STATE OF ILLINOIS

Health Care Professional Credentialing and Business Data Gathering Form

The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that this form be collected from health care professionals by hospitals, health care entities, and health care plans which desire to credential such professional. Each hospital, health care entity, and health care plan may also require completion of supplemental forms.

INSTRUCTIONS

This form is for initial credentialing only. Other forms are required for recredentialing and for updating information. YOU ONLY HAVE TO FILL OUT AND SUBMIT WHAT IS REQUESTED BY THE CREDENTIALING ENTITY. PLEASE REFER TO THE INSTRUCTIONS PROVIDED TO YOU BY THE ORGANIZATION YOU ARE APPLYING TO FOR THEIR REQUIREMENTS.

This form has been segmented into two (2) different Chapters, each containing various sections:

Chapter A: Practice and Professional Information
Chapter B: Business Information

As previously noted, please consult the specific credentialing entity instructions for their individual Chapter or Section requirements for submission.

GENERAL INSTRUCTIONS: Wherever this application requests information but does not provide sufficient space to provide a complete response (for example, you have more licenses, specialties, work history, etc.) provide attachments which contain all of the information requested in the relevant section OR duplicate the relevant section as many times as necessary and attach it to the back of this application.

The data marked as "Confidential Information" shall be maintained in confidence to the extent required by law. They may be used by the health care plan, entity or hospital and by their agents for credentialing and internal business purposes. Other data contained in this form may be released.

ATTACHMENTS

Attach forms A-F as needed to support "yes" responses in Section J: Professional History and copies of the following:

- ☐ Curriculum Vitae

CONFIDENTIAL INFORMATION:

- ☐ All Current Professional Licenses
- ☐ Current Federal DEA License, If Applicable
- ☐ Current State Controlled Substance License(s), If Applicable
- ☐ Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amount Displayed per Occurrence and In Aggregate
- ☐ Current CLIA Certificate, If Applicable
- ☐ Current W-9s, If Applicable
- ☐ ECFMG Certificate, If Applicable
- ☐ Professional School Diploma, Residency Certificates, Fellowship Certificates, and Board Certifications, As Applicable

AFFIRMATION OF INFORMATION

I represent and warrant that all of the information provided and the responses given are correct and complete to the best of my knowledge and belief. I understand that falsification or omission of information may be grounds for rejection or termination, in addition to any penalties provided by law. I further agree to promptly inform all entities to which this form was sent and not rejected of any change required to be updated by the Health Care Professional Credentialing and Business Data Gathering Update Form.

I understand that this application does not entitle me to participation in any hospital, health care entity, or health plan.

Applicant's Signature	Type or Print Name	Date

** ***PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY,*** **
** ***AND HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN*** **
** ***ATTESTATION AND RELEASE OF INFORMATION FORM.*** **

CHAPTER A:
PRACTICE AND PROFESSIONAL INFORMATION

SECTION A. GENERAL INFORMATION

Name: _____
Last First MI Degree

List other names by which you have been known: _____
Last First MI

If you have been known by other names, please explain why your name changed:

Birth Date: _____ Place of Birth: _____
(mm/dd/yy) City State Country

Sex: ☐ Male ☐ Female Language Fluency of Applicant: ☐ English ☐ Other: _____

U.S. Citizen? ☐ Yes ☐ No ☐ Spanish

If no, do you have a legal right to reside permanently and work in the U.S.? ☐ Yes ☐ No

CONFIDENTIAL INFORMATION

Resident Visa No: _____

Social Security Number: _____

Emergency Contact Person: _____
Last First MI

Telephone Number: _____

Mailing Address: _____
Street City State Zip

Daytime Phone: _____ Fax Number: _____

E-Mail Address: _____

Check here if you have appended additional information for this section: ☐

(Please continue next page)

SECTION B. PROFESSIONAL INFORMATION

Illinois Professional License Number: _____

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation: _____

Current and Previous Professional License(s) in Other States

State: _____ License #: _____ Exp. Date: _____ (mm/dd/yy)

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation: _____

State: _____ License #: _____ Exp. Date: _____ (mm/dd/yy)

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation: _____

State: _____ License #: _____ Exp. Date: _____ (mm/dd/yy)

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation: _____

Check here if you have appended additional information for this section: ☐

Current Federal DEA License Number: _____ ***CONFIDENTIAL INFORMATION***

DEA License Number Expiration Date: _____ License Unlimited? Yes ☐ No ☐

If No, please explain limitation: _____

Check here if you have appended additional information for this section: ☐

Current and Previous State Controlled Substance Number(s):

CONFIDENTIAL INFORMATION

State: _____ CS License #: _____ Expiration Date: _____ (mm/dd/yy)

State: _____ CS License #: _____ Expiration Date: _____ (mm/dd/yy)

State: _____ CS License #: _____ Expiration Date: _____ (mm/dd/yy)

Please identify all limitation related to the above Controlled Substances Number(s) and explain limitation.

