

PROVIDER CREDENTIALING APPLICATION

We appreciate your interest in becoming a TRICARE network provider, offering medical services for Prime Beneficiaries. Please read this instruction sheet carefully before you begin completing the credentialing application.

STEP 1. Complete the Humana Military Healthcare Services (Humana Military) credentialing application in its entirety. If a section does not apply to you mark it as "not applicable" or "N/A". Incomplete applications will delay the credentialing process. You will not be considered a network provider until the credentialing process is completed.

STEP 2. Mail your completed contract and credentialing application to:

**500 West Main
PO Box 740085
Louisville, KY 40201**

To meet the minimum credentialing criteria established by Humana Military you must:

- have graduated from a school appropriate to your profession, and completed post graduate training appropriate to your practicing specialty;
- have a current, valid, unrestricted and unprobated professional state license in the State(s) you practice within;
- have a current, valid, unrestricted and unprobated DEA, if applicable to your profession/specialty
- have a current, valid, unrestricted and unprobated State Controlled Dangerous Substance registration, if applicable to your profession/specialty and the State you practice within;
- have current professional liability insurance or meet the State/local guidelines;
- be able to participate in Federal healthcare programs;
- not have been convicted of a felony related to controlled substances, healthcare fraud, a child or patient abuse;
- not have any physical or mental health condition that can not be accommodated without undue hardship or without reasonable accommodation;
- not have untreated chemical/substance dependency; and
- not have any unexplained gaps of six months or more in your work history during the past five years.

If you are a Nurse Practitioner, you must have a sponsoring physician who is a Humana Military TRICARE network provider.

In addition to the minimum criteria listed, Humana Military may take other information into consideration when determining credentialing/network participation status. All providers are subject to the satisfaction and maintenance, in Humana Military's sole judgment of all credentialing standards adopted by Humana Military.

After Humana Military receives your completed Credentialing Application, you may be contacted by a Credentialing Specialist, or other Humana Military representative, for additional information.

Upon completion of the credentialing process, you will be mailed a letter indicating the decision made by the Humana Military Credentialing Committee.

If at any time during the credentialing process you have any questions regarding the status of your application, please call 1-877-414-9948 between the hours of 8 a.m. – 5 p.m. Central Time.

The information requested in this application is required under a Federal Program and supercedes any and all information that may be found in a centralized state credentialing database.

A. GENERAL INFORMATION

Please Print or Type Information

Last Name	Generation (i.e., Sr., Jr., III)	Date of Birth	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No
First Name	Middle Initial	<input type="checkbox"/> Male <input type="checkbox"/> Female	If No, list alien Registration Number_____
Social Security Number	Languages spoken by self: Primary _____ Secondary _____ Other _____		

AKA Name: Please list any/all other names you may be/have been known as. List any name, other than the name listed above, that your degree(s), professional license(s) has ever been issued under (e.g. maiden name, alias, nickname) etc.

Last Name	Generation (i.e., Sr., Jr., III)	Provider Type <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> OD <input type="checkbox"/> NP <input type="checkbox"/> Other healthcare professional, please specify: _____
First Name	Middle Initial	

B. PRACTICING SPECIALTY - Family Practitioners, Internists, Pediatricians and General Practitioners offering primary health services are usually classified as a "Primary Care Physicians" and physicians practicing all other specialties are considered to be "Specialists." "Other Health Professionals" are non-physician practitioners licensed, certified, or registered to provide direct patient care services. In each case, please indicate the area(s) of healthcare that is/are your main patient focus.

Primary Care Physician Specialist Other Health Professional

My Primary Practicing Specialty is : _____ My Secondary Practicing Specialty is: _____

C. GENERAL INFORMATION ABOUT YOUR PRACTICE - Primary Office Practice If you have additional office practices, please include them on the *Office Practice Form* located on page 10 of this application.

Legal Practice Name		Tax ID Number
Practice Address		
City	State	Zip Code +4
Office Phone Number	General Office Fax Number	Referral Fax Number
Office Practice Type <input type="checkbox"/> Solo/Individual <input type="checkbox"/> Multi Provider group		
Date (mm/yy) you started with this practice:	E-mail Address	Are you currently accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you able to submit claims or referrals electronically? <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Phone Number	* If yes, how many TRICARE patients will you accept? _____
Are there age limitations on your patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	Credentialing Contact Name _____ E-Mail Address _____ Phone Number _____ Fax _____	
From () years To () years		

D. CORRESPONDENCE ADDRESS (If different from Primary Office)				E. BILLING ADDRESS (If different from Primary Office)			
Name				Name			
Street Address			Suite #	Street Address			Suite #
City				City			
State	Zip Code +4	County		State	Zip Code +4	County	
Office Phone Number		Office Fax Number		Office Phone Number		Office Fax Number	

What hours do you see patients in your office?

