

CREREDENTIALING ELIGIBILITY CRITERIA

SLHP/BrightPath maintains a Credentialing/Recredentialing Program to assist in selection and reevaluation of all providers within its delivery system. This application includes fields to enter race, ethnicity, language, and the type of insurance accepted. Providing this information is optional. SLHP/BrightPath does not discriminate on race, ethnicity, language, or the type of insurance accepted in which the provider specializes. All providers must successfully complete the credentialing process to be approved for SLHP/BrightPath Participation. The provider has the right to review information obtained in the process of evaluating the credentialing and recredentialing application exclusive of peer review information.

Provider Criteria Consists of the Following:

1. Provider will have an executed Participating Provider Agreement with SLHP or BrightPath or be joining a group Tax ID who has an executed Agreement with SLHP/BrightPath.
2. Provider must participate in the initial credentialing process and will be required to recredential at least every three (3) years. The credentialing process requires verification of licensure, education, training experience of the Provider and other such information as may be required by SLHP/BrightPath and the established NCQA compliant process.
3. Must hold a current unrestricted license to practice for each state as applicable.
4. Providers, if they are Medical Doctors, Doctors of Osteopathy, Doctors of Podiatric Medicine, Nurse Practitioners or Physician Assistants shall either hold active Medical Staff admitting privileges at an in-network full-service hospital or use an admitting group or hospitalist service as designated by the participating hospital or make other suitable arrangements, as approved by SLHP. **Exceptions to this requirement are Anesthesiology, Pathology, Radiology, Emergency Medicine, Psychiatry, or Telemedicine.*
5. A current, unrestricted DEA and State Board of Pharmacy certificates as applicable. Multiple state locations will require individual DEA certificates.
6. Provider, if a physician, is either Board Certified, Board Admissible or is otherwise approved for credentialing by SLHP through its Participating Provider Committee. If not a physician, Provider shall be appropriately certified or credentialed.
7. Continuous work history of, at least, the most recent five (5) years including from and to dates MM/YYYY with an explanation of any gaps that exceed three (3) months.
8. Proof of Professional Liability insurance for at least the amount listed:
 - \$1,000,000 per occurrence and \$3,000,000 aggregate.
9. Provider shall be, and remain, enrolled in the Medicare program unless granted an exception, by SLHP.
10. Provider will practice within the accepted community standards of care as deemed appropriate by the SLHP Participating Provider Committee.

11. The applicant has the right, upon request, subject to policies and procedures, to be informed of the status of their application. The Credentialing Department will make every effort to provide status at the time of request and, if unable, will respond by telephone or in writing within three (3) working days.
12. Applicants have the right to revise, supplement or correct erroneous information to the Credentialing and Recredentialing Applications. This may be done at the provider's discovery or if deficiencies are discovered during the verification process by SLHP. Credentialing staff will provide notice to the Provider and must receive a response within 30 days of the date of the notification in order to correct, amend or provide the incorrect and/or omitted information. If no response is received from the Provider after 30 calendar days, a second attempt to contact the Provider is made by credentialing staff. If a second attempt to contact the Provider is unsuccessful, notification will be sent to the Provider that failure to respond within 15 business days will invalidate the application and the Provider will not be credentialed. All supplemental documents and correspondence is to be forwarded to the Credentialing Department at PO Box 1990 Boise, ID 83702 or faxed to (208) 381-9444.
13. If information is not received by the Credentialing Department within sixty (60) days of request, an updated Attestation may be required prior to final processing.
14. National Practitioner Identifier (NPI) Number.
15. Credentialing and Recredentialing is non-transferrable.
16. A copy of any portion/section of this Criteria Sheet and or Credentialing Application has the same force and effect as the original.
17. The applicant certifies by his/her signature on the application that the information in the entire application is complete, accurate, current and acknowledges that any misstatements in or omissions from this application constitute cause for denial of membership/participation or cause for summary dismissal by the entity to which this statement has been made. A photocopy of the application has the same force and effect as the original. The applicant confirms that he/she has reviewed this information as of the most recent date listed in the application.
18. Signature stamps are not permitted, except in cases where the practitioner has a physical impairment.
19. Copy of W-9.