_____

_____

Medicare Unique Provider ID# (UPIN): _____

National Provider Identification Number (NPI): _____

Medicaid ID#: _____

X-Ray Certification: State: _____ Certificate #: _____ Expiration Date: _____ (mm/dd/yy)

Check here if you have appended additional information for this section: ☐

COMPLETE FOR EACH SPECIALTY

Specialty I: _____

Are you Board Certified in Specialty I? Yes ☐ No ☐

If Yes, name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date: _____ (mm/yy) Certification Expiration Date, if Any: _____ (mm/yy)

If not taken, date scheduled to take Specialty Boards: _____ (mm/yy)

Specialty/Subspecialty II: _____

Are you Board Certified in Specialty II? Yes ☐ No ☐

If Yes, name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date: _____ (mm/yy) Certification Expiration Date, if Any: _____ (mm/yy)

If not taken, date scheduled to take Specialty Boards: _____ (mm/yy)

(Please continue next page)

Specialty/Subspecialty III: _____

Are you Board Certified in Specialty III? Yes ☐ No ☐

If Yes, name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date: _____ (mm/yy) Certification Expiration Date, if Any: _____ (mm/yy)

If not taken, date scheduled to take Specialty Boards: _____ (mm/yy)

Specialty/Subspecialty IV: _____

Are you Board Certified in Specialty IV? Yes ☐ No ☐

If Yes, name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date: _____ (mm/yy) Certification Expiration Date, if Any: _____ (mm/yy)

If not taken, date scheduled to take Specialty Boards: _____ (mm/yy)

Check here if you have appended additional information for this section: ☐

(Please continue next page)

SECTION C. PROFESSIONAL LIABILITY INSURANCE

Please provide information on all professional liability insurance carriers from whom you have received coverage in the past 10 years.

CURRENT PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number: _____ Original Effective Date: _____ (mm/dd/yy) Expiration Date: _____ (mm/dd/yy)

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

Retroactive Date: _____ (mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number: _____ Original Effective Date: _____ (mm/dd/yy) Expiration Date: _____ (mm/dd/yy)

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

Retroactive Date: _____ (mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number: _____ Original Effective Date: _____ Expiration Date: _____
(mm/dd/yy) (mm/dd/yy)

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

Retroactive Date: _____
(mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number: _____ Original Effective Date: _____ Expiration Date: _____
(mm/dd/yy) (mm/dd/yy)

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

Retroactive Date: _____
(mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
☐ Yes ☐ No

Check here if you have appended additional information for this section: ☐

SECTION D. EDUCATION AND TRAINING

If there are any gaps in your training (greater than 30 days), or if you have not completed any portion of your training, please explain on a separate sheet of paper and attach to this application.

MEDICAL/PROFESSIONAL SCHOOL

Institution Name: _____

Mailing Address: _____
Street City State Zip

Telephone Number: _____ Fax Number: _____

Degree: _____ Year Graduated: _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

If you are a graduate of a foreign medical school, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No

Date Issued: _____ Serial Number for ECFMG: _____
mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.) ←

If you attended more than one medical/professional school, please check here and attach an explanation that duplicates the information requested above: ☐

INTERNSHIP

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: _____ Fax Number: _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of internship: ☐ Rotating ☐ Straight → If straight, please list specialty: _____

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.) ←

If more than one internship, please check here and attach additional information that duplicates the information requested above: ☐

FIRST RESIDENCY

Institution Name: _____

Department Chair or Program Director: _____ _____ _____ _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: _____ Fax Number: _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of residency: _____

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.) ←

SECOND RESIDENCY

Institution Name: _____

Department Chair or Program Director: _____ _____ _____ _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: _____ Fax Number: _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of residency: _____

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.) ←

If more than two residencies, please check here and attach additional information that duplicates the information requested above: ☐

(Please continue next page)