	FROM	TO		FROM	TO		FROM	TO
Monday			Wednesday			Friday		
Tuesday			Thursday			Saturday		
						Sunday		

Please list your covering practitioners

Name		Name	
Phone Number	Specialty	Phone Number	Specialty

F. CREDENTIALS INFORMATION

Medicare UPIN Number		Medicare Number(s)	
National Provider Identifier (NPI) NPI is a unique 10-digit numeric identifier assigned to health care providers and organizations defined as covered entities under HIPAA. For more information see the CMS website: www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/default.asp .			

State Licenses/Certificates

List all professional licenses or certificates held in any jurisdiction. If the license(s) is not current, please explain why. If you need additional space, attach a separate sheet.

1.	State	License/Certificate #	Type (i.e., MD,DO)	2.	State	License/Certificate #	Type (i.e., MD,DO)		
	Date of Initial License/Certificate		Expiration Date of Current State License/Certificate		Date of Initial License/Certificate		Expiration Date of Current State License/Certificate		
	Is this license certificate active? <input type="checkbox"/> Yes <input type="checkbox"/> No If not active, why?		Do you currently practice under it? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this license certificate active? <input type="checkbox"/> Yes <input type="checkbox"/> No If not active, why?		Do you currently practice under it? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Does your license/certification level require supervision? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.				Does your license/certification level require supervision? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.				
	State		License/Certificate #		Type (i.e., MD,DO)	State		License/Certificate #	Type (i.e., MD,DO)
3.	Date of Initial License/Certificate		Expiration Date of Current State License/Certificate	4.	Date of Initial License/Certificate		Expiration Date of Current State License/Certificate		
	Is this license certificate active? <input type="checkbox"/> Yes <input type="checkbox"/> No If not active, why?		Do you currently practice under it? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this license certificate active? <input type="checkbox"/> Yes <input type="checkbox"/> No If not active, why?		Do you currently practice under it? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Does your license/certification level require supervision? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.				Does your license/certification level require supervision? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.				
	State		License/Certificate #		Type (i.e., MD,DO)	State		License/Certificate #	Type (i.e., MD,DO)
	Date of Initial License/Certificate		Expiration Date of Current State License/Certificate		Date of Initial License/Certificate		Expiration Date of Current State License/Certificate		

Federal DEA Certificate Attach a copy of your current Federal DEA Certificate(s).

1.	State	DEA Certificate Number	Expiration Date	Limited or Restricted? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain.
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State Narcotics Registration Attach a copy of all your current Controlled Dangerous Substance (CDS) Registration(s).

2.	State	CDS Certificate Number	Expiration Date	Limited or Restricted? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain.
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G. BOARD CERTIFICATION STATUS

For each certification, please indicate your specialty, the certificate number, and the dates of certification and expiration. Please include issuing board (ABMS, AOA, etc.).

1.	Specialty		2.	Specialty	
	Issuing Board (ABMS, AOA, etc.)			Issuing Board (ABMS, AOA, etc.)	
Certificate Number	Original Effective Date	Certificate Number		Original Effective Date	
Expiration Date	Last Recertification Date	Expiration Date		Last Recertification Date	

H. EDUCATION, TRAINING AND PROFESSIONAL ACTIVITY MEDICAL/PROFESSIONAL EDUCATION

Month and year must be indicated. **Foreign Medical School Graduates:** Please enclose a copy of your ECFMG certificate.

