

# Global TPA



## ALLIED HEALTH PROFESSIONAL CREDENTIALING APPLICATION FORM

### Independent Practitioners:

Acupuncturist, Audiologist, Dietitian, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Master Social Worker, Licensed Mental Health Counselor, Massage Therapist, Occupational Therapist, Pharmacist, Physical Therapist, Speech Language Pathologist/ Therapist

### Collaborative Practice Practitioners:

Nurse Practitioner, Nurse Midwife, Physician Assistant

APPLICANT NAME: \_\_\_\_\_ TYPE OF SERVICE: \_\_\_\_\_

*In order to expedite the credentialing process, please complete every item on this application. Please DO NOT write "see CV" or "refer to CV" in place of completing the information requested. Please enclose copies of the documentation listed below, and sign and date the attestation of accuracy and the consent and release form. Thank you for your assistance!*

"X" if enclosed

### APPLICATION CHECKLIST

- ☒ Current Professional Liability Insurance Certificate;
- ☒ Curriculum Vitae/Work History/Resume (must include month & year)
- ☒ Signed and dated Consent and Release Form

### FOR PLAN USE ONLY – To be completed by Provider Representative:

- ☐ Contract Processing Form (CPF)
- ☐ Application information and supporting documentation has been reviewed;
- ☐ All information meets Plan criteria and documentation is current and complete.

**Practitioner**  
**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle Initial** \_\_\_\_\_ **Degree** \_\_\_\_\_

Primary Physical Office Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ for Additional Locations *(Please complete next page)*

County \_\_\_\_\_ Office Phone# \_\_\_\_\_ Office Fax # \_\_\_\_\_ Handicap Access(Y/N) \_\_\_\_\_ Handicap Assistance (Y/N) \_\_\_\_\_ Bus Rte. (Y/N) \_\_\_\_\_

Office Manager or Contact Name \_\_\_\_\_ Telephone and Extension *(if applicable)* \_\_\_\_\_ Email Address *(for receiving email from plan)* \_\_\_\_\_

Office Hours: Mon \_\_\_\_\_ Tues \_\_\_\_\_ Wed \_\_\_\_\_ Thu \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_ Sun \_\_\_\_\_

Practice or Group Name \_\_\_\_\_

Name to whom checks should be made payable *(if different than Practice/Group name)* \_\_\_\_\_

Billing Address *(Location where payments will be sent)* \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Billing Office Telephone Number \_\_\_\_\_ Billing Office Fax Number \_\_\_\_\_

Correspondence Address *(for credentialing purposes only)* \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone # \_\_\_\_\_ Office Fax# \_\_\_\_\_ Contact Name \_\_\_\_\_

## Patient Age Ranges

- ☐ 00 yrs - 21 yrs Pediatrics
 ☐ 00 yrs - 99+ yrs Family Practice
 ☐ 12 yrs - 99+ yrs Internal Medicine  
☐ 12 yrs - 99+ yrs Geriatric Medicine
 ☐ 2 yr s- 99+ yrs General Practice
 ☐ 00 yrs - 99+ yrs General Practice for Health Dept Only

Other \_\_\_\_\_

General Information:

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth \_\_\_\_\_

Language(s) spoken in addition to English \_\_\_\_\_

For EEOC Compliance Requirements Only: *Please indicate the following:*

- ☐ African American
 ☐ Arabic
 ☐ Hispanic American  
☐ Asian American
 ☐ Caucasian
 ☐ Native American

Practitioner's Name: \_\_\_\_\_

## Information Sheet Required for Additional Locations

(PLEASE PRINT)

Name of Provider/Group/Practice Name: \_\_\_\_\_

List any additional Office Locations: Please include all necessary information listed below.

**Second Physical Address:** \_\_\_\_\_

Practice/Group Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Tax Identification Number: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Handicapped Access Yes \_\_\_\_\_ No \_\_\_\_\_ Handicapped Assistance Yes \_\_\_\_\_ No \_\_\_\_\_ Bus Rte. Yes \_\_\_\_\_ No \_\_\_\_\_

Office Hours \_\_\_\_\_

**Second Billing Address:** \_\_\_\_\_

Checks payable to: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Tax Identification Number: \_\_\_\_\_

Contact Name: \_\_\_\_\_

**Third Physical Address:** \_\_\_\_\_

Practice/Group Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Tax Identification Number: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Handicapped Access Yes \_\_\_\_\_ No \_\_\_\_\_ Handicapped Assistance Yes \_\_\_\_\_ No \_\_\_\_\_ Bus Rte. Yes \_\_\_\_\_ No \_\_\_\_\_

Office Hours \_\_\_\_\_

**Third Billing Address:** \_\_\_\_\_

Checks payable to: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Tax Identification Number: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Please attach additional location information as necessary.