FIRST FELLOWSHIP

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: _____ Fax Number: _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of fellowship: _____

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.) ←

SECOND FELLOWSHIP

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: _____ Fax Number: _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of fellowship: _____

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.) ←

If more than two fellowships, please check here and attach additional information that duplicates the information requested above: ☐

(Please continue next page)

TEACHING EXPERIENCE/FACULTY APPOINTMENT (MOST RECENT)

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: _____ Fax Number: _____

Dates: From: _____ To: _____ Rank/Position, if applicable: _____
mm/yy mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

TEACHING EXPERIENCE/FACULTY APPOINTMENT (PREVIOUS)

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: _____ Fax Number: _____

Dates: From: _____ To: _____ Rank/Position, if applicable: _____
mm/yy mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

If more than two teaching experiences/faculty appointments, please check here and attach additional information that duplicates the information requested above: ☐

(Please continue next page)

MEMBERSHIP STATUS – USE FOR SECTIONS E, F, AND G

Please use the following key to indicate membership status in Sections E (Hospital Membership – Current and Pending), F (Hospital Membership – Previous), and G (Ambulatory Surgery Center Practice) below.

A. Active	E. Suspended / Terminated/ Resigned	I. Provisional
B. Courtesy	F. Active Provisional Staff	J. Affiliate
C. Consulting	G. Senior Staff	K. Pending
D. Adjunct	H. Associate	L. Other (Specify)

SECTION E. HOSPITAL MEMBERSHIP - CURRENT AND PENDING

Please list all hospitals at which you are a member of the Medical Staff and have clinical privileges or have applications for privileges pending. (Include additional sheets if more than three hospitals.)

A. Primary Hospital

Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ **To Present**
From (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: _____

Department Telephone #: _____

Any Limitations in Your Area of Specialty at this Hospital? _____

_____

B. Other Hospital

Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: _____

Department Telephone #: _____

Any Limitations in Your Area of Specialty at this Hospital? _____

_____

C. Other Hospital

Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: _____

Department Telephone #: _____

Any Limitations in Your Area of Specialty at this Hospital? _____

_____

Check here if you have appended additional information for this section: ☐

SECTION F. HOSPITAL MEMBERSHIP – PREVIOUS

Please list all hospitals where you previously held privileges other than during your Internship/Residency/Fellowship. Use the Membership Status key listed prior to Section E. (Include additional sheets if more than three hospitals.)

A. Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: _____

Department Telephone #: _____

Any Limitations in Your Area of Specialty at this Hospital? _____

_____

B. Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: _____

Department Telephone #: _____

Any Limitations in Your Area of Specialty at this Hospital? _____

_____

C. Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: _____

Department Telephone #: _____

Any Limitations in Your Area of Specialty at this Hospital? _____

_____

Check here if you have appended additional information for this section: ☐

SECTION G. AMBULATORY SURGERY CENTER PRACTICE

Please list all ambulatory surgery centers where you currently have or previously had privileges. Use the Membership Status key at the top of page 13. (Include additional sheets if more than three ambulatory surgery centers.)

A. Primary Ambulatory Surgery Center

ASC Name: _____

Address: _____
Street City State Zip

Telephone: _____ Fax Number: _____

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

B. Other Ambulatory Surgery Center

ASC Name: _____

Address: _____
Street City State Zip

Telephone: _____ Fax Number: _____

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

C. Other Ambulatory Surgery Center

ASC Name: _____

Address: _____
Street City State Zip

Telephone: _____ Fax Number: _____

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

Check here if you have appended additional information for this section: ☐

SECTION H. WORK HISTORY

List chronologically (most recent first) all work engagements (including employment, self-employment, service as an independent contractor, and military service). Do not duplicate internship, residency, and fellowship information previously reported. If there is any gap of greater than 30 days in chronology, explain it on a separate page.