Universal Provider Credentials Verification Application

To use the Idaho Provider Application (IPA), follow these instructions

- ✓ Complete the application in its entirety using black or blue ink. **Keep an unsigned and undated copy of the application on file for future requests.** When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate. Please sign and date pages 12 and 13. Please document any YES responses on the Attestation Question page.
- ✓ **Prior to submitting this application to any health care related organization, inquire with the organization, as you may need authorization (through a pre-application process) before the application is accepted.** Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- ✓ Attach copies of requested documents each time the application is submitted.
- ✓ If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- ✓ If a section does not apply to you, please check the provided box at the top of the section.

This application is submitted to: **St. Luke's Health Partners / BrightPath**

I. INSTRUCTIONS	<p>This form should be typed or legibly printed in black or blue ink. If more space is needed than provided, attach additional sheets and reference the question being answered. <u>Please do not use abbreviations</u>. Current copies of the following documents must be submitted with this application (all are required for MDs, DOs; as applicable for other health providers). If not available, indicate why.</p> <ul style="list-style-type: none"> • State Professional License(s) • DEA Certificate w/ current address • ECFMG (if applicable) • State Controlled Substance Certificate (if applicable) • Passport photo (for hospitals only) • Face Sheet of Professional Liability Policy or Certificate • Curriculum Vitae (Not an acceptable substitute for completing the application.) <p style="text-align: center; color: red;">** All sections must be completed in their entirety**</p>
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II. PROVIDER INFORMATION	Last name (include suffix; Jr., Sr., III)		First (do not abbreviate)		Middle (do not abbreviate)		
	Other name(s) under which you have been known by reference, licensing and/or educational institutions?				Degree(s)		
	Home telephone number			Pager number	Cell number	E-mail address	
	Home mailing address			City	State	Zip code	
	Birth date	Birthplace (city, state, country)		Social security number		Medicare Opt-Out - §1128 of the Social Security Act <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Languages spoken other than English		Type of Provider <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Urgent Care			Opt-Out Start Date	Opt-Out End Date
	Individual NPI #	Individual Medicare Number	Individual Medicaid number(s)		Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Prefer not to disclose		
	Specialty at the primary practice location:		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Prefer not to disclose		Race <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian or Asian Indian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other		

III. PRACTICE INFORMATION	Effective Date at Primary Practice location _____			On average, how soon can a new patient get an appointment? <input type="checkbox"/> Within 48 hours <input type="checkbox"/> Within 2 weeks <input type="checkbox"/> 2-4 weeks <input type="checkbox"/> 4-6 weeks <input type="checkbox"/> Beyond 6 weeks				
	Name of practice, affiliation, or clinic name				Telehealth <input type="checkbox"/> Yes <input type="checkbox"/> No		Telehealth Modalities <input type="checkbox"/> Clinic to Clinic <input type="checkbox"/> Phone <input type="checkbox"/> Video	
	Primary office street address			City	State	Zip code		
	Patient appointment telephone number		Fax number		Federal tax ID number			
	Mailing address (if different from above)			City	State	Zip code		

III. PRACTICE INFORMATION (CONTINUED)	Billing address (if different from above)		City	State	Zip code	
	Office manager / Administrator name		Administration telephone number	Fax number	E-mail address	
	Credentialing contact (if different from above)		Credentialing telephone number	Fax number	E-mail address	
	Effective Date at Secondary Practice location _____			On average, how soon can a new patient get an appointment? <input type="checkbox"/> Within 48 hours <input type="checkbox"/> Within 2 weeks <input type="checkbox"/> 2-4 weeks <input type="checkbox"/> 4-6 weeks <input type="checkbox"/> Beyond 6 weeks		
	Name of secondary practice, affiliation, or clinic name			Telehealth <input type="checkbox"/> Yes <input type="checkbox"/> No	Telehealth Modalities <input type="checkbox"/> Clinic to Clinic <input type="checkbox"/> Phone <input type="checkbox"/> Video	
	Secondary office street address		City	State	Zip code	
	Patient appointment telephone number		Fax number	Name affiliated with tax ID number	Federal tax ID number	
	Mailing address (if different from above)		City	State	Zip code	
	Billing address (if different from above)		City	State	Zip code	
	Office manager / Administrator name		Administration telephone number	Fax number	E-mail address	
	Credentialing contact (if different from above)		Credentialing telephone number	Fax number	E-mail address	