Practitioner's Name: \_\_\_\_\_

## REGULATORY \*\*Please provide copy of document

Tax ID# ** (copy of W-9)		SS#
State License #		DEA #
CDS # (if applicable)		CSR # (if applicable)
Medicare Provider #		Medicaid Provider #
National Provider Identification # - Type 1 must be completed		CLIA Registration or Waiver # **
Type 1 - Individual Practitioner	Type 2 - Group	

## SPECIALTY/TAXONOMY

Name of Specialty	Taxonomy Code

## EDUCATION – Please complete separate sheet if necessary

Name of School/College	Type of Training	Dates Attended

## CERTIFICATION STATUS

Name of Specialty Board	Certification Status	Certification Date	Expiration Date

## PROFESSIONAL LIABILITY DATA – Please provide full address

Name & Address of Insurer	Policy # Effective and end dates	Policy Limits of Coverage	Retroactive date of coverage

## COLLABORATIVE PRACTICE INFORMATION- Please provide name, address and phone number of a Plan practitioner with whom you have a collaborative agreement, if applicable (this section must be completed by those practitioners whose state license requires a protocol be entered into with a State Licensed Physician or Dentist)

Last Name	First	Middle	Degree	Specialty
Office Address, City, State, Zip Code		Office Phone #	Office Fax#	

Practitioner's Name: \_\_\_\_\_

**QUESTIONNAIRE** – If the answer to any question is **yes**, please provide details on a separate sheet.

<b><i>Please answer the following questions by checking the appropriate box:</i></b>	<b>YES</b>	<b>NO</b>
Do you have any physical or mental health problems or limitations in ability that may affect your ability to practice medicine and provide health care with reasonable skill and safety?		
Do you have any history of chemical dependency / substance abuse?		
Have you been the subject of an investigation, or have proceedings <b>ever</b> been initiated to have your license to practice limited, suspended, revoke, denied, sanctioned or subject to probationary conditions, or have you voluntarily or involuntarily relinquished your license in this or any other state?		
Has your narcotics registration certificate <b>ever</b> been voluntarily or involuntarily relinquished, limited, suspended, sanctioned or revoked, or are any such actions pending?		
Have you been the subject of an investigation, or have <b>ever</b> been suspended, sanctioned or otherwise restricted from participating in any private, state, or federal health insurance program, for example Medicare or Medicaid?		
Are you aware of any information that may prevent you from participating in Medicaid?		
Have you <b>ever</b> been named as a defendant in criminal proceeding?		
Has your medical staff membership, employment, or medical staff status at any health care institution, <b>ever</b> been rejected, limited, suspended, revoked, not renewed or subject to probationary conditions, or have you been the subject of an investigation, or, relinquished medical staff membership or clinical privileges while under investigation or disciplinary action, or are any such actions pending?		
In the past five years, have you been a defendant in a malpractice/professional liability suit, or are there currently any pending or potential suits against you, or have any judgments been made or settlements paid on your behalf?		
Have you <b>ever</b> been denied professional liability insurance coverage or had your professional liability insurance coverage cancelled by your carrier for reasons other than the carrier's termination of operation in your state?		
Have you <b>failed</b> to meet the State Licensure requirements for continuing medical education?		

**AFFIRMATION OF ACCURACY AND COMPLETENESS**

I understand I have the responsibility for producing adequate information for proper evaluation of my qualifications and for addressing any concerns about such qualifications. I understand that a condition of this application is this any misrepresentation or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and it shall not be processed any further. In the event credentialing information received from other sources substantially varies from that provided by me, I will be notified by the Company, and I understand I will be given the opportunity to correct such information. In the event that my application is rejected for this reason, I may not be entitled to any hearing, appeal or other due process rights as may otherwise be provided in the Policies and Procedures of the Company. I affirm that information provided in or attached to this application is correct and complete.

**Practitioner's Name:** \_\_\_\_\_

---

### **APPLICANT'S RELEASE AND HOLD HARMLESS**

By applying for provider participation, I accept the following conditions. These conditions shall remain in effect for the duration of any term of participation I may be granted.

I acknowledge that the Company may at its sole discretion share or disclose the information provided in the credentialing and re-credentialing process to affiliates and subsidiaries or other related entities of Global TPA, Inc.

- 1) I release and hold harmless the Company, its authorized representatives and third parties, as defined below, for any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken or received by the Company or its authorized representative in good faith, relating to matters or inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; or any other matter that might directly or indirectly have an effect on my competence, on patient care, or on the orderly operation of this health care organization.
- 2) I authorize the Company and its authorized representatives to consult with any third party who may have information bearing on my professional qualifications (credentials). This authorization includes the right to inspect or obtain clinical privileges, documents, recommendations, reports, statements or disclosures relating to such questions. I also authorize said third parties to release this information to the Company and its authorized representatives upon request.
- 3) The term "Company and its authorized representatives" means any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application:
  - a. member of the Board and its appointed representative;
  - b. the Chief Executive Officer or his/her designee;
  - c. all appointees to committees;
  - d. Company employees;
  - e. Consultants to the Company;
  - f. the Company's attorney and members of his/her firm, associates or designee;
  - g. delegated or sub-delegated agency with which the Company contracts for credentialing purposes.
- 4) The term "third parties" means the following:
  - a. Government agencies;
  - b. Professional liability insurance carriers;
  - c. Peer references;
  - d. Hospital affiliations;
  - e. delegated or sub-delegated agency with which the Company contracts for credentialing purposes.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME