

Provider Application

CORRECT NUMBERS
AND LETTERS

A B C 1 2 3

CORRECT
MARK XINCORRECT
MARKS

CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING,
COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE
MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Instructions

Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays

1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1**Personal Information and Professional IDs****Provider Type**

Code list is found on page 36. Enter the associated 3-digit code in the space provided.*

YES NO

DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?*
(E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name

Do not use nicknames or initials, unless they are part of your legal name.

LAST NAME*

SUFFIX (JR, III)

FIRST NAME*

MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?*

 YES

 NO

IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME

SUFFIX (JR, III)

OTHER FIRST NAME

OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME

DATE STOPPED USING OTHER NAME

General Information

Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

GENDER* MALE FEMALE

DATE OF BIRTH*

CITY OF BIRTH

STATE OF BIRTH

COUNTRY OF BIRTH

SSN*

FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN)

FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK

LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE

Home Address

STREET

CITY

STATE

ZIP CODE

TELEPHONE

NOTE: CAQH will use this method for application follow-up.

E-MAIL

FAX

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1 Personal Information and Professional IDs (Continued)			
Professional IDs Include all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers. Provide all current and previous licenses/certifications. Non-licensed professionals should enter certification/registration number in the space provided for license number. If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.	FEDERAL DEA NUMBER	DEA ISSUE DATE	
	DEA STATE OF REGISTRATION	DEA EXPIRATION DATE	
	CDS CERTIFICATE NUMBER	CDS ISSUE DATE	
	CDS STATE OF REGISTRATION	CDS EXPIRATION DATE	
	STATE LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE ISSUE DATE
	IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? <input type="checkbox"/> YES <input type="checkbox"/> NO	LICENSE EXPIRATION DATE	
	LICENSE STATUS CODE	Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.	Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.
	LICENSE TYPE		
	STATE LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE ISSUE DATE
	IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? <input type="checkbox"/> YES <input type="checkbox"/> NO	LICENSE EXPIRATION DATE	
LICENSE STATUS CODE	Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.	Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.	
LICENSE TYPE			
ARE YOU A PARTICIPATING MEDICARE PROVIDER?* <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE NUMBER	UPIN	
ARE YOU A PARTICIPATING MEDICAID PROVIDER?* <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAID NUMBER	MEDICAID STATE	
NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER		USMLE NUMBER (WITHOUT HYPHENS)	
WORKERS COMPENSATION NUMBER			
ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)		ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY)	

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Section 2		Education and Training			
Undergraduate School(s) Provide the appropriate information for the school that issued your undergraduate degree and all schools attended.	UNDERGRADUATE SCHOOL				
	OFFICIAL NAME OF UNDERGRADUATE SCHOOL				
Professional School(s) Provide the appropriate information for the school that issued your professional degree.	ADDRESS		STATE	ZIP/POSTAL CODE	
	CITY	STATE	ZIP/POSTAL CODE		
Fifth Pathway Graduates please complete the following sections: U.S. School that issued your certificate, the Non-U.S. School where you attended, and the Fifth Pathway institution where you completed your training on Supplemental Page 20.	COUNTRY CODE	TELEPHONE	FAX		
	START DATE	END DATE (GRADUATION DATE)	DEGREE AWARDED		
DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL?	<input type="checkbox"/> YES	<input type="checkbox"/> NO			
GRADUATE TYPE*:					
<input type="checkbox"/> U.S. OR CANADIAN GRADUATE	<input type="checkbox"/> NON-U.S./CANADIAN GRADUATE	<input type="checkbox"/> FIFTH PATHWAY GRADUATE			
PROFESSIONAL/MEDICAL SCHOOL					
SCHOOL CODE (U.S./CANADIAN ONLY)	NAME OF U.S./CANADIAN SCHOOL: _____				
ADDRESS					
CITY	STATE	COUNTRY	POSTAL CODE		
START DATE*	END DATE (GRADUATION DATE)*	DEGREE AWARDED			
DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?	<input type="checkbox"/> YES	<input type="checkbox"/> NO			
NON - U.S. OR CANADIAN SCHOOL					
OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL					
ADDRESS	CITY				
COUNTRY	POSTAL CODE	TELEPHONE	FAX		
START DATE*	END DATE (GRADUATION DATE)*	DEGREE AWARDED			
DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?	<input type="checkbox"/> YES	<input type="checkbox"/> NO			

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Section 2

Education and Training (Continued)

Training

List all training programs you attended. Use one section per institution.

If you have additional post-graduate training programs, use the Supplemental Training Form on page 21.

Please explain on the Supplemental Professional / Work History Gap Form on page 33 any training gap(s) of three (3) months or greater, or any gap(s) of a shorter duration if required by the organization for which you are being credentialed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

AFFILIATED MEDICAL SCHOOL

INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

NUMBER STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION?

YES NO

(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)

List each department separately, if applicable.

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

START DATE

END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

START DATE

END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

START DATE

END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3		Professional / Medical Specialty Information					
Primary Specialty Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.	SPECIALTY CODE BOARD CERTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	INITIAL CERTIFICATION DATE RECERTIFICATION DATE (IF APPLICABLE)	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO <input type="checkbox"/> YES <input type="checkbox"/> NO			
	CERTIFYING BOARD CODE	EXPIRATION DATE (IF APPLICABLE)	PPO <input type="checkbox"/> YES <input type="checkbox"/> NO	POS <input type="checkbox"/> YES <input type="checkbox"/> NO			
	IF NOT BOARD CERTIFIED (SELECT ONE) <input type="checkbox"/> I HAVE TAKEN EXAM, RESULTS PENDING FOR	<input type="checkbox"/> I INTEND TO SIT FOR AN EXAM ON	<input type="checkbox"/> I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.				
	CERTIFYING BOARD CODE						
	IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.						
Secondary Specialty Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided. If you have additional Professional / Medical Specialties to report, use the Additional Specialties Supplemental Form on page 22.	SPECIALTY CODE BOARD CERTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	INITIAL CERTIFICATION DATE RECERTIFICATION DATE (IF APPLICABLE)	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO <input type="checkbox"/> YES <input type="checkbox"/> NO			
	CERTIFYING BOARD CODE	EXPIRATION DATE (IF APPLICABLE)	PPO <input type="checkbox"/> YES <input type="checkbox"/> NO	POS <input type="checkbox"/> YES <input type="checkbox"/> NO			
	IF NOT BOARD CERTIFIED (SELECT ONE) <input type="checkbox"/> I HAVE TAKEN EXAM, RESULTS PENDING FOR	<input type="checkbox"/> I INTEND TO SIT FOR AN EXAM ON	<input type="checkbox"/> I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.				
	CERTIFYING BOARD CODE						
	IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.						