Complete School Name	From (month/year)	To (month/year)			
Mailing Address	City	State	Zip Code	Country	Degree Granted

INTERNSHIP

Complete School Name	From (month/year)	To (month/year)	Did you successfully complete the program?		
Mailing Address	City	State	Zip Code	Country	Program Specialty

RESIDENCY

Complete School Name	From (month/year)	To (month/year)	Did you successfully complete the program?		
Mailing Address	City	State	Zip Code	Country	Program Specialty

SECOND RESIDENCY

Complete School Name	From (month/year)	To (month/year)	Did you successfully complete the program?		
Mailing Address	City	State	Zip Code	Country	Program Specialty

FELLOWSHIP

Complete School Name	From (month/year)	To (month/year)	Did you successfully complete the program?		
Mailing Address	City	State	Zip Code	Country	Program Specialty

OTHER POST GRADUATE TRAINING

Complete School Name	From (month/year)	To (month/year)	Did you successfully complete the program?		
Mailing Address	City	State	Zip Code	Country	Program Specialty

I. PROFESSIONAL WORK HISTORY

Please account for your professional history during the past 5 years. You **must include both month and year for each position.**

1.	From (Month/Year)			2.	From (Month/Year)		
	To (Month/Year)				To (Month/Year)		
	Organization or Office Practice Name				Organization or Office Practice Name		
	Mailing Address				Mailing Address		
	City	State	Zip Code		City	State	Zip Code
	County	Phone Number			County	Phone Number	
Position			Position				
3.	From (Month/Year)			4.	From (Month/Year)		
	To (Month/Year)				To (Month/Year)		
	Organization or Office Practice Name				Organization or Office Practice Name		
	Mailing Address				Mailing Address		
	City	State	Zip Code		City	State	Zip Code
	County	Phone Number			County	Phone Number	
Position			Position				

J. WORK HISTORY ATTESTATION

Please explain any work history gap of 6 months or greater in the space provided below. Please attach a separate sheet if additional space is needed.

During the most recent five year period:

- I have had no periods of six months or greater where I was not actively engaged in patient care.
- I have had a period(s) of six months or greater wherein I was not actively engaged in patient care. During this period(s) I was:

K. PROFESSIONAL LIABILITY INSURANCE

Attach a copy of your current Professional Liability Insurance Certificate or declaration page (usually the first page of your policy) showing the name of the insured, the dates of coverage, and the amounts of coverage. Your name must appear on the page as a covered provider.

CURRENT INSURANCE CARRIER		STATE INSURANCE FUND			
1.	Name of Carrier		2.	Name of Carrier	
	State	Zip Code		State	Zip Code
	Years with Carrier	Amounts of Coverage		Years with Carrier	Amounts of Coverage
	Effective Date	Expiration Date		Effective Date	Expiration Date

L. ALLIED ASSOCIATE PROVIDERS

Do you employ Allied Health Practitioners (e.g. nurse midwives, nurse practitioners, physician assistant, etc...?) Yes No

1.	Allied Practitioner Name			2.	Allied Practitioner Name		
	Correspondence Address				Correspondence Address		
	City				City		
	State	Zip Code	County		State	Zip Code	County
	State License/Certification Number		Specialty		State License/Certification Number		Specialty

3. I attest each Allied Practitioner employed and/or utilized by me or the group I am affiliated with, has registered and holds a current valid license with the State Medical/Professional Board in the state he/she practices within.

Signature: _____ Date: _____

M. SPONSORING HUMANA MILITARY TRICARE PHYSICIAN(S) – *to be completed by Nurse Practitioners only*

Name of Sponsoring Physician (must be an Humana Military TRICARE network provider)

Phone Number	Sponsoring Physician's Social Security Number
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Sponsoring Physician's Signature - I attest the Nurse Practitioner employed and/or utilized by me or the group I am affiliated with has registered, and holds a current valid license with the State Medical/Professional Board in the state he/she practices within.

Signature: _____ Date: _____

N. CONFLICT OF INTEREST STATEMENT

Do you or any member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgery center, or other business dealing with the provision of ancillary health services, equipment or supplies? Yes No **If yes, please provide the following information:**

Name of Organization	Percent of Investment/Ownership	
Address		
City	State	Zip Code
Phone Number	Tax ID Number	Nature of business interest (i.e., Partner, owner, investor)
Type of Organization	Size of Organization	

O. HOSPITAL AFFILIATIONS – *list hospitals in the order of use*

Name of Hospital	Location of Hospital (City/State)	Do you have the right to admit patients to this hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Hospital	Location of Hospital (City/State)	Do you have the right to admit patients to this hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Hospital	Location of Hospital (City/State)	Do you have the right to admit patients to this hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Hospital	Location of Hospital (City/State)	Do you have the right to admit patients to this hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No

P. MANDATORY QUESTIONNAIRE

IMPORTANT: If you answer "Yes" to any question, attach a detailed explanation. If any question does not apply to you, please answer "No". Failure to check an answer or provide an explanation may result in delay of application processing. **DO NOT** use whiteout to correct/change answers; if you need to correct/change an answer, cross-out the incorrect answer, initial it and then mark the correct answer.

