



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

| MEDICAL RECORDS                                                                                                                                                                                                                                                                                                                                                            |            |                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|------------------------|
| Please check location where you would like medical records requests sent.<br><input type="checkbox"/> Primary <input type="checkbox"/> Second <input type="checkbox"/> Third <input type="checkbox"/> Fourth <input type="checkbox"/> Correspondence<br><input type="checkbox"/> Other address _____<br>If different from practice or correspondence located checked above |            |                        |
| PHONE NUMBER                                                                                                                                                                                                                                                                                                                                                               | FAX NUMBER | EMAIL                  |
| SPECIALTY                                                                                                                                                                                                                                                                                                                                                                  |            |                        |
| TYPE OF PROVIDER: <input type="checkbox"/> PRIMARY CARE PHYSICIAN <input type="checkbox"/> PHYSICIAN SPECIALIST <input type="checkbox"/> BOTH <input type="checkbox"/> 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 |          |
|-------------------|----------|
| 1                 | 1/1/2020 |
| 2                 | 1/1/2021 |
| 3                 | 1/1/2022 |
| 4                 | 1/1/2023 |
| 5                 | 1/1/2024 |
| 6                 | 1/1/2025 |
| 7                 | 1/1/2026 |
| 8                 | 1/1/2027 |
| 9                 | 1/1/2028 |
| 10                | 1/1/2029 |
| 11                | 1/1/2030 |
| 12                | 1/1/2031 |
| 13                | 1/1/2032 |
| 14                | 1/1/2033 |
| 15                | 1/1/2034 |
| 16                | 1/1/2035 |
| 17                | 1/1/2036 |
| 18                | 1/1/2037 |
| 19                | 1/1/2038 |
| 20                | 1/1/2039 |
| 21                | 1/1/2040 |
| 22                | 1/1/2041 |
| 23                | 1/1/2042 |
| 24                | 1/1/2043 |
| 25                | 1/1/2044 |
| 26                | 1/1/2045 |
| 27                | 1/1/2046 |
| 28                | 1/1/2047 |
| 29                | 1/1/2048 |
| 30                | 1/1/2049 |
| 31                | 1/1/2050 |
| 32                | 1/1/2051 |
| 33                | 1/1/2052 |
| 34                | 1/1/2053 |
| 35                | 1/1/2054 |
| 36                | 1/1/2055 |
| 37                | 1/1/2056 |
| 38                | 1/1/2057 |
| 39                | 1/1/2058 |
| 40                | 1/1/2059 |
| 41                | 1/1/2060 |
| 42                | 1/1/2061 |
| 43                | 1/1/2062 |
| 44                | 1/1/2063 |
| 45                | 1/1/2064 |
| 46                | 1/1/2065 |
| 47                | 1/1/2066 |
| 48                | 1/1/2067 |
| 49                | 1/1/2068 |
| 50                | 1/1/2069 |
| 51                | 1/1/2070 |
| 52                | 1/1/2071 |
| 53                | 1/1/2072 |
| 54                | 1/1/2073 |
| 55                | 1/1/2074 |
| 56                | 1/1/2075 |
| 57                | 1/1/2076 |
| 58                | 1/1/2077 |
| 59                | 1/1/2078 |
| 60                | 1/1/2079 |
| 61                | 1/1/2080 |
| 62                | 1/1/2081 |
| 63                | 1/1/2082 |
| 64                | 1/1/2083 |
| 65                | 1/1/2084 |
| 66                | 1/1/2085 |
| 67                | 1/1/2086 |
| 68                | 1/1/2087 |
| 69                | 1/1/2088 |
| 70                | 1/1/2089 |
| 71                | 1/1/2090 |
| 72                | 1/1/2091 |
| 73                | 1/1/2092 |
| 74                | 1/1/2093 |
| 75                | 1/1/2094 |
| 76                | 1/1/2095 |
| 77                | 1/1/2096 |
| 78                | 1/1/2097 |
| 79                | 1/1/2098 |
| 80                | 1/1/2099 |
| 81                | 1/1/2100 |
| 82                | 1/1/2101 |
| 83                | 1/1/2102 |
| 84                | 1/1/2103 |
| 85                | 1/1/2104 |
| 86                | 1/1/2105 |
| 87                | 1/1/2106 |
| 88                | 1/1/2107 |
| 89                | 1/1/2108 |
| 90                | 1/1/2109 |
| 91                | 1/1/2110 |
| 92                | 1/1/2111 |
| 93                | 1/1/2112 |
| 94                | 1/1/2113 |
| 95                | 1/1/2114 |
| 96                | 1/1/2115 |
| 97                | 1/1/2116 |
| 98                | 1/1/2117 |
| 99                | 1/1/2118 |
| 100               | 1/1/2119 |
| 101               | 1/1/2120 |
| 102               | 1/1/2121 |
| 103               | 1/1/2122 |
| 104               | 1/1/2123 |
| 105               | 1/1/2124 |
| 106               | 1/1/2125 |
| 107               | 1/1/2126 |
| 108               | 1/1/2127 |
| 109               | 1/1/2128 |
| 110               | 1/1/2129 |
| 111               | 1/1/2130 |
| 112               | 1/1/2131 |
| 113               | 1/1/2132 |
| 114               | 1/1/2133 |
| 115               | 1/1/2134 |
| 116               | 1/1/2135 |
| 117               | 1/1/2136 |
| 118               | 1/1/2137 |
| 119               | 1/1/2138 |
| 120               | 1/1/2139 |
| 121               | 1/1/2140 |
| 122               | 1/1/2141 |
| 123               | 1/1/2142 |
| 124               | 1/1/2143 |
| 125               | 1/1/2144 |
| 126               | 1/1/2145 |
| 127               | 1/1/2146 |
| 128               | 1/1/2147 |
| 129               | 1/1/2148 |
| 130               | 1/1/2149 |
| 131               | 1/1/2150 |
| 132               | 1/1/2151 |
| 133               | 1/1/2152 |
| 134               | 1/1/2153 |
| 135               | 1/1/2154 |
| 136               | 1/1/2155 |
| 137               | 1/1/2156 |
| 138               | 1/1/2157 |
| 139               | 1/1/2158 |

Do you participate in the Louisiana Patients' Compensation Fund?

Ç YES      Ç 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.