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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Section 4 Practice Location Information					
Primary Practice Location If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 25-29. NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information. TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.	NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT QUESTION ABOVE. SECTION 4 MAY BE LEFT BLANK. YOU MAY PROCEED TO SECTION 5 ON PAGE 11.				
	CURRENTLY PRACTICING AT THIS ADDRESS?*	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PREVIOUS OR FUTURE START DATE?	
PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*					
GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)					
NUMBER*	STREET*			SUITE/BUILDING	
CITY*				STATE*	ZIP CODE*
SEND GENERAL CORRESPONDENCE HERE?*	<input type="checkbox"/> YES	<input type="checkbox"/> NO	TELEPHONE*	FAX	
OFFICE E-MAIL ADDRESS			INDIVIDUAL TAX ID	GROUP TAX ID	PRIMARY TAX ID (ONE ONLY)* <input type="checkbox"/> USE INDIVIDUAL TAX ID <input type="checkbox"/> USE GROUP TAX ID
Office Manager or Business Office Staff Contact List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.		LAST NAME*			
FIRST NAME*				M.I.	
TELEPHONE*				FAX	
E-MAIL ADDRESS					
Billing Contact		LAST NAME*			
CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION <input type="checkbox"/>				M.I.	
NOTE: Even if you checked the box above, please provide the E-mail Address of the Billing Contact.	FIRST NAME*				
	NUMBER*	STREET*	SUITE/BUILDING		
	CITY*				STATE* ZIP CODE*
	TELEPHONE*				FAX
	E-MAIL ADDRESS				

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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Section 4		Practice Location Information (Continued)																																																											
Payment and Remittance <small>YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.</small> <small>CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS PAYEE INFORMATION</small>		<p>ELECTRONIC BILLING CAPABILITIES? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>BILLING DEPARTMENT (IF HOSPITAL-BASED)</p> <p>CHECK PAYABLE TO*</p> <p>LAST NAME*</p> <p>FIRST NAME* M.I.</p> <p>NUMBER* STREET* SUITE/BUILDING</p> <p>CITY* STATE* ZIP CODE*</p> <p>TELEPHONE* FAX</p> <p>E-MAIL ADDRESS</p>																																																											
NOTE: <small>Even if you checked the box above, please provide the E-mail Address of the Payee Contact.</small>																																																													
Office Hours <small>NOTE:</small> <small>After hours back office telephone will be used only by the health plan and will not be published under any circumstances.</small>		<p>(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)</p> <table border="1"> <thead> <tr> <th></th> <th>START</th> <th>A=AM P=PM</th> <th>END</th> <th>A=AM P=PM</th> <th></th> <th>START</th> <th>A=AM P=PM</th> <th>END</th> <th>A=AM P=PM</th> </tr> </thead> <tbody> <tr> <td>MONDAY</td> <td></td> <td></td> <td></td> <td></td> <td>FRIDAY</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>TUESDAY</td> <td></td> <td></td> <td></td> <td></td> <td>SATURDAY</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>WEDNESDAY</td> <td></td> <td></td> <td></td> <td></td> <td>SUNDAY</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>THURSDAY</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>24/7 PHONE COVERAGE?* IF YES AFTER HOURS BACK OFFICE TELEPHONE</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ANSWERING SERVICE <input type="checkbox"/> VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE <input type="checkbox"/> VOICE MAIL WITH OTHER INSTRUCTIONS</p>											START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM	MONDAY					FRIDAY					TUESDAY					SATURDAY					WEDNESDAY					SUNDAY					THURSDAY									
	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM																																																				
MONDAY					FRIDAY																																																								
TUESDAY					SATURDAY																																																								
WEDNESDAY					SUNDAY																																																								
THURSDAY																																																													
Open Practice Status		<p>ACCEPT NEW PATIENTS INTO THIS PRACTICE?* <input type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT ALL NEW PATIENTS?* <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* <input type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT NEW MEDICARE PATIENTS?* <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* <input type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT NEW MEDICAID PATIENTS?* <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN (USE BOTH LINES IF REQUIRED)</p> <p>ARE THERE ANY PRACTICE LIMITATIONS?* <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES GENDER LIMITATIONS AGE LIMITATIONS LIST OTHER LIMITATIONS</p> <p><input type="checkbox"/> MALE ONLY <input type="checkbox"/> NONE MINIMUM AGE</p> <p><input type="checkbox"/> FEMALE ONLY MAXIMUM AGE</p>																																																											

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Section 4 Practice Location Information (Continued)		
Mid-Level Practitioners	DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)	
	PRACTITIONER LAST NAME	
	PRACTITIONER FIRST NAME	M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)
PRACTITIONER LICENSE / CERTIFICATE NUMBER	PRACTITIONER STATE	
PRACTITIONER LAST NAME		
PRACTITIONER FIRST NAME	M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)	
PRACTITIONER LICENSE / CERTIFICATE NUMBER	PRACTITIONER STATE	
PRACTITIONER LAST NAME		
PRACTITIONER FIRST NAME	M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)	
PRACTITIONER LICENSE / CERTIFICATE NUMBER	PRACTITIONER STATE	
PRACTITIONER LAST NAME		
PRACTITIONER FIRST NAME	M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)	
PRACTITIONER LICENSE / CERTIFICATE NUMBER	PRACTITIONER STATE	

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Section 4	Practice Location Information (Continued)							
Languages	LANGUAGES NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL Code lists are found on pages 37. Enter the associated 3-digit code in the space provided.							
	INTERPRETERS AVAILABLE?*		LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	
	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	LANGUAGES INTERPRETED			
				LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	
Accessibilities	DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* <input type="checkbox"/> YES <input type="checkbox"/> NO DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING <input type="checkbox"/> YES <input type="checkbox"/> NO BUILDING?* <input type="checkbox"/> YES <input type="checkbox"/> NO TEXT TELEPHONY (TTY)* <input type="checkbox"/> YES <input type="checkbox"/> NO PARKING?* <input type="checkbox"/> YES <input type="checkbox"/> NO AMERICAN SIGN LANGUAGE* <input type="checkbox"/> YES <input type="checkbox"/> NO RESTROOM?* <input type="checkbox"/> YES <input type="checkbox"/> NO MENTAL/PHYSICAL IMPAIRMENT SERVICES* <input type="checkbox"/> YES <input type="checkbox"/> NO OTHER HANDICAPPED ACCESS OTHER DISABILITY SERVICES OTHER TRANSPORTATION ACCESS							
Services	Does this location provide any of the following services? LABORATORY SERVICES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PROVIDE ACCREDITING/CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE) RADIOLOGY SERVICES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PROVIDE X-RAY CERTIFICATION TYPE EKGs? <input type="checkbox"/> YES <input type="checkbox"/> NO ALLERGY INJECTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO ALLERGY SKIN TESTING? <input type="checkbox"/> YES <input type="checkbox"/> NO ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? <input type="checkbox"/> YES <input type="checkbox"/> NO DRAWING BLOOD? <input type="checkbox"/> YES <input type="checkbox"/> NO AGE APPROPRIATE IMMUNIZATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO FLEXIBLE SIGMOIDOSCOPY? <input type="checkbox"/> YES <input type="checkbox"/> NO TYPANOMETRY/Y/AUDIOMETRY SCREENING? <input type="checkbox"/> YES <input type="checkbox"/> NO ASTHMA TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO OSTEOPATHIC MANIPULATION? <input type="checkbox"/> YES <input type="checkbox"/> NO IV HYDRATION/TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO CARDIAC STRESS TEST? <input type="checkbox"/> YES <input type="checkbox"/> NO PULMONARY FUNCTION TESTING? <input type="checkbox"/> YES <input type="checkbox"/> NO PHYSICAL THERAPY? <input type="checkbox"/> YES <input type="checkbox"/> NO CARE OF MINOR LACERATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHAT CLASS/CATEGORY DO YOU USE? IF YES, WHO ADMINISTERS IT?							
	LAST NAME				FIRST NAME			
	TYPE OF PRACTICE (SELECT ONE ONLY)*		SOLO PRACTICE	SINGLE SPECIALTY GROUP	MULTI-SPECIALTY GROUP			
	ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)							

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Section 4	Practice Location Information (Continued)		
Partners/ Associates Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided. If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.	LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE		
	LAST NAME	SPECIALTY CODE	<input type="checkbox"/> COVERING COLLEAGUE (Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
	LAST NAME	SPECIALTY CODE	<input type="checkbox"/> COVERING COLLEAGUE (Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
LAST NAME	SPECIALTY CODE	<input type="checkbox"/> COVERING COLLEAGUE (Y/N)?	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
Covering Colleagues Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided. If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.	LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE		
LAST NAME	SPECIALTY CODE		
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
LAST NAME	SPECIALTY CODE		
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
LAST NAME	SPECIALTY CODE		
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
Section 5	Hospital Affiliations		
Admitting Arrangements	DO YOU HAVE HOSPITAL PRIVILEGES?* <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?	