Current work place: ____________________

Address: ____________________
Street City State Zip

Telephone: __________ Fax Number: __________

Title or Professional Occupation: ____________________

Time in this employment: From: __________ **to Present**
(mm/yy)

Previous work place: ____________________

Address: ____________________
Street City State Zip

Telephone: __________ Fax Number: __________

Title or Professional Occupation: ____________________

Time in this employment: From: __________ **to:** __________
(mm/yy) (mm/yy)

Previous work place: ____________________

Address: ____________________
Street City State Zip

Telephone: __________ Fax Number: __________

Title or Professional Occupation: ____________________

Time in this employment: From: __________ **to:** __________
(mm/yy) (mm/yy)

Previous work place: ____________________

Address: ____________________
Street City State Zip

Telephone: __________ Fax Number: __________

Title or Professional Occupation: ____________________

Time in this employment: From: __________ **to:** __________
(mm/yy) (mm/yy)

Previous work place: ____________________

Address: ____________________
Street City State Zip

Telephone: __________ Fax Number: __________

Title or Professional Occupation: ____________________

Time in this employment: From: __________ **to:** __________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ____________ Fax Number: ____________

Title or Professional Occupation: ______________________________

Time in this employment: From: ____________ **to:** ____________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ____________ Fax Number: ____________

Title or Professional Occupation: ______________________________

Time in this employment: From: ____________ **to:** ____________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ____________ Fax Number: ____________

Title or Professional Occupation: ______________________________

Time in this employment: From: ____________ **to:** ____________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ____________ Fax Number: ____________

Title or Professional Occupation: ______________________________

Time in this employment: From: ____________ **to:** ____________
(mm/yy) (mm/yy)

Check here if you have appended additional information for this section: ☐

(Please continue next page)

SECTION I. PROFESSIONAL REFERENCES

Please list the names of three individuals who have personal knowledge (within the past 12 months) of your current clinical abilities, ethical character and interpersonal skills and who would be willing to provide this information upon request. Do not list partners or department chairpersons. Do not list relatives or people listed elsewhere in this credentialing form.

CONFIDENTIAL INFORMATION

1. Name: _____ Title: _____
Last First MI Degree

Specialty: _____

Mailing Address: _____
Street City State Zip

Telephone: _____ Fax Number: _____

Relationship: _____ Years Known: _____

2. Name: _____ Title: _____
Last First MI Degree

Specialty: _____

Mailing Address: _____
Street City State Zip

Telephone: _____ Fax Number: _____

Relationship: _____ Years Known: _____

3. Name: _____ Title: _____
Last First MI Degree

Specialty: _____

Mailing Address: _____
Street City State Zip

Telephone: _____ Fax Number: _____

Relationship: _____ Years Known: _____

(Please continue next page)

SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL

ADVERSE OR OTHER ACTIONS

Submit with all applications. Please answer the following questions to the best of your knowledge with a "yes" or "no." If you answer "yes" to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each "yes" answer.

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? ☐ Yes ☐ No

2. Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers? ☐ Yes ☐ No
?

3. Have you lost any board certification(s), and/or failed to recertify? ☐ Yes ☐ No

4. Have you been examined by a Certifying Board but failed to pass? ☐ Yes ☐ No

5. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank? ☐ Yes ☐ No

6. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?? ☐ Yes ☐ No

7. Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed? ☐ Yes ☐ No

8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? ☐ Yes ☐ No

9 Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license?? ☐ Yes ☐ No

10. Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs?? ☐ Yes ☐ No

11. Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues?? ☐ Yes ☐ No

12. Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO?? ☐ Yes ☐ No

13. Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision? ☐ Yes ☐ No

PROFESSIONAL LIABILITY ACTIONS

If you answer yes to any question(s) in this section please complete FORM B. Please make copies of FORM B if needed, and complete one for each yes answer.

1. Have any professional liability judgments ever been entered against you? ☐ Yes ☐ No

2. Have any professional liability claim settlements ever been paid by you and/or paid on your behalf? ☐ Yes ☐ No

3. Are there any currently pending professional liability suits, actions and/or claims filed against you? ☐ Yes ☐ No

4. Has any person or entity ever been sued for your clinical actions? ☐ Yes ☐ No

LIABILITY INSURANCE

If you answer yes to this question please complete FORM C.

Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled, non-renewed or limits reduced ? ☐ Yes ☐ No

CRIMINAL ACTIONS

If you answer yes to any question(s) in this section please complete FORM D. Please make copies of FORM D if needed, and complete one for each yes answer.

1. Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country? ☐ Yes ☐ No

2. Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse? ☐ Yes ☐ No

MEDICAL CONDITION

If you answer yes to this question please complete FORM E.

Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety? ☐ Yes ☐ No

CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

If you answer yes to any question(s) in this section please complete FORM F. Please make copies of FORM F if needed, and complete one for each yes answer.

