/Plaintiff Filed Suit In Court? Yes _____ No _____

14. _____ State Court Case Number

15. _____ State

16. _____ County/Parish

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

18. _____ District

19. Present Status of Claim: Open _____ Closed _____ Pending _____

If PENDING, DO NOT Complete the Rest of This Page EXCEPT For Signature and Date.

20. If Closed, Indicate the Method of Resolution:

_____ Dismissed Date: _____

_____ Settled (With Prejudice) Date: _____

_____ Settled (Without Prejudice) Date: _____

_____ Judgment for Defendant(s) Date: _____

_____ Judgment for Plaintiff(s) Date: _____

_____ Other Date: _____

21. _____ Settlement Amount Paid On Your Behalf (If Any)

22. Additional Information/Explanation:
(e.g. Patient Condition and Diagnosis At Time of Incident, Description of Treatment, Subsequent Patient Outcome, Etc.)

_____

_____

_____

_____

_____ Signature

_____ Date (month/day/year)

X. ADDITIONAL INFORMATION

Please Answer the Following Questions By Circling "Y" (Yes) or "N" (No).
Please Provide an Explanation For Any "Yes" Responses on a Separate Page.

1. Have any of your board certifications ever been suspended, revoked, not renewed, denied renewal, or voluntarily or involuntarily surrendered?	Y	N	N/A
2. Have you ever been named as a defendant in any criminal case?	Y	N	N/A
3. Have you ever been convicted, pled guilty, or pled nolo contendere to any felony, any offense reasonably related to your qualifications, functions, or duties as a medical professional, or any offense an essential element of which is fraud, dishonesty, or an act of violence?	Y	N	N/A
4. Has your malpractice insurance ever been canceled, suspended, not renewed, special rated, or restricted by the exclusion of any specific procedures from coverage?	Y	N	N/A
5. Have you ever been denied participation, suspended from, or denied renewal from the Medicare or Medicaid program, or had participation status modified?	Y	N	N/A
6. Has your authority to practice in any state been suspended, revoked, voluntarily or involuntarily surrendered, been subject to a consent order or stipulation, not renewed, denial renewal, or has probation ever been invoked?	Y	N	N/A
7. Has your federal or state controlled substance license ever been suspended, revoked, voluntarily or involuntarily surrendered, restricted, not renewed, denied renewal, or has probation ever been invoked?	Y	N	N/A
8. Have your privileges at any hospital or other health care setting ever been suspended, revoked, voluntarily or involuntarily surrendered, reduced, restricted, not renewed, denied renewal, or has probation ever been invoked?	Y	N	N/A
9. Within the last five years, have you ever been a participating provider of another HMO, PPO, PHO, or MSO, etc., with which you are not affiliated at this time?	Y	N	N/A
10. Have you ever received sanctions from a regulatory agency (e.g., CLIA, OSHA, etc.)	Y	N	N/A
11. Has any information on you ever been reported to the National Practitioner Data Bank?	Y	N	N/A
12. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances which are obtained illegally, as well as use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner).	Y	N	N/A
13. Within the last five years, have you ever been reprimanded or disciplined in any manner by any state licensing authority or other professional board or peer review committee for conduct related to the use of alcohol or the use of any drug?	Y	N	N/A
14. Have you discontinued practice for any reason (other than for routine vacation) for one month (30 days) or more?	Y	N	N/A
15. 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 suppliers?	Y	N	N/A

If so, please provide the following information, attaching additional copies as necessary:

(a) _____ Organization Name

(b) _____ Type of Organization

(c) _____ Address/Street

(d) _____ City/State/Zip

(e) _____ Phone Number

(f) _____ Federal Tax ID#

(g) _____ Percent of Business Owned/Invested by Applicant

(h) _____ Nature of Business Interest (owner, partner, investor)

XI. ADDITIONAL DOCUMENTATION/ATTACHMENTS

Please Attach Copies of the Following Documents (if specifically requested):

1. W9 form for each entity the applicant expects will receive payments or reimbursements.
2. Collaborative practice and/or physician assistant agreement(s).
3. A list of other members of your practice, their specialties, and coverage arrangements.
4. Education Council for Foreign Medical Graduates (ECFMG) certificate.
5. Board certification certificate(s).
6. Copies of professional diplomas, internship, residency, and fellowship certificates, as applicable.
7. Current state licenses (for all states practicing).
8. Federal DEA certificate.
9. State controlled substance certificate(s) for all states practicing (i.e. BNDD for Missouri).
10. Current certificate(s) or declaration(s) of insurance, including HCSF for Kansas practitioners.
11. Curriculum Vitae (if required by health carrier).
12. Professional references (if required by health carrier).
13. Signed copy of an affirmation and release of information document (attestation page) as stipulated by the health carrier to which the applicant is seeking to become a participating provider.
14. Attach a copy of all postgraduate (CME) activities which you have attended and for which you have received credit in the past 2 years.
15. A list of societies of which you are currently a member.
16. United States Military discharge papers/DD214 if discharged from U.S. Military, or status if currently serving.
17. CLIA waiver number and identification number (or copy of certificate).
18. Provide a statement regarding the reasons for any inability to perform the essential functions, with or without reasonable accommodation, for the practice in which you are seeking to become a participating provider.