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 5 Hospital Affiliations (Continued)		
Hospital Privileges <p>If applicable, list all hospital affiliations. List primary hospital, then other current affiliations, followed by previous affiliations in chronological order.</p> <p>If you have additional hospital privileges, use the Supplemental Hospital Privileges Form on page 30.</p> <p>TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.</p>	PRIMARY HOSPITAL	
	HOSPITAL NAME	
	NUMBER STREET	SUITE/BUILDING
	CITY	STATE ZIP CODE
	TELEPHONE	FAX
	DEPARTMENT NAME	
	DEPARTMENT DIRECTOR'S LAST NAME	
	DEPARTMENT DIRECTOR'S FIRST NAME	
	AFFILIATION START DATE	AFFILIATION END DATE
	FULL, UNRESTRICTED PRIVILEGES? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ARE PRIVILEGES TEMPORARY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
M.I.		
OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %		
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)		
OTHER HOSPITAL		
HOSPITAL NAME		
NUMBER STREET	SUITE/BUILDING	
CITY	STATE ZIP CODE	
TELEPHONE	FAX	
DEPARTMENT NAME		
DEPARTMENT DIRECTOR'S LAST NAME		
DEPARTMENT DIRECTOR'S FIRST NAME		
AFFILIATION START DATE	AFFILIATION END DATE	
FULL, UNRESTRICTED PRIVILEGES? <input type="checkbox"/> YES <input type="checkbox"/> NO		
ARE PRIVILEGES TEMPORARY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
M.I.		
OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %		
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)		
PLEASE EXPLAIN TERMINATED AFFILIATION		

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Section 6		Professional Liability Insurance Carrier							
Professional Liability Insurance Carrier <small>IMPORTANT IF YOU DO NOT CARRY MALPRACTICE INSURANCE, CHECK THIS BOX AND SKIP THIS SECTION.</small>	CARRIER OR SELF-INSURED NAME*						SELF-INSURED?* <input type="checkbox"/> YES <input type="checkbox"/> NO		
	NUMBER*	STREET*					SUITE/BUILDING		
	CITY*					STATE* <input type="checkbox"/>	ZIP CODE* <input type="checkbox"/>		
	ORIGINAL EFFECTIVE DATE*	EFFECTIVE DATE*	EXPIRATION DATE				INDIVIDUAL <input type="checkbox"/> SHARED <input type="checkbox"/>		
	DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?* <input type="checkbox"/> YES <input type="checkbox"/> NO	\$	AMOUNT OF COVERAGE PER OCCURRENCE				\$		
	POLICY INCLUDES TAIL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO					AMOUNT OF COVERAGE AGGREGATE			
	POLICY NUMBER*								
	CARRIER OR SELF-INSURED NAME							SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	NUMBER* STREET* SUITE/BUILDING								
Professional Liability Insurance Carrier <small>List other current, future, or previous carrier(s) if current carrier is less than ten (10) years. NOTE: A longer period may be required by your healthcare entity. If you have additional insurance, use the Supplemental Insurance Form on page 31.</small>	CITY*					STATE* <input type="checkbox"/> ZIP CODE* <input type="checkbox"/>			
	ORIGINAL EFFECTIVE DATE*	EFFECTIVE DATE*	EXPIRATION DATE				TYPE OF COVERAGE?* <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SHARED <input type="checkbox"/>		
	DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? <input type="checkbox"/> YES <input type="checkbox"/> NO	\$	AMOUNT OF COVERAGE PER OCCURRENCE				\$		
	POLICY INCLUDES TAIL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO					AMOUNT OF COVERAGE AGGREGATE			
	POLICY NUMBER*								
	Section 7		Work History and References						
	Military Duty <small>Include a chronological work history for the past 10 years. A longer period may be required by your healthcare entity. If you have additional work history, use the Supplemental Work History Form on page 32.</small>	Are you currently on active military duty or military reserve?* <input type="checkbox"/> YES <input type="checkbox"/> NO							
	Work History	WORK HISTORY							
	PRACTICE / EMPLOYER NAME								
NUMBER	STREET					SUITE/BUILDING			
CITY					STATE	ZIP/POSTAL CODE			

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Page 14

Std. App. v.5.0
Reprinted on 10/31/06

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7	Work History and References (Continued)				
Gaps in Professional / Work History If you have additional professional / work history gaps, use the Supplemental Professional Work History Gaps Form on page 33.	PLEASE EXPLAIN ANY TIME PERIODS OR GAPS IN TRAINING OR WORK HISTORY THAT HAVE OCCURRED SINCE GRADUATION FROM PROFESSIONAL SCHOOL AND ARE LONGER THAN THREE MONTHS IN DURATION OR OF A SHORTER DURATION IF REQUIRED BY THE ORGANIZATION FOR WHICH YOU ARE BEING CREDENTIALLED.				
	GAP START DATE	GAP END DATE			
Professional References Provide three professional references to whom you are not related or are not partners in your practice. Code lists are found on pages 36-43. Enter the associated 3-digit code for provider type. NOTE: You are required to provide exactly 3 references. Your application will not be complete without this information. Please check with credentialing entity for any special requirements.	LAST NAME*				
	FIRST NAME*				PROVIDER TYPE (CODE PG 36)
	NUMBER*	STREET*			
	CITY*		STATE*	ZIP CODE*	
	TELEPHONE	FAX			
	LAST NAME*				
	FIRST NAME*				PROVIDER TYPE (CODE PG 36)
	NUMBER*	STREET*			
	CITY*		STATE*	ZIP CODE*	
	TELEPHONE	FAX			
LAST NAME*					
FIRST NAME*				PROVIDER TYPE (CODE PG 36)	
NUMBER*	STREET*				
CITY*		STATE*	ZIP CODE*		
TELEPHONE	FAX				

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8	Disclosure Questions	
Disclosure Questions <p>Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.</p> Allied Health Providers <p>If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".</p>	LICENSURE	
	1. <input type="checkbox"/> YES <input type="checkbox"/> NO	Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?*
	2. <input type="checkbox"/> YES <input type="checkbox"/> NO	Has there been any challenge to your licensure, registration or certification?*
	HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS	
	3. <input type="checkbox"/> YES <input type="checkbox"/> NO	Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*
	4. <input type="checkbox"/> YES <input type="checkbox"/> NO	Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*
	5. <input type="checkbox"/> YES <input type="checkbox"/> NO	Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*
	EDUCATION, TRAINING AND BOARD CERTIFICATION	
	6. <input type="checkbox"/> YES <input type="checkbox"/> NO	Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*
	7. <input type="checkbox"/> YES <input type="checkbox"/> NO	Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*
	8. <input type="checkbox"/> YES <input type="checkbox"/> NO	Have any of your board certifications or eligibility ever been revoked?*
	9. <input type="checkbox"/> YES <input type="checkbox"/> NO	Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*
	DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION	
	10. <input type="checkbox"/> YES <input type="checkbox"/> NO	Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*
	MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION	
	11. <input type="checkbox"/> YES <input type="checkbox"/> NO	Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*
	OTHER SANCTIONS OR INVESTIGATIONS	
	12. <input type="checkbox"/> YES <input type="checkbox"/> NO	Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
13. <input type="checkbox"/> YES <input type="checkbox"/> NO	To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*	
14. <input type="checkbox"/> YES <input type="checkbox"/> NO	Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*	
15. <input type="checkbox"/> YES <input type="checkbox"/> NO	Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*	
16. <input type="checkbox"/> YES <input type="checkbox"/> NO	Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*	
PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY		
17. <input type="checkbox"/> YES <input type="checkbox"/> NO	Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*	
18. <input type="checkbox"/> YES <input type="checkbox"/> NO	Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*	