1. Are you currently engaged in illegal use of any legal or illegal substances? ☐ Yes ☐ No
2. Do you currently overuse and/or abuse alcohol or any other controlled substances? ☐ Yes ☐ No
3. If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety? ☐ Yes ☐ No
4. Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse? ☐ Yes ☐ No

INVESTMENTS

In the last five (5) years have you and/or a member of your family purchased or made an investment in (other than securities of a publicly traded company), or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, and/or other business dealing with the provision of ancillary health services, equipment or supplies? ☐ Yes ☐ No

If Yes, please provide explanation: _____

_____

_____

_____

_____

(Please continue next page)

CHAPTER B:
BUSINESS INFORMATION

SECTION K. PRIMARY SITE INFORMATION

Please provide the following information for the primary site at which you practice.

Primary Site

Group/Business Name

Building Name

Office Address – Number and Street – Suite

City County State Zip

Main Telephone Number Office Administrator – Last First MI

Beeper Number FAX Number E-mail

Emergency Number Answering Service

Specialty practiced at this site: _____

Is your practice restricted within your specialty (e.g., by age or type of patient)? ☐ Yes ☐ No

If yes, describe the restrictions: _____

Briefly describe your practice at this location, including any special practice focus or equipment:

Are you currently accepting new patients at this location? ☐ Yes ☐ No

If yes, describe any restrictions (e.g., appointment type, patient type): _____

Please provide the number of active patients enrolled with you at this site: _____

Please provide the number of patient visits you have at this site per year: _____

Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours	to	to	to	to	to	to	to

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing Patient
Emergency Care		
Urgent Care		
Symptomatic Care (e.g., sore throat)		
Routine Visits (e.g., blood pressure check)		
Preventive Routine Care (e.g., school or annual physical)		

Please provide the following regarding your practice at this site:

Maximum Number of Appointments per Hour		
Average Waiting Time in Office (from scheduled appointment time to actual examination)		
Average Response Time for Returning Patient Calls:	Acute or Urgent Situation:	
	Emergency Situation:	
	Routine Call:	

Please check all procedures you perform at this site:

☐ Age-appropriate immunizations	☐ EKG	☐ Drawing blood
☐ Tympanometry/audiometry screening	☐ X-rays	☐ Minor surgery
☐ Pulmonary function studies	☐ Flexible sigmoidoscopy	☐ Laceration repair
☐ Office gynecology (routine pelvic/PAP)	☐ Asthma treatment	☐ Allergy skin testing
☐ Osteopathic /Chiropractic manipulation	☐ IV hydration/treatment	☐ Physical Therapy

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special Skills of Practitioner: _____

Special Skills of Staff: _____

Languages Spoken by Practitioner: _____

Languages Written by Practitioner: _____

Languages Spoken by Staff: _____

Languages Written by Staff: _____

Is this practice site handicapped accessible (check all that apply)?

☐ Building ☐ Parking ☐ Wheelchair ☐ Restroom

Does this site employ paraprofessionals for direct patient care? ☐ Yes ☐ No

If yes, is supervision always provided on premises during paraprofessionals' direct patient care?

☐ Yes ☐ No

Do the paraprofessional(s) bill under any of your Tax ID Numbers? ☐ Yes ☐ No

If yes, list Tax ID Numbers used: ***CONFIDENTIAL INFORMATION***

_____ _____ _____

Lab Service at this site? ☐ Yes ☐ No

If yes, check whether: ☐ Primary ☐ Secondary ☐ Tertiary

CLIA Waiver: ☐ Yes ☐ No

If yes, CLIA Expiration Date: ____________

Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.

Name: ____
Last First MI Degree

Specialty: ______________________________

Address: ______________________________ Telephone: ____________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ____________

Name: ____
Last First MI Degree

Specialty: ______________________________

Address: ______________________________ Telephone: ____________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ____________

Name: ____
Last First MI Degree

Specialty: ______________________________

Address: ______________________________ Telephone: ____________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ____________

Please provide the following information about physician(s)/practitioner(s) who practice in this office:

Name: ______________________________ Specialty: ____________
Last First MI

Name: ______________________________ Specialty: ____________
Last First MI

Name: ______________________________ Specialty: ____________
Last First MI

SECTION L. PRIMARY SITE TAX INFORMATION

Please provide the following information for your Primary Site. Include tax information for each business arrangement you use at this site. (Please include additional sheets if more than four applicable business arrangements.)