List other office locations with above information on a separate sheet.

IV. PROFESSIONAL LICENSURE	State professional license/registration/certificate number		Status <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Temporary		
	Issue date	Expiration date	Name of sponsor if required by licensure, (i.e. Physician's Assistant).		
	Drug Enforcement Administration (DEA) registration number		Issue date	Expiration date	
	State controlled substance certificate number		Issue date	Expiration date	
	ECFMG number (applicable to foreign medical graduates)			Date issued	

V. ALL OTHER PROFESSIONAL LICENSES	State	License/registration/certificate number	Date issued		
	Expiration date	Year relinquished	Reason		
	State	License/registration/certificate number	Date issued		
	Expiration date	Year relinquished	Reason		
	State	License/registration/certificate number	Date issued		
	Expiration date	Year relinquished	Reason		

VI. UNDER-GRADUATE EDUCATION	Name of college or university				Does Not Apply <input type="checkbox"/>	
	Degree received		Start date	Graduation date		
	Mailing address			City	State	Zip code
	Name of college or university					
	Degree received		Start Date	Graduation date		
	Mailing address			City	State	Zip code

(Do not abbreviate) (Attach additional sheet if necessary)

VII. MEDICAL/PROFESSIONAL EDUCATION	Medical/Professional school			
	Start date	Graduation date	Degree received	
	Mailing address	City	State	Zip code
		Phone	Fax	
	Medical/Professional School			
	Start date	Graduation date	Degree received	
	Mailing address	City	State	Zip code
		Phone	Fax	

(Do not abbreviate) (Attach additional sheet if necessary)

VIII. GRADUATE EDUCATION	Institution			Does Not Apply <input type="checkbox"/>
	Program or course of study		Faculty director	
	Mailing address	City	State	Zip code
	Dates attended (/) - (/)	Phone	Fax	

(Do not abbreviate) (Attach additional sheet if necessary)

IX. INTERNSHIP/PGYI	Institution			Does Not Apply <input type="checkbox"/>
	Program director			
	Mailing address	City	State	Zip code
	Start date	Completion date	Phone	Fax
	Type of internship	Specialty		
	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)			

(Do not abbreviate) (Attach additional sheet if necessary)

X. RESIDENCIES	Institution			Does Not Apply <input type="checkbox"/>
	Program director			
	Mailing address	City	State	Zip code
	Start date	Completion date	Phone	Fax
	Type of residency	Specialty		
	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)			
	Institution			Does Not Apply <input type="checkbox"/>
	Program director			
	Mailing address	City	State	Zip code
	Start date	Completion date	Phone	Fax
	Type of residency	Specialty		
	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)			

(Do not abbreviate) (Attach additional sheet if necessary)

XI. FELLOWSHIPS	Institution Does Not Apply <input type="checkbox"/>					
	Program director					
	Mailing address			City	State	Zip code
	Start date		Completion date	Phone	Fax	
	Course of study					
	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)					
	Institution Does Not Apply <input type="checkbox"/>					
	Program director					
	Mailing address			City	State	Zip code
	Start date		Completion date	Phone	Fax	
Course of study						
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)						

(Do not abbreviate) (Attach additional sheet if necessary)

XII. PRECEPTORSHIP	Institution Does Not Apply <input type="checkbox"/>					
	Department chairman					
	Mailing address			City	State	Zip code
	Start date		Completion date	Phone	Fax	
	Training					