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8	Disclosure Questions (Continued)
Disclosure Questions Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34. IMPORTANT If you answered "Yes" to question #19, you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.	<p>MALPRACTICE CLAIMS HISTORY</p> <p>19. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?* If yes, provide information for each case.</p> <p>CRIMINAL/CIVIL HISTORY</p> <p>20. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*</p> <p>21. <input type="checkbox"/> YES <input type="checkbox"/> NO In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*</p> <p>22. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever been court-martialed for actions related to your duties as a medical professional?*</p> <p>Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.</p> <p>ABILITY TO PERFORM JOB</p> <p>23. <input type="checkbox"/> YES <input type="checkbox"/> NO Are you currently engaged in the illegal use of drugs?* ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)</p> <p>24. <input type="checkbox"/> YES <input type="checkbox"/> NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*</p> <p>25. <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*</p> <p>26. <input type="checkbox"/> YES <input type="checkbox"/> NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*</p>

Additional Credentialing Contacts

CH Yf
Credentialing
Contact

LAST NAME		
FIRST NAME	M.I.	
NUMBER	STREET	SUITE/BUILDING
CITY	STATE	ZIP CODE
TELEPHONE	FAX	
E-MAIL ADDRESS		

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Additional Practice Location IMPORTANT <p>In the box provided, indicate to which practice location this page belongs. For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.</p> <p>TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.</p>	<p>Practice Location Information - Page 1 of 5</p> <p>→ LOCATION* #</p> <p>CURRENTLY PRACTICING AT THIS ADDRESS?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PREVIOUS OR FUTURE START DATE?</p> <p>PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*</p> <p>GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)</p> <p>NUMBER* STREET* SUITE/BUILDING</p> <p>CITY* STATE* ZIP CODE*</p> <p>SEND GENERAL CORRESPONDENCE HERE?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO TELEPHONE* FAX</p> <p>OFFICE E-MAIL ADDRESS</p> <p>INDIVIDUAL TAX ID GROUP TAX ID PRIMARY TAX ID (ONE ONLY)* <input type="checkbox"/> USE INDIVIDUAL TAX ID <input checked="" type="checkbox"/> USE GROUP TAX ID</p> <hr/> <p>Office Manager or Business Office Contact List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.</p> <p>LAST NAME*</p> <p>FIRST NAME* M.I.</p> <p>TELEPHONE* FAX</p> <p>E-MAIL ADDRESS</p> <hr/> <p>Billing Contact</p> <p>CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION <input type="checkbox"/></p> <p>LAST NAME*</p> <p>FIRST NAME* M.I.</p> <p>NUMBER* STREET* SUITE/BUILDING</p> <p>CITY* STATE* ZIP CODE*</p> <p>TELEPHONE* FAX</p> <p>E-MAIL ADDRESS</p>
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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Add'l Practice Location (Cont.) Payment and Remittance YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9. CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION <input type="checkbox"/>	Practice Location Information - Page 2 of 5 LOCATION* # ELECTRONIC BILLING CAPABILITIES?* <input type="checkbox"/> YES <input type="checkbox"/> NO BILLING DEPARTMENT (IF HOSPITAL-BASED) CHECK PAYABLE TO: LAST NAME* FIRST NAME* M.I. NUMBER* STREET* SUITE/BUILDING CITY* STATE* ZIP CODE* TELEPHONE* FAX E-MAIL ADDRESS																																																		
NOTE: Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.	(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)																																																		
Office Hours NOTE: After hours back office telephone will be used only by the health plan and will not be published under any circumstances.	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>START</th> <th>A=AM P=PM</th> <th>END</th> <th>A=AM P=PM</th> <th></th> <th>START</th> <th>A=AM P=PM</th> <th>END</th> <th>A=AM P=PM</th> </tr> </thead> <tbody> <tr> <td>MONDAY</td> <td></td> <td></td> <td></td> <td></td> <td>FRIDAY</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>TUESDAY</td> <td></td> <td></td> <td></td> <td></td> <td>SATURDAY</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>WEDNESDAY</td> <td></td> <td></td> <td></td> <td></td> <td>SUNDAY</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>THURSDAY</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> 24/7 PHONE COVERAGE?* IF YES <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ANSWERING SERVICE <input type="checkbox"/> VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE <input type="checkbox"/> VOICE MAIL WITH OTHER INSTRUCTIONS AFTER HOURS BACK OFFICE TELEPHONE		START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM	MONDAY					FRIDAY					TUESDAY					SATURDAY					WEDNESDAY					SUNDAY					THURSDAY									
	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM																																										
MONDAY					FRIDAY																																														
TUESDAY					SATURDAY																																														
WEDNESDAY					SUNDAY																																														
THURSDAY																																																			
Open Practice Status ACCEPT NEW PATIENTS INTO THIS PRACTICE?* <input type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT ALL NEW PATIENTS?* <input type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* <input type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT NEW MEDICARE PATIENTS?* <input type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* <input type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT NEW MEDICAID PATIENTS?* <input type="checkbox"/> YES <input type="checkbox"/> NO IF ANY OF THE ABOVE VARIES BY PLAN, EXPLAIN ARE THERE ANY PRACTICE LIMITATIONS?* IF YES GENDER LIMITATIONS AGE LIMITATIONS LIST OTHER LIMITATIONS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MALE ONLY <input type="checkbox"/> NONE MINIMUM AGE <input type="checkbox"/> FEMALE ONLY MAXIMUM AGE																																																			

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4	Practice Location Information - Page 3 of 5		
Additional Practice Location <small>(Continued)</small> <hr/> IMPORTANT In the box provided, indicate to which practice location this page belongs. Mid-Level Practitioners	→ LOCATION* # <hr/> <p>DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)</p> <hr/> <p>PRACTITIONER LAST NAME</p> <p>PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)</p> <p>PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE</p> <hr/> <p>PRACTITIONER LAST NAME</p> <p>PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)</p> <p>PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE</p> <hr/> <p>PRACTITIONER LAST NAME</p> <p>PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)</p> <p>PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE</p> <hr/> <p>PRACTITIONER LAST NAME</p> <p>PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)</p> <p>PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE</p> <hr/>		