Provider Name	Social Security Number
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Disciplinary Actions

1. Have any of the following been, or currently in the process of being investigated, suspended, reduced, limited, placed on probation, not renewed, revoked, cancelled, denied, reprimanded, granted with limitation (either temporarily or permanently) or voluntarily relinquished?
 - a. Medical License in any State or Commonwealth? Yes No
 - b. DEA Registration? Yes No
 - c. State CDS (Controlled Dangerous Substance) or other Professional Registration? Yes No
 - d. Board Certification? Yes No
 - e. Education, Internship, Residency, Fellowship or other Academic Positions? Yes No
 - f. Clinical Privileges? Yes No
 - g. Membership on any Hospital or other Medical Staff? Yes No
 - h. Participation in any Managed Care Organization or Federal or State Health Program? (including the Medicare and/or Medicaid Programs)? Yes No
 - i. Military Agency? Yes No
2. Have you ever been convicted of a felony or are you presently under investigation or have you been indicted for a felony? Yes No

Malpractice Claims and Professional Negligence History – During the past five years

3. Have you had any malpractice or professional negligence claims, suits, or actions settled, arbitrated, mediated or litigated? Yes No
4. Have any malpractice or professional negligence claims, suits, or actions been filed against you that are presently pending? Yes No
5. Have you ever been denied professional liability insurance coverage, ever been terminated or modified by action of an insurance carrier or rated in a higher-than-average risk class for your specialty? Yes No
6. Are you currently uninsured for professional liability (malpractice insurance) coverage? Yes No

Health Status

7. Do you have any physical, mental, or substance abuse problem(s) that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of beneficiaries? Yes No
8. Are you currently engaged in the illegal use of drugs? Yes No

Hospital Affiliations

9. Are you a physician without admitting privileges/rights to a Joint Commission accredited hospital? If "Yes" print the name, specialty and telephone number of the Humana Military network provider who admits on your behalf. Yes No

NOTE: If you practice Allergy & Immunology or Dermatology, or are a Podiatrist, Optometrist or Nurse Practitioner, this section does not apply to you.

Admitting Provider: _____

Specialty: _____ Phone #: _____

Q. CONSENT and RELEASE FORM - Provider Authorization and Attestation DO NOT ALTER THIS FORM

I hereby give permission to Humana Military and/or its designee(s) to request information regarding my professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certifying boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, present and past employers, and any other entity/agency needed to obtain information necessary to complete the credentialing process. The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and or professional competence, character, ethics, or any other matter applicable to the credentialing procedure. I release and agree to hold harmless Humana Military and its designee(s) and their respective authorized representatives, from any and all liability for any damages, costs and expenses which may result from the gathering of and good faith use of the information gathered during the credentialing process.

I hereby authorize the education facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certifying boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, present and past employers to submit information requested by Humana Military, directly and/or through its designee(s) including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and lawsuit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I hereby further release and agree to hold harmless any such entity referenced in the previous sentence, their representatives, employees, and agents from any damages which may result from providing this information as long as such release of information is done in good faith and without malice.

I agree a photocopy or facsimile of this document with my signature may be accepted by any person or entity from which information is needed to complete the credentialing process. The photocopy or facsimile is sought with the same authority as the original, and I specifically waive written notice from any such entity or individual who may provide information based upon this authorized request.

I understand a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application by Humana Military and may result in denial of my application or termination of my participation in the Humana Military network. I further understand any misrepresentation, misstatement, or omission from this application, if discovered after network participation has been awarded to me, may lead to immediate suspension or termination of my network status. I agree to inform Humana Military in writing, within 15 days, if there is any change in the information contained in this application as a result of developments subsequent to my signing this application (i.e. license status).

If I am accepted for participation, I consent to the inspection of my patient records as necessary for peer, utilization, and quality review purposes and agree to be bound by the participation agreement, credentialing plan and provider manual. I understand if my application is rejected for reasons related to my professional conduct or competence, Humana Military may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank.

I understand I have the right to review and correct erroneous information obtained by Humana Military to evaluate my credentialing application. This includes information obtained from any outside primary source (e.g., malpractice insurance carriers, state licensing boards, Criminal History Background Checks, etc). The review must take place within 6 months of this application. Any corrections must be made in writing within 30 days of the review. This does not require Humana Military to allow a provider to review references, recommendations or other information that is peer-review protected.