(Do not abbreviate) (Attach additional sheet if necessary)

XIII. FACULTY APPOINTMENT	Institution Does Not Apply <input type="checkbox"/>					
	Faculty director					
	Mailing address			City	State	Zip code
	Start date		Completion date	Phone	Fax	
	Position					

(Do not abbreviate) (Attach additional sheet if necessary)

XIV. BOARD CERTIFICATION	Are you board or otherwise professionally certified? Does Not Apply <input type="checkbox"/>					
	<input type="checkbox"/> Yes If "Yes", please complete below		<input type="checkbox"/> No If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.			
	Issuing Board/Entity	Certificate Number	Specialty	Date Certified	Date Recertified	Expiration Date (if any)
	Have you applied for certification other than those indicated above? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If so, list certification and date						
If you participate in a specialty which does not have board certification, please indicate specialty						

(Do not abbreviate) (Attach additional sheet if necessary)

XV. OTHER CERTIFICATIONS	ACLS, BLS, ATLS, PALS, NRP, NALS (i.e., Fluoroscopy, Radiography, etc. – Attach certificate if applicable)		Does Not Apply <input type="checkbox"/>
	Type	Number	Expiration date
	Type	Number	Expiration date
	Type	Number	Expiration date

XVI. HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS	Does Not Apply <input type="checkbox"/>
	Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you (A) have current affiliations, (B) applications in process, (C) have had previous affiliations or, if no current affiliation, (D) have a current coverage plan. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.

(Do not abbreviate) (Attach additional sheet if necessary)

A. CURRENT AFFILIATIONS	Name of primary facility (Do you have admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No)			
	Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
	Mailing address	City	State	Zip code
	Phone number	Fax number	Appointment date	
	Name of secondary facility (Do you have admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No)			
	Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
	Mailing address	City	State	Zip code
	Phone number	Fax number	Appointment date	
	Name of other facility (Do you have admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No)			
	Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
	Mailing address	City	State	Zip code
	Phone number	Fax number	Appointment date	

(Do not abbreviate) (Attach additional sheet if necessary)

B. APPLICATIONS IN PROCESS	Hospital/Institution			
	Mailing address	City	State	Zip code
	Phone number	Fax number	Date application submitted	
	Hospital/Institution			
	Mailing address	City	State	Zip code
	Phone number	Fax number	Date application submitted	

(Do not abbreviate) (Attach additional sheet if necessary)

C. PREVIOUS AFFILIATIONS	Name of facility				Does Not Apply <input type="checkbox"/>
	Department		Department / Clinical Chair		
	Mailing address		City	State	Zip code
	Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)		
	Reason for leaving			Appointment date (from– to)	
	Name of facility				
	Department		Department / Clinical Chair		
	Mailing address		City	State	Zip code
	Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)		
	Reason for leaving			Appointment date (from– to)	
	Name of other facility				
	Department		Department / Clinical Chair		
Mailing address		City	State	Zip code	
Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)			
Reason for leaving			Appointment date (from– to)		

D. INPATIENT COVERAGE PLAN	This Section only applicable for those without admitting privileges	
	Provider may attach signed letter of agreement from the physician or group representative that admits and manages the inpatient care for your patients. *Admit plan must be to an in network facility.	
	Does Not Apply <input type="checkbox"/>	
	Name of participating admitting physician/practice/clinic/group	Hospital where privileged

(Do not abbreviate) (Attach additional sheet if necessary)

XVII. WORK HISTORY	Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vita may be substituted as long as it is current and has exact dates of employment.				
	Name of current practice/employer				
	Contact name	Telephone number	Fax number	From (mo/year)	To (mo/year)
	Mailing address		City	State	Zip code
	Reason for leaving				
	Name of practice/employer				
	Contact name	Telephone number	Fax number	From (mo/year)	To (mo/year)
	Mailing address		City	State	Zip code
Reason for leaving					