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Additional Practice Location <small>(Continued)</small>	Practice Location Information - Page 4 of 5												
IMPORTANT In the box provided, indicate to which practice location this page belongs.	LOCATION* #												
	LANGUAGES NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL												
Accessibilities	INTERPRETERS AVAILABLE?*	<input type="checkbox"/> YES	<input type="checkbox"/> NO	LANGUAGES INTERPRETED		LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE			
	DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?*	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?*		<input type="checkbox"/> YES	<input type="checkbox"/> NO	ACCESSED BY PUBLIC TRANSPORTATION?*					
Services	BUILDING?*	<input type="checkbox"/> YES	<input type="checkbox"/> NO	TEXT TELEPHONY (TTY)*		<input type="checkbox"/> YES	<input type="checkbox"/> NO	BUS*					
	PARKING?*	<input type="checkbox"/> YES	<input type="checkbox"/> NO	AMERICAN SIGN LANGUAGE*		<input type="checkbox"/> YES	<input type="checkbox"/> NO	SUBWAY*					
Accessibilities	RESTROOM?*	<input type="checkbox"/> YES	<input type="checkbox"/> NO	MENTAL/PHYSICAL IMPAIRMENT SERVICES*		<input type="checkbox"/> YES	<input type="checkbox"/> NO	REGIONAL TRAIN*					
	OTHER HANDICAPPED ACCESS			OTHER DISABILITY SERVICES			OTHER TRANSPORTATION ACCESS						
Services	Does this location provide any of the following services?												
	LABORATORY SERVICES?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES, PROVIDE ACCREDITING/CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)									
	RADIOLOGY SERVICES?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES, PROVIDE X-RAY CERTIFICATION TYPE									
	EKGS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ALLERGY INJECTIONS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ALLERGY SKIN TESTING?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
	DRAWING BLOOD?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	AGE APPROPRIATE IMMUNIZATIONS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	FLEXIBLE SIGMOIDOSCOPY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	TYMPANOMETRY/AUDIOMETRY SCREENING?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
	ASTHMA TREATMENT?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	OSTEOPATHIC MANIPULATION?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IV HYDRATION/TREATMENT?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	CARDIAC STRESS TEST?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
	PULMONARY FUNCTION TESTING?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PHYSICAL THERAPY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	CARE OF MINOR LACERATIONS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
	IS ANESTHESIA ADMINISTERED IN YOUR OFFICE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES, WHAT CLASS/CATEGORY DO YOU USE?									
	IF YES, WHO ADMINISTERS IT?												
		LAST NAME					FIRST NAME						
TYPE OF PRACTICE (SELECT ONE ONLY)*	<input type="checkbox"/>	SOLO PRACTICE		<input type="checkbox"/>	SINGLE SPECIALTY GROUP		<input type="checkbox"/>	MULTI-SPECIALTY GROUP					
ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)													

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Additional Practice Location <small>(Continued)</small>	Practice Location Information - Page 5 of 5		
IMPORTANT In the box provided, indicate to which practice location this page belongs. If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page. Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.	LOCATION* #		
	LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE		
	LAST NAME	SPECIALTY CODE	<input type="checkbox"/> COVERING COLLEAGUE (Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
	LAST NAME	SPECIALTY CODE	<input type="checkbox"/> COVERING COLLEAGUE (Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
	LAST NAME	SPECIALTY CODE	<input type="checkbox"/> COVERING COLLEAGUE (Y/N)?
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
Covering Colleagues Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided. If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.	LIST ALL COVERING COLLEAGUES THAT ARE <u>NOT</u> PARTNERS/ASSOCIATES AT THIS PRACTICE		
	LAST NAME	SPECIALTY CODE	<input type="checkbox"/>
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
	LAST NAME	SPECIALTY CODE	<input type="checkbox"/>
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
	LAST NAME	SPECIALTY CODE	<input type="checkbox"/>
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
	3104		

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Professional Liability Insurance Carrier Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6	Professional Liability Insurance Carrier								
Other Professional Liability Insurance Carrier List secondary / second layer / future or previous carrier(s). For second layer coverage list name of hospital/organization providing coverage	SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO								
	CARRIER OR SELF-INSURED NAME								
	NUMBER*	STREET*		SUITE/BUILDING					
	CITY*			STATE*	ZIP CODE*				
	ORIGINAL EFFECTIVE DATE*	EFFECTIVE DATE*	EXPIRATION DATE		TYPE OF COVERAGE?*		<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SHARED		
	DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	AMOUNT OF COVERAGE PER OCCURRENCE		\$	AMOUNT OF COVERAGE AGGREGATE		
	POLICY INCLUDES TAIL COVERAGE?	<input type="checkbox"/> YES <input type="checkbox"/> NO							
	POLICY NUMBER*								
		SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO							
Other Professional Liability Insurance Carrier List secondary / second layer / future or previous carrier(s). For second layer coverage list name of hospital/organization providing coverage If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.	CARRIER OR SELF-INSURED NAME								
	NUMBER*	STREET*		SUITE/BUILDING					
	CITY*			STATE*	ZIP CODE*				
	ORIGINAL EFFECTIVE DATE*	EFFECTIVE DATE*	EXPIRATION DATE		TYPE OF COVERAGE?*		<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SHARED		
	DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	AMOUNT OF COVERAGE PER OCCURRENCE		\$	AMOUNT OF COVERAGE AGGREGATE		
	POLICY INCLUDES TAIL COVERAGE?	<input type="checkbox"/> YES <input type="checkbox"/> NO							
	POLICY NUMBER*								
		SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO							

3106

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Professional Liability Insurance Carrier Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6	Professional Liability Insurance Carrier								
Other Professional Liability Insurance Carrier List secondary / second layer / future or previous carrier(s). For second layer coverage list name of hospital/organization providing coverage	SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO								
	CARRIER OR SELF-INSURED NAME								
	NUMBER*	STREET*		SUITE/BUILDING					
	CITY*			STATE*	ZIP CODE*				
	ORIGINAL EFFECTIVE DATE*	EFFECTIVE DATE*	EXPIRATION DATE		TYPE OF COVERAGE?*		<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SHARED		
	DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	AMOUNT OF COVERAGE PER OCCURRENCE		\$	AMOUNT OF COVERAGE AGGREGATE		
	POLICY INCLUDES TAIL COVERAGE?	<input type="checkbox"/> YES <input type="checkbox"/> NO							
	POLICY NUMBER*								
		SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO							
Other Professional Liability Insurance Carrier List secondary / second layer / future or previous carrier(s). For second layer coverage list name of hospital/organization providing coverage If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.	CARRIER OR SELF-INSURED NAME								
	NUMBER*	STREET*		SUITE/BUILDING					
	CITY*			STATE*	ZIP CODE*				
	ORIGINAL EFFECTIVE DATE*	EFFECTIVE DATE*	EXPIRATION DATE		TYPE OF COVERAGE?*		<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SHARED		
	DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	AMOUNT OF COVERAGE PER OCCURRENCE		\$	AMOUNT OF COVERAGE AGGREGATE		
	POLICY INCLUDES TAIL COVERAGE?	<input type="checkbox"/> YES <input type="checkbox"/> NO							
	POLICY NUMBER*								
		SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO							

3106

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Work History Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7	Work History			
Work History Use this form to continue listing work history. If you need additional space for Work History, photocopy this page as needed and submit as instructed.	WORK HISTORY			
	PRACTICE / EMPLOYER NAME			
	NUMBER	STREET	SUITE/BUILDING	
	CITY	STATE	ZIP/POSTAL CODE	
	TELEPHONE	FAX		
	COUNTRY CODE	START DATE	END DATE	
	REASON FOR DEPARTURE (IF APPLICABLE)			
	WORK HISTORY			
	PRACTICE / EMPLOYER NAME			
NUMBER	STREET	SUITE/BUILDING		
CITY	STATE	ZIP/POSTAL CODE		
TELEPHONE	FAX			
COUNTRY CODE	START DATE	END DATE		
REASON FOR DEPARTURE (IF APPLICABLE)				

3107

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Work History Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7	Work History			
Work History Use this form to continue listing work history. If you need additional space for Work History, photocopy this page as needed and submit as instructed.	WORK HISTORY			
	PRACTICE / EMPLOYER NAME			
	NUMBER	STREET	SUITE/BUILDING	
	CITY	STATE	ZIP/POSTAL CODE	
	TELEPHONE	FAX		
	COUNTRY CODE	START DATE	END DATE	
	REASON FOR DEPARTURE (IF APPLICABLE)			
	WORK HISTORY			
	PRACTICE / EMPLOYER NAME			
	NUMBER	STREET	SUITE/BUILDING	
CITY	STATE	ZIP/POSTAL CODE		
TELEPHONE	FAX			
COUNTRY CODE	START DATE	END DATE		
REASON FOR DEPARTURE (IF APPLICABLE)				

3107

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Professional Training / Work History Gaps

Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7	Professional Training / Work History Gaps	
Professional Training / Work History Gaps Please explain any time periods or gaps in training or work history that have occurred since graduation from professional school and are longer than three month in duration or of a shorter duration if required by the organization for which you are being credentialed.	GAP START DATE	GAP END DATE
	GAP START DATE	GAP END DATE
	GAP START DATE	GAP END DATE
	GAP START DATE	GAP END DATE
	GAP START DATE	GAP END DATE

3108

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Page 33

Std. App. v.5.0
Reprinted on 10/31/06

Provider:

Provider CAQH ID:

Date Generated:

Last Attestation Date:

List of Authorized Plans

AND to any healthcare organization that in the future represents to CAQH either that I am a participating provider or that I am in the process of being credentialed as a participating provider.