Business Arrangement #1

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: _____

Business Arrangement #2

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: _____

Business Arrangement #3

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: _____

Business Arrangement #4

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: _____

SECTION M. ADDITIONAL SITE INFORMATION

Please provide the following information for each additional site at which you practice.

Site #

Group/Business Name

Building Name

Office Address – Number and Street – Suite

City County State Zip

Main Telephone Number Office Administrator – Last First MI

Beeper Number FAX Number E-mail

Emergency Number Answering Service

Specialty practiced at this site: _____

Is your practice restricted within your specialty (e.g., by age or type of patient)? ☐ Yes ☐ No

If yes, describe the restrictions: _____

Briefly describe your practice at this location, including any special practice focus or equipment:

Are you currently accepting new patients at this location? ☐ Yes ☐ No

If yes, describe any restrictions (e.g., appointment type, patient type): _____

Please provide the number of active patients enrolled with you at this site: _____

Please provide the number of patient visits you have at this site per year: _____

Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours	to	to	to	to	to	to	to

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing Patient
Emergency Care		
Urgent Care		
Symptomatic Care (e.g., sore throat)		
Routine Visits (e.g., blood pressure check)		
Preventive Routine Care (e.g., school or annual physical)		

Please provide the following regarding your practice at this site:

Maximum Number of Appointments per Hour		
Average Waiting Time in Office (from scheduled appointment time to actual examination)		
Average Response Time for Returning Patient Calls:	Acute or Urgent Situation:	
	Emergency Situation:	
	Routine Call:	

Please check all procedures you perform at this site:

☐ Age-appropriate immunizations	☐ EKG	☐ Drawing blood
☐ Tympanometry/audiometry screening	☐ X-rays	☐ Minor surgery
☐ Pulmonary function studies	☐ Flexible sigmoidoscopy	☐ Laceration repair
☐ Office gynecology (routine pelvic/PAP)	☐ Asthma treatment	☐ Allergy skin testing
☐ Osteopathic /Chiropractic manipulation	☐ IV hydration/treatment	☐ Physical Therapy

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special Skills of Practitioner: _____

Special Skills of Staff:

Languages Spoken by Practitioner: _____

Languages Written by Practitioner:

Languages Spoken by Staff: _____

Languages Written by Staff:

Is this practice site handicapped accessible (check all that apply)?

☐ Building ☐ Parking ☐ Wheelchair ☐ Restroom

Does this site employ paraprofessionals for direct patient care? ☐ Yes ☐ No

If yes, is supervision always provided on premises during paraprofessionals' direct patient care?

☐ Yes ☐ No

Do the paraprofessional(s) bill under any of your Tax ID Numbers? ☐ Yes ☐ No

If yes, list Tax ID Numbers used: ***CONFIDENTIAL INFORMATION***

Lab Service at this site? ☐ Yes ☐ No

If yes, check whether: ☐ Primary ☐ Secondary ☐ Tertiary

CLIA Waiver: ☐ Yes ☐ No

If yes, CLIA Expiration Date: ________________

Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.

Name: ____

Last First MI Degree

Specialty: ______________________________________

Address: ______________________________________ Telephone: ______________

Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ________________

Name: ____

Last First MI Degree

Specialty: ______________________________________

Address: ______________________________________ Telephone: ______________

Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ________________

Name: ____

Last First MI Degree

Specialty: ______________________________________

Address: ______________________________________ Telephone: ______________

Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ________________

Please provide the following information about physician(s)/practitioner(s) who practice in this office:

Name: ______________________________________ Specialty: ______________

Last First MI

Name: ______________________________________ Specialty: ______________

Last First MI

Name: ______________________________________ Specialty: ______________

Last First MI

SECTION N. ADDITIONAL SITE TAX INFORMATION

Please provide the following information for each additional site at which you practice. Include tax information for each business arrangement you use at this site. (If there is more than one additional site, or more than five business arrangements at any one site, please copy and complete this page for each additional site and business arrangement.)

Business Arrangement #1
Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: _____

Business Arrangement #2
Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: _____

Business Arrangement #3
Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: _____

Business Arrangement #4
Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: _____

End Credentialing and Business Data Gathering Form.
Attach Forms A-F As Required.