I represent the information provided in or attached to this application is complete, accurate and true to the best of my knowledge.

I agree the submission of the application does not constitute approval or acceptance as a participating provider and Humana Military retains sole judgment regarding who is approved/accepted for credentialing/network participation.

I understand I must meet the minimum credentialing criteria listed on page one of this application to be considered for credentialing/network participation. I also understand that if I'm denied for not meeting the above listed minimum credentialing criteria, I can not appeal that decision. However, I may reapply at such time I meet the minimum credentialing criteria as defined by Humana Military.

Humana Military does not discriminate against any provider seeking qualification as a participating provider.

I understand that if at any time during the credentialing process I have any question regarding the status of my application I can call **1-877-414-9948** between the hours of 8 a.m. – 5 p.m. Central Time.

This attestation statement must be signed no more than 180 days prior to the credentialing decision. If the credentialing review and decision takes place more than 180 days after the signature below, you must re-sign and date this application page attesting that all application information remains current, complete, and correct.

Your signature is required to complete this application. STAMPED SIGNATURES ARE NOT ACCEPTABLE.

Name (Please Print or Type)	Signature	Date

MALPRACTICE CLAIM INFORMATION WORKSHEET – DO NOT include any form of PHI

Please provide the following information for each malpractice claim in which you have been named.

Date of Occurrence (mm/dd/yy)

Insurance company defending your claim:

Insurance company address	City	State	Zip Code
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Procedure(s) performed:

Co-defendant(s):

Court Trial? <input type="checkbox"/> Yes <input type="checkbox"/> No	Settlement out of court? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Settlement?(mm/dd/yy)
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Is the claim pending? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ Amount in reserve by insurance company?
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\$ Total amount paid to claimant on your behalf/settlement amount?	\$ Total amount paid to claimant for all defendants:
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Please provide a clinical, **detailed description of the events leading up to each malpractice case, but DO NOT include PHI.**

Please add additional sheets if necessary, or a copy of the court documentation.

OFFICE PRACTICE FORM

Please complete a separate form for each additional office practice. If additional sheets are needed, please photocopy this page prior to completing.

ADDITIONAL OFFICE PRACTICE

Legal Practice Name		Tax ID Number		
Practice Address		Suite #		
City	State		Zip Code	County
Office phone number	Office Fax Number		Referral Fax Number	
E-mail address		Date (mm/yy) you started with this practice:		
Correspondence Address		Billing Address (If different from Primary Office)		
Name		Name		
Street Address	Suite #	Street Address	Suite #	
City		City		
State	Zip Code	County	State	Zip Code
Office phone number		Office phone number		
Office Fax Number		Office Fax Number		
E-mail address		E-mail address		
What hours do you see patients in this office		FROM	TO	
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				
Please list your covering practitioners				
Name		Name		
Phone Number		Phone Number		
Emergency Number		Emergency Number		
Specialty		Specialty		

CONGRATULATIONS! YOU HAVE REACHED THE FINAL PAGE OF THIS APPLICATION. To ensure the credentialing process is quickly expedited, please ensure you have completed the following:

- YES NO Have you marked all of the sections of the application that do not apply to you as "N/A"?
- YES NO Have you included your work history, with all information for the past five years? Months and years must be indicated on each work item.
- YES NO Have you included a current professional liability insurance/malpractice insurance declaration sheet, including name of insured, amounts and dates of coverage?

NOTE: Invoices or documentation that states, "upon receipt of premium your coverage will be..." will not be accepted as proof of current professional liability insurance/malpractice insurance.
- YES NO Have you included your entire malpractice claims history? Each claim must include the clinical details of the events leading up to the issue, the current status, and the financial outcome of each case.
- YES NO Have you included a copy of your current Drug Enforcement Administration (DEA) certificate, if applicable?
- YES NO Have you included a copy of your current State Controlled Dangerous Substance (CDS) registration, if applicable?
- YES NO Have you provided a detailed explanation to every "YES" response on the Mandatory Questionnaire section of the application?

IF YOU SAID "NO" TO ANY OF THESE QUESTIONS OR IF ANY ITEM IS MISSING FROM THE APPLICATION, THE CREDENTIALING PROCESS WILL BE DELAYED.

THANK YOU.