Note: Please refer to the online CAQH Proview for the most current version.

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

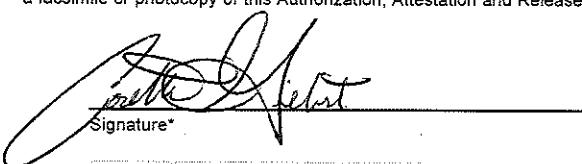
Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.



Signature*

02032020

DATE SIGNED*



Name (print)*

3094

Request for Taxpayer Identification Number and Certification

► Go to www.irs.gov/FormW9 for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type.
See Specific Instructions on page 3

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.			
Coretta Gilbert			
2 Business name/disregarded entity name, if different from above			
Piece to Peace, LLC			
3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.		4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):	
<input checked="" type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate		Exempt payee code (if any) _____	
<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► <small>Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.</small>		Exemption from FATCA reporting code (if any) _____	
5 Address (number, street, and apt. or suite no.) See instructions.		Requester's name and address (optional)	
51 Park Avenue			
6 City, state, and ZIP code			
Bloomfield, CT 06002			
7 List account number(s) here (optional)			

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

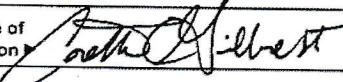
Social security number								
		-						
		-						
or								
Employer identification number								
8	4	-	4	0	7	6	8	5

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person 	Date ►
		1/1/2024

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.



1100 Virginia Drive, Suite 250
Fort Washington, PA 19034-3278
Phone: 1-888-288-3534 Fax: 1-847-953-0134
Website: www.hpsos.com

01/31/23

Piece To Peace, LLC
151 New Park Ave Unit 2d
Hartford, CT 06106-2191

Dear Coretta Gilbert:

Enclosed is the replacement certificate of insurance that you requested.

If you have any questions or need assistance, please call us toll free at 1-888-288-3534. Our Customer Service Representatives are available weekdays from 8:00 a.m. to 6:00 p.m., EST.

Sincerely,

Customer Service

Enclosure

Q032

Dedicated To Serving The Insurance Needs of Healthcare Providers

Healthcare Providers Service Organization is a registered trade name of Affinity Insurance Services, Inc.; (AR 244489); in CA & MN, AIS Affinity Insurance Agency, Inc. (CA 0795465); in OK, AIS Affinity Insurance Services Inc.; in CA, Aon Affinity Insurance Services, Inc., (0G94493), Aon Direct Insurance Administrators and Berkely Insurance Agency and in NY, AIS Affinity Insurance Agency.



Certificate of Insurance

OCCURRENCE PROFESSIONAL LIABILITY POLICY FORM

Print Date: 1/31/2023

The application for the Policy and any and allsupplementary information, materials, and statements submitted therewith shall be maintained on file by us or our Program Administrator and will be deemed attached to and incorporated into the Policy as if physically attached.

PRODUCER	BRANCH	PREFIX	POLICY NUMBER	POLICY PERIOD
018098	970	HPG	0684396532	From: 02/01/23 to 02/01/24 at 12:01 AM Standard Time
Named Insured and Address:				Program Administered by:
Piece To Peace, LLC 151 New Park Ave Unit 2d Hartford, CT 06106-2191				Healthcare Providers Service Organization 1100 Virginia Drive, Suite 250 Fort Washington, PA 19034 1-888-288-3534 www.hpsos.com
Medical Specialty: Social Worker, Clinical Firm Excludes Cosmetic Procedures	Code: 80723			Insurance Provided by: American Casualty Company of Reading, Pennsylvania 151 N. Franklin Street Chicago, IL 60606

Professional Liability	\$ 1,000,000	each claim	\$ 3,000,000	aggregate
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Your professional liability limits shown above include the following:

- * Good Samaritan Liability
- * Malplacement Liability
- * Personal Injury Liability
- * Sexual Misconduct Included in the PL limit shown above subject to \$ 25,000 aggregate sublimit

Coverage Extensions

License Protection	\$ 25,000	per proceeding	\$ 25,000	aggregate
Defendant Expense Benefit	\$ 1,000	per day limit	\$ 25,000	aggregate
Deposition Representation	\$ 10,000	per deposition	\$ 10,000	aggregate
Assault	\$ 25,000	per incident	\$ 25,000	aggregate
Includes Workplace Violence Counseling				
Medical Payments	\$ 25,000	per person	\$ 100,000	aggregate
First Aid	\$ 10,000	per incident	\$ 10,000	aggregate
Damage to Property of Others	\$ 10,000	per incident	\$ 10,000	aggregate
Enterprise Privacy Protection - Claims Made	\$ 25,000	per incident	\$ 25,000	aggregate
Retroactive Date: 2/01/2020 (Defense inside limits)				
Media Expense	\$ 25,000	per incident	\$ 25,000	aggregate

General Liability

General Liability	\$1,000,000	each claim / \$3,000,000	aggregate
Fire & Water Legal Liability	Included in the GL limit shown above subject to \$250,000 aggregate sublimit		
Personal Liability	Excluded		
Total \$ 782.00			
Base Premium \$782.00			

Policy Forms and Endorsements (Please see attached list of policy forms and endorsements)

Chairman of the Board

Secretary

Keep this Certificate of Insurance in a safe place. It and proof of payment are your proof of coverage. There is no coverage in force unless the premium is paid in full. To activate your coverage, please remit premium in full by the effective date of this Certificate of Insurance.

Coverage Change Date:

CNA93692 (11-2018)

Endorsement Date:

Master Policy: 188711433

POLICY FORMS & ENDORSEMENTS

The following are the policy forms and endorsements that apply to your current professional liability policy.