FORM A – ADVERSE AND OTHER ACTIONS

DUPLICATE this form as necessary to complete separate sheet for EACH occurrence that applies. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

Indicate the number of ONE of the questions in Section J to which you answered "yes": Question Number: ____

A. Describe the circumstances surrounding this occurrence. Please include the date of the occurrence.

_____

_____

_____

_____

_____

B. Provide an explanation of any actions taken. Please include the date the action was taken.

_____

_____

_____

_____

_____

C. Provide the current status of the issue.

_____

_____

_____

_____

_____

D. If known: Contact: _____

Department/Committee: _____

Address: _____
Street City State Zip

Telephone: _____

Signature: _____ **Date:** _____

FORM B – PROFESSIONAL LIABILITY ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

A. Plaintiff's Name: _____
Last First MI

If court case, Case Name & Case Number: _____

B. Your Involvement in the Care (Attending, Consulting, Etc.): _____

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): _____

D. Allegations, including Patient Outcome, if Available: _____

E. Date of Incident (mm/yy): _____ F. Date Filed (mm/yy): _____

G. Date Case Closed (mm/yy): _____

Resolution Case: ☐ Dismissed ☐ Judgment ☐ Arbitration ☐ Other
☐ Settlement out of Court ☐ Pending ☐ Mediation

H. Amount Paid on Your Behalf (if any): $ _____

I. Professional Liability Insurer Name (if one was involved): _____

J. Insurer Telephone Number: _____ K. Policy Number: _____

L. Insurer Address (Street, City, State, Zip Code):

_____

_____

Signature: _____ **Date:** _____

FORM C – LIABILITY INSURANCE

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

A. **History of Professional Liability Insurance (Please check One)**

☐ Canceled Voluntarily ☐ Non-Renewed

☐ Canceled Involuntarily ☐ Application Denied

B. Carrier Name: _____

C. Carrier Telephone Number: _____

D. Policy Number: _____

E. Carrier Address (Street, City, State, Zip Code):

_____

_____

F. Dates of Coverage: From (mm/yy): _____ To (mm/yy): _____

G. Circumstances Involved: _____

_____

Signature: _____ **Date:** _____

FORM D – CRIMINAL ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH incident. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

A. Date of Incident (mm/yy): _____

B. Date of Complaint or Conviction (mm/yy): _____

C. Date of Resolution (mm/yy): _____

D. Type of Resolution (Dismissed, Plea Bargain, Misdemeanor, Felony): _____

E. Allegation(s): _____

F. Details of Incident: _____

G. Actions Taken Against You: _____

H. Current Status of Situation: _____

I. Medical Practice Privileges Affected as a Result of This Situation: _____

Signature: _____ **Date:** _____

FORM E – MEDICAL CONDITION

DUPLICATE this form as necessary to complete a separate sheet for EACH condition. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

A. Describe this medical condition: _____

B. To what extent does or could this condition affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

C. What is the current status of your condition? _____

D. Provide the name and address of your personal physician/health care provider who can provide information about your health condition.

Name **Telephone Number**

_____ _____
Last First MI Degree

_____ _____
Last First MI Degree

Signature: _____ **Date:** _____

FORM F – CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

DUPLICATE this form as necessary to complete a separate sheet for EACH chemical substance incident. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

Describe the substance you use:

_____

A. To what extent does, or could, your use of this substance affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

_____

_____

B. Monitored by State Board Mandate (Name and Address)

_____

_____

_____

C. Monitored Voluntarily (Name and Address)

_____

_____

_____

D. Other information about the current status of your use of substances:

_____

_____

E. Abstinent since (mm/yy): _____

F. Provide the name and address of your personal physician/health care provider who can provide information about your treatment for alcohol or chemical substance use and can comment on what impact (if any) it has on your current/future professional practice.

Name: _____

Address: _____
Street City State Zip

Telephone: _____

Signature: _____ **Date:** _____

Please be sure to include the following current documents with your fully completed and signed application:

- Healthcare and Family Services Provider Information Sheet
- Certificate of Professional Malpractice Liability
- Contracting Paperwork - Agreement, W9, Disclosure of Ownership, ADA Survey (1 per TIN)

Mail:

Avesis
Attn: Credentialing
10324 South Dolfield Road
Owings Mills, MD 21117

Email:

credentialingdept@avesis.com

Fax:

1-855-828-5648

Avesis does not discriminate against any provider applicant based on age, race, color, creed, religious affiliation, marital status, sexual orientation, disability status or any other basis including the provider's practice being substantially comprised of patients requiring expensive or uncompensated care. Credentialing shall be based only upon the material facts contained in their application and subsequent information obtained. You have the right to request the status of your application and to provide us with updated information at any time during the Credentialing process.

