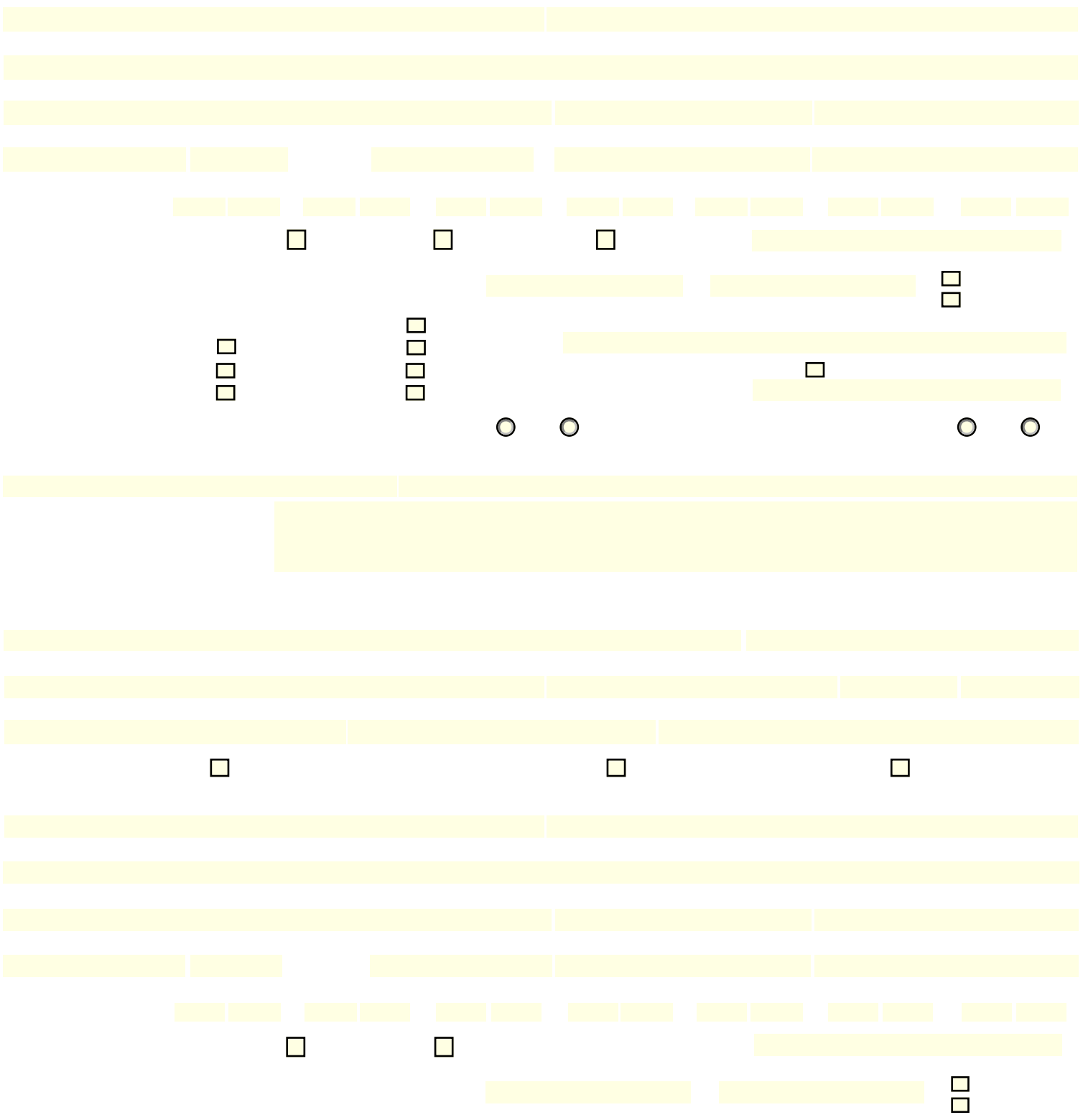
SECOND PRACTICE LOCATION

INSTITUTION/GROUP/CLINIC NAME (If applicable)		OFFICE MANAGER	
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	**OFFICE E-MAIL**	

TYPE OF PRACTICE: ☐ SOLO ☐ MULTISPECIALTY GROUP ☐ SINGLE SPECIALTY GROUP ☐



THIRD PRACTICE LOCATION CONTINUED

Accepting Patients?	☐ New ☐ Existing Only	☐ Only family members of existing patients ☐ Other (Specify): _____		
Age group(s) treated:	☐ 0-6 years ☐ Over 65	☐ 7-11 years ☐ All Ages	☐ 12-18 years ☐ Other (Specify): _____	☐ 19-65 years
Are PAs and/or nurse/paraprofessional practitioners used? ○ Yes ○ No			Is this facility handicapped Accessible? ○ Yes ○ No	

MEDICAL RECORDS

Please check location where you would like medical records requests sent.

○ Primary ○ Second ○ Third ○ Fourth ○ Correspondence

○ Other address _____

If different from practice or correspondence located checked above

PHONE NUMBER	FAX NUMBER	**EMAIL**

SPECIALTY

TYPE OF PROVIDER: ○ PRIMARY CARE PHYSICIAN ○ PHYSICIAN SPECIALIST ○ BOTH ○ OTHER SPECIALTY: _____

PLEASE LIST PRIMARY AND SUB-SPECIALTIES (as applicable)	**BOARD CERTIFIED (ABMS)**	
	○	○
	○	○
	○	○

WORK HISTORY

Using the following codes, please list in

PROFESSIONAL LIABILITY INSURANCE COVERAGE	
NAME OF CARRIER	POLICY NUMBER
ADDRESS AND PHONE NUMBER OF CARRIER	
AMOUNTS PER OCCURRENCE/AGGREGATE	DATES OF COVERAGE
Do you participate in the Louisiana Patients' Compensation Fund?	◯ YES ◯ NO
Has current liability insurance carrier required exclusion of any procedures from insurance coverage? (If yes, attach explanation)	◯ ◯

REQUIRED ATTACHMENTS

V State Licenses including current licenses held in other states, State CDS license and Federal DEA Registration

V Curriculum Vitae

V Certificate(s) of Professional Liability Insurance

V History of Malpractice suits in past 5 years, regardless of whether judgments or settlements paid.

V Explanation of any "Yes" Answer(s) from General Questions Section on page 8.

V Current Employer Identification Number (EIN) Letter, W-9 Form or Federal Tax Deposit Coupon

V Education Certificate for Foreign Medical Graduates (ECFMG) (If applicable)

V Health Plan Agreement (If applicable)

STATEMENT TO APPLICANTS

All providers applying for network participation have the right to review the credentialing application and supporting documents. Exceptions may vary as prohibited by law or health plan policy.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have the opportunity to submit additional information to correct the discrepancy or provide clarification that might positively impact the credentialing decision.

According to La. R.S. 22:11.1.A (8) an adverse medical review panel opinion is included in the type of information a health plan may require you to submit on a credentialing or re-credentialing application.

According to La. R.S. 22:11.1, a health insurance issuer is required to complete the credentialing process within 90 days from the date of receipt of all information needed. The issuer is required to inform you within 30 days of receipt all defects and reasons known at the time in the event an application is deemed to be not correctly completed. The issuer is also required to inform you in the event that any needed verification or verification supporting statement has not been received from a third party within 60 days of the date of such a request.