COMMON POLICY FORMS & ENDORSEMENTS

FORM #	FORM NAME
CNA95181CT (02-19)	Amendment to the Limits of Liability Endorsement - CT
G-121500-D (04-08)	Common Policy Conditions
G-121501-C (07-01)	Occurrence Policy Form
CNA94164 (11-18)	Amendment Definition of Claim Endorsement
G-145184-A (06-03)	Policyholder Notice - OFAC Compliance Notice
G-147292-A (03-04)	Policyholder Notice - Silica, Mold & Asbestos Disclosure
GSL15564 (10-09)	Sexual Misconduct Sublimits of Liability Professional Liability & Sexual Misconduct Exclusion
GSL15565 (03-10)	Healthcare Providers Professional Liability Assault Coverage
GSL17101 (02-10)	Exclusion of Specified Activities Reuse of Parenteral Devices and Supplies
GSL13424 (05-09)	Services to Animals
GSL13425 (05-09)	Business Owner Coverage Extension Endorsement
CNA80052 (10-14)	Distribution or Recording of Material or Information in Violation of Law Exclusion Endorsement
G-123846-C06 (07-01)	Connecticut Cancellation and Non-Renewal
G-142833-A06 (07-02)	State Endorsement
CNA81753 (03-15)	Coverage & Cap on Losses from Certified Acts Terrorism
CNA81758 (01-21)	Notice - Offer of Terrorism Coverage & Disclosure of Premium
CNA82011 (04-15)	Related Claims Endorsement
CNA79575 (07-14)	Exclusion of Cosmetic Procedures
CNA79516CT (11-14)	Enterprise Privacy Protection
CNA89026 (05-17)	Media Expense Coverage
CNA96096 (06-19)	Amended Definition of You and Yours
G-121504-C (07-01)	General Liability Form
G-123827-B (07-01)	Additional Insured General Liability

PLEASE REFER TO YOUR CERTIFICATE OF INSURANCE FOR THE POLICY FORMS & ENDORSEMENTS SPECIFIC TO YOUR STATE AND YOUR POLICY PERIOD.

For NJ residents: The PLIGA surcharge shown on the Certificate of Insurance is the NJ Property & Liability Insurance Guaranty Association.

For KY residents: The Surcharge shown on the Certificate of Insurance is the KY Firefighters and Law Enforcement Foundation Program Fund and the Local Tax is the KY Local Government Premium Tax.

As required by 806 Ky. Admin Regs. 2:100, this Notice is to advise you that a surcharge has been applied to your insurance premium and is separately itemized on the Declarations page or billing instrument attached to your policy, as required KRS. §136.392.

For WV residents: The surcharge shown on the Certificate of Insurance is the WV Premium Surcharge.

For FL residents: The FIGA Assessment shown on the Certificate of Insurance is the FL Insurance Guaranty Association - 2022 Regular Assessment.

Form #:CNA93692 (11-2018)

Named Insured: Piece To Peace, LLC

Master Policy #: 188711433

Policy #: 0684396532



HEALTHCARE PROVIDERS GENERAL LIABILITY COVERAGE PART ENDORSEMENT

Additional Insured General Liability

In consideration of the premium paid, and subject to the General Liability limit of liability shown on the **certificate of insurance**, it is agreed that the **GENERAL LIABILITY COVERAGE PART** is amended as follows:

The person or entity named below (the "additional insured") is an insured under this Coverage Part but only as respects its liability arising out of **named insured's** operations, or premises owned by or rented by the **named insured** and solely to the extent that:

1. a **general liability claim** is made against the **named insured** and the additional insured; and
2. in any ensuing litigation arising out of such **claim**, the **named insured** and the additional insured remain as co-defendants.

In no event is there any coverage provided under this policy for an **occurrence** that is the direct liability of the additional insured.

Additional Insured: New Park Partners LLC
 151 New Park Ave
 Hartford, CT 06106

This endorsement is a part of **your** policy and takes effect on the effective date of **your** policy, unless another effective date is shown below. All other provisions of the policy remain unchanged.

Must Be Completed		Complete Only When This Endorsement Is Not Prepared with the Policy <u>Or Is Not to be Effective with the Policy</u>	
ENDT. NO.	POLICY NO.	ISSUED TO	ENDORSEMENT EFFECTIVE DATE
01	0684396532	Piece To Peace, LLC	2/01/2023



1100 Virginia Drive, Suite 250
Fort Washington, PA 19034-3278
Phone: 1-888-288-3534 Fax: 1-847-953-0134
Website: www.hpso.com

03/23/22

Piece To Peace, LLC
151 New Park Ave Unit 2d
Hartford, CT 06106-2191

Dear Coretta Gilbert:

Enclosed is the replacement certificate of insurance that you requested.

If you have any questions or need assistance, please call us toll free at 1-888-288-3534. Our Customer Service Representatives are available weekdays from 8:00 a.m. to 6:00 p.m., EST.

Sincerely,

Customer Service

Enclosure

Q032

Dedicated To Serving The Insurance Needs of Healthcare Providers

Healthcare Providers Service Organization is a registered trade name of Affinity Insurance Services, Inc.; (AR 244489); in CA & MN, AIS Affinity Insurance Agency, Inc. (CA 0795465); in OK, AIS Affinity Insurance Services Inc.; in CA, Aon Affinity Insurance Services, Inc., (0G94493), Aon Direct Insurance Administrators and Berkely Insurance Agency and in NY, AIS Affinity Insurance Agency.



Certificate of Insurance
OCCURRENCE PROFESSIONAL LIABILITY POLICY FORM

Print Date: 3/23/2022

The application for the Policy and any and allsupplementary information, materials, and statements submitted therewith shall be maintained on file by us or our Program Administrator and will be deemed attached to and incorporated into the Policy as if physically attached.

PRODUCER	BRANCH	PREFIX	POLICY NUMBER	POLICY PERIOD
018098	970	HPG	0684396532	From: 02/01/22 to 02/01/23 at 12:01 AM Standard Time
Named Insured and Address:				Program Administered by:
Piece To Peace, LLC 151 New Park Ave Unit 2d Hartford, CT 06106-2191				Healthcare Providers Service Organization 1100 Virginia Drive, Suite 250 Fort Washington, PA 19034 1-888-288-3534 www.hpso.com
Medical Specialty: Social Worker, Clinical Firm				Insurance Provided by: American Casualty Company of Reading, Pennsylvania 151 N. Franklin Street Chicago, IL 60606
Excludes Cosmetic Procedures				

Professional Liability	\$ 1,000,000	each claim	\$ 3,000,000	aggregate
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Your professional liability limits shown above include the following:

- * Good Samaritan Liability
- * Malplacement Liability
- * Personal Injury Liability
- * Sexual Misconduct Included in the PL limit shown above subject to \$ 25,000 aggregate sublimit

Coverage Extensions

License Protection	\$ 25,000	per proceeding	\$ 25,000	aggregate
Defendant Expense Benefit	\$ 1,000	per day limit	\$ 25,000	aggregate
Deposition Representation	\$ 10,000	per deposition	\$ 10,000	aggregate
Assault	\$ 25,000	per incident	\$ 25,000	aggregate
Includes Workplace Violence Counseling				
Medical Payments	\$ 25,000	per person	\$ 100,000	aggregate
First Aid	\$ 10,000	per incident	\$ 10,000	aggregate
Damage to Property of Others	\$ 10,000	per incident	\$ 10,000	aggregate
Enterprise Privacy Protection - Claims Made	\$ 25,000	per incident	\$ 25,000	aggregate
Retroactive Date: 2/01/2020 (Defense inside limits)				
Media Expense	\$ 25,000	per incident	\$ 25,000	aggregate
Employment Practices Liability - Claims Made	\$ 25,000	per incident	\$ 25,000	aggregate
Retroactive Date: 2/01/2022 (Defense Only)				

Workplace Liability

Workplace Liability	Included in Professional Liability Limit shown above		
Fire & Water Legal Liability	Included in the PL limit shown above subject to \$150,000	aggregate sublimit	
Personal Liability	Excluded		
Total \$	\$ 675.00		
Base Premium	\$ 675.00		

Policy Forms and Endorsements (Please see attached list of policy forms and endorsements)

Chairman of the Board

Secretary

Keep this Certificate of Insurance in a safe place. It and proof of payment are your proof of coverage. There is no coverage in force unless the premium is paid in full. To activate your coverage, please remit premium in full by the effective date of this Certificate of Insurance.

Coverage Change Date:

CNA93692 (11-2018)

Endorsement Date:

Master Policy: 188711433

POLICY FORMS & ENDORSEMENTS

The following are the policy forms and endorsements that apply to your current professional liability policy.