ILLINOIS SUPPLEMENTAL MEDICAID APPLICATION

Provider Information

Provider's Name:			Suffix (Jr., Sr., etc.):
Maiden/Other Name(s) (if applicable):		D Owner D Assoc.	D Employee
SSN: - -	TIN (if different):	DOB (MM/DD/YY): / /	D Male D Female
Medicaid Number (if applicable):		NPI-1:	
Medicare Number (if applicable):		E-mail:	
Do you submit claims under your TIN or Social Security Number: D TIN D Social Security Number			

Professional Training

Professional School:					
Degree:	Year Graduated:	Years in Practice:			
Provider Type: D General Dentist	D Specialty:	D *Endo* D *Pedo*	D *Perio* D *Oral Surgery*	D *Prosth* D *Ortho*	
If trained outside of the United States, check here and attach copy of ECFMG D					
Residency Program (if applicable):		From:	To:		
Advanced Training (if applicable):		From:	To:		
Board Certified: D Yes D No D Not Applicable		Board Eligible: D Yes D No D Not Applicable			
Name and Address of Board:					

Professional Liability Insurance Information

Please attach a copy of your Insurance Declaration page or Certificate of Insurance.

Professional Liability Insurance Carrier:	Policy #:
Limits of Coverage: Individual:	Aggregate:
Effective Date (MM/DD/YY):	Expiration Date (MM/DD/YY):
American Dental Association Member: D Yes D No	
Do you accept patients with AIDS, HIV+, Hepatitis B carrier, etc. in accordance with requirements of the American Dental Association and professionally recognized standards? D Yes D No	

ILLINOIS SUPPLEMENTAL MEDICAID APPLICATION

Primary Office Location Please provide information for only those locations to participate with Avesis.

Practice Name:

Complete Address (Street, City, State, 9-digit Zip):

Office Manager: Phone: ( ) Fax: ( )

Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Please complete if different from above Practice Information

Billing Address for this Location:

TIN: NPI-2 (if applicable):

Type of Practice, if applicable: D FQHC D Mobile

Patient Relation Services

Languages Spoken by Provider:	D English	D Spanish	D French	D Other:
Languages Spoken by Staff:	D English	D Spanish	D French	D Other:

Accepts Patients with Developmental Disabilities: D Yes D No | TTY Available: D Yes D No | Signing Available: D Yes D No

Handicap Accessible Office (ADA Compliant): D Yes D No | Handicap Parking Available: D Yes D No

Provider or Staff CPR certified: D Yes D No | Accepts New Patients: D Yes D No | Age of Patients: From To

Patient Procedure Services

Nitrous Oxide: D Yes D No General Anethesia: D Yes D No	IV Sedation: D Yes D No Oral Sedation: D Yes D No	Panoramic X-Ray: D Yes D No Intaoral X-Ray: D Yes D No

Electronic Claims Submission: D Yes D No | Digital Radiograph Submission: D Yes D No | Web Access: D Yes D No

Sterilization Method: D Autoclave D Chemiclave D Other:

ILLINOIS SUPPLEMENTAL MEDICAID APPLICATION

Additional Office Location (If Applicable)

Please provide information for only those locations to participate with Avesis.

Practice Name:

Complete Address (Street, City, State, 9-digit Zip):

Office Manager: Phone: ( ) Fax: ( )

Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Please complete if different from above Practice Information

Billing Address for this Location:

TIN: NPI-2 (if applicable):

Type of Practice, if applicable: D FQHC D Mobile

Patient Relation Services

Languages Spoken by Provider:	D English	D Spanish	D French	D Other:
Languages Spoken by Staff:	D English	D Spanish	D French	D Other:

Accepts Patients with Developmental Disabilities: D Yes D No | TTY Available: D Yes D No | Signing Available: D Yes D No

Handicap Accessible Office (ADA Compliant): D Yes D No | Handicap Parking Available: D Yes D No

Provider or Staff CPR certified: D Yes D No | Accepts New Patients: D Yes D No | Age of Patients: From To

Patient Procedure Services

Nitrous Oxide: D Yes D No General Anethesia: D Yes D No	IV Sedation: D Yes D No Oral Sedation: D Yes D No	Panoramic X-Ray: D Yes D No Intaoral X-Ray: D Yes D No

Electronic Claims Submission: D Yes D No | Digital Radiograph Submission: D Yes D No | Web Access: D Yes D No