COMMON POLICY FORMS & ENDORSEMENTS

FORM #	FORM NAME
CNA95181CT (02-19)	Amendment to the Limits of Liability Endorsement - CT
G-121503-C (07-01)	Workplace Liability Form
G-121500-D (04-08)	Common Policy Conditions
G-121501-C (07-01)	Occurrence Policy Form
CNA94164 (11-18)	Amendment Definition of Claim Endorsement
G-145184-A (06-03)	Policyholder Notice - OFAC Compliance Notice
G-147292-A (03-04)	Policyholder Notice - Silica, Mold & Asbestos Disclosure
GSL15564 (10-09)	Sexual Misconduct Sublimits of Liability Professional Liability & Sexual Misconduct Exclusion
GSL15565 (03-10)	Healthcare Providers Professional Liability Assault Coverage
GSL17101 (02-10)	Exclusion of Specified Activities Reuse of Parenteral Devices and Supplies
GSL13424 (05-09)	Services to Animals
GSL13425 (05-09)	Business Owner Coverage Extension Endorsement
CNA80052 (10-14)	Distribution or Recording of Material or Information in Violation of Law Exclusion Endorsement
G-123846-C06 (07-01)	Connecticut Cancellation and Non-Renewal
G-142833-A06 (07-02)	State Endorsement
CNA81753 (03-15)	Coverage & Cap on Losses from Certified Acts Terrorism
CNA81758 (01-21)	Notice - Offer of Terrorism Coverage & Disclosure of Premium
CNA82011 (04-15)	Related Claims Endorsement
CNA79575 (07-14)	Exclusion of Cosmetic Procedures
CNA88921CT (11-18)	Connecticut Amendatory Change for EPL
CNA79516CT (11-14)	Enterprise Privacy Protection
CNA89026 (05-17)	Media Expense Coverage
CNA93658 (08-18)	Employment Practices Liability Coverage - Defense Only
CNA96096 (06-19)	Amended Definition of You and Yours

PLEASE REFER TO YOUR CERTIFICATE OF INSURANCE FOR THE POLICY FORMS & ENDORSEMENTS SPECIFIC TO YOUR STATE AND YOUR POLICY PERIOD.

For NJ residents: The PLIGA surcharge shown on the Certificate of Insurance is the NJ Property & Liability Insurance Guaranty Association.

For KY residents: The Surcharge shown on the Certificate of Insurance is the KY Firefighters and Law Enforcement Foundation Program Fund and the Local Tax is the KY Local Government Premium Tax.
As required by 806 Ky. Admin Regs. 2:100, this Notice is to advise you that a surcharge has been applied to your insurance premium and is separately itemized on the Declarations page or billing instrument attached to your policy, as required KRS. §136.392.

For WV residents: The surcharge shown on the Certificate of Insurance is the WV Premium Surcharge.

For FL residents: The FIGA Assessment shown on the Certificate of Insurance is the FL Insurance Guaranty Association - 2022 Regular Assessment.

Form #:CNA93692 (11-2018)

Named Insured: Piece To Peace, LLC

Master Policy #: 188711433

Policy #: 0684396532



1100 Virginia Drive, Suite 250
Fort Washington, PA 19034-3278
Phone: 1-888-288-3534 Fax: 1-847-953-0134
Website: www.hpsocom

02/05/24

Piece To Peace, LLC
151 New Park Ave Unit 2d
Hartford, CT 06106-2191

Dear Coretta Gilbert:

Enclosed is the replacement certificate of insurance that you requested.

If you have any questions or need assistance, please call us toll free at 1-888-288-3534. Our Customer Service Representatives are available weekdays from 8:00 a.m. to 6:00 p.m., EST.

Sincerely,

Customer Service

Enclosure

Q032

Dedicated To Serving The Insurance Needs of Healthcare Providers

Healthcare Providers Service Organization is a registered trade name of Affinity Insurance Services, Inc.; (AR 244489); in CA & MN, AIS Affinity Insurance Agency, Inc. (CA 0795465); in OK, AIS Affinity Insurance Services Inc.; in CA, Aon Affinity Insurance Services, Inc., (0G94493), Aon Direct Insurance Administrators and Berkely Insurance Agency and in NY, AIS Affinity Insurance Agency.



Certificate of Insurance
OCCURRENCE PROFESSIONAL LIABILITY POLICY FORM

Print Date: 2/05/2024

The application for the Policy and any and allsupplementary information, materials, and statements submitted therewith shall be maintained on file by us or our Program Administrator and will be deemed attached to and incorporated into the Policy as if physically attached.

PRODUCER	BRANCH	PREFIX	POLICY NUMBER	POLICY PERIOD
018098	970	HPG	0684396532	From: 02/01/24 to 02/01/25 at 12:01 AM Standard Time
Named Insured and Address:				Program Administered by:
Piece To Peace, LLC 151 New Park Ave Unit 2d Hartford, CT 06106-2191				Healthcare Providers Service Organization 1100 Virginia Drive, Suite 250 Fort Washington, PA 19034 1-888-288-3534 www.hpso.com
Medical Specialty: Social Worker, Clinical Firm				Insurance Provided by: American Casualty Company of Reading, Pennsylvania 151 N. Franklin Street Chicago, IL 60606
Excludes Cosmetic Procedures				

Professional Liability	\$ 1,000,000	each claim	\$ 3,000,000	aggregate
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Your professional liability limits shown above include the following:

- * Good Samaritan Liability
- * Malplacement Liability
- * Personal Injury Liability
- * Sexual Misconduct Included in the PL limit shown above subject to \$ 25,000 aggregate sublimit

Coverage Extensions

License Protection	\$ 25,000	per proceeding	\$ 25,000	aggregate
Defendant Expense Benefit	\$ 1,000	per day limit	\$ 25,000	aggregate
Deposition Representation	\$ 10,000	per deposition	\$ 10,000	aggregate
Assault	\$ 25,000	per incident	\$ 25,000	aggregate
Includes Workplace Violence Counseling				
Medical Payments	\$ 25,000	per person	\$ 100,000	aggregate
First Aid	\$ 10,000	per incident	\$ 10,000	aggregate
Damage to the Property of Others	\$ 10,000	per incident	\$ 10,000	aggregate
Enterprise Privacy Protection - Claims Made	\$ 25,000	per incident	\$ 25,000	aggregate
Retroactive Date: 2/01/2020 (Defense inside limits)				
Media Expense	\$ 25,000	per incident	\$ 25,000	aggregate

General Liability

General Liability	\$1,000,000	each claim / \$3,000,000	aggregate
Fire & Water Legal Liability	Included in the GL limit shown above subject to \$250,000		aggregate sublimit
Personal Liability	Excluded		

Total \$ 782.00

Base Premium \$782.00

Policy Forms and Endorsements (Please see attached list of policy forms and endorsements)

Chairman of the Board

Secretary

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Coverage Change Date:

CNA93692 (11-2018)

Endorsement Date:

Master Policy: 188711433

POLICY FORMS & ENDORSEMENTS

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CNA79575 (07-14)	Exclusion of Cosmetic Procedures
CNA79516CT (12-14)	Enterprise Privacy Protection
CNA89026 (05-17)	Media Expense Coverage
CNA96096 (06-19)	Amended Definition of You and Yours
G-121504-C (07-01)	General Liability Form
G-123827-B (07-01)	Additional Insured General Liability

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For FL residents:

Form #:CNA93692 (11-2018)

Master Policy #: 188711433

Named Insured: Piece To Peace, LLC

Policy #: 0684396532