XVII. WORK HISTORY (CONTINUED)	Name of practice/employer				
	Contact name	Telephone number	Fax number	From (mo/year)	To (mo/year)
	Mailing address		City	State	Zip code
	Reason for leaving				
	Please account for all gaps in time between dates of medical / professional school graduation to present not covered elsewhere within this application. Include dates, activity, and names where applicable.				
	Activity / Name			From	To

XVIII. PROFESSIONAL AFFILIATIONS	Please list membership in all professional societies. Complete Name of Society			Date Joined	Current Member	
					Yes	No

XIX. PROFESSIONAL REFERENCES	List at least one professional reference from your specialty area, not including relatives, who have worked with you in the past two years. Reference must be from an individual who through recent observation, is directly familiar with your work and can attest to your clinical competence in your specialty area.					
	Name of reference			Title and specialty		
	Mailing address		City	State	Zip code	
	E-mail address	Telephone number	Fax number	Cell phone number		
	Name of reference			Title and specialty		
	Mailing address		City	State	Zip code	
	E-mail address	Telephone number	Fax number	Cell phone number		
	Name of reference			Title and specialty		
	Mailing address		City	State	Zip code	
	E-mail address	Telephone number	Fax number	Cell phone number		

XX. PROFESSIONAL LIABILITY	Current insurance carrier			Policy number		
	Mailing address		City		State	Zip code
	Phone number		Fax number		Origination (retroactive) date	
	Per claim amount		Aggregate amount		Effective date	Expiration date
	Please list ALL professional liability carriers within the past ten years					
	Name of carrier			Policy number		
	Mailing address		City		State	Zip code
	Phone number		Fax number		From	To
	Name of carrier			Policy number		
	Mailing address		City		State	Zip code
	Phone number		Fax number		From	To
	Name of carrier			Policy number		
	Mailing Address		City		State	Zip code
Phone number		Fax number		From	To	

XXI. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL	Provider name(print or type) Does Not Apply <input type="checkbox"/>	
	Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected health information (PHI). Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed provider narrative that addresses all of the following details is an acceptable alternative.	
	Date and clinical details of the incident, with preceding events	
	Date	Details
	Your role and specific responsibility in the incident	
	Subsequent events, including patient's clinical outcome	
	Date suit or claim was filed	
	Name and Address of Insurance Carrier that handled the claim	
	Your status in the legal action (primary defendant, co-defendant, other)	
	Current status of suit or other action	
	Date of settlement, judgment, or dismissal	
If case was settled out-of-court, or with a judgment, settlement amount attributed to you? \$		

PROVIDER ATTESTATION QUESTIONS - To be completed by the provider

Please answer **all** of the following questions. If your answer to any of the following questions is "Yes", provide details as specified on a separate sheet. If you attach additional sheets, sign and date each sheet.

A. PROFESSIONAL SANCTIONS			
①	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct? <i>(Please include an explanation sheet for any "Yes" answer in this section)</i>		
		Yes	No
	a. License to practice any profession in any jurisdiction		
	b. Other professional registration or certification in any jurisdiction		
	c. Specialty or subspecialty board certification		
	d. Membership on any hospital medical staff		
	e. Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.		
	f. Medicare, Medicaid, FDA, governmental, national or international regulatory agency or any public program		
	g. Professional society membership or fellowship		
	h. Participation/membership in an HMO, PPO, IPA, PHO or other entity		
	i. Academic Appointment		
	j. Authority to prescribe controlled substances (DEA or other authority)		
②	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		
③	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		
④	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		
B. CRIMINAL HISTORY		Yes	No
<i>(Please include an explanation sheet for any "Yes" answers in this section)</i>			
①	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		
	a. Do you have notice of any such anticipated charges?		
	b. Are you currently under governmental investigation?		
C. AFFIRMATION OF ABILITIES		Yes	No
①	Do you presently use any drugs illegally?		
②	Do you have any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or could affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		
③	Are you unable to perform any of the services/clinical privileges required by the applicable participating provider agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		
D. LITIGATION AND MALPRACTICE COVERAGE HISTORY			
<i>(If you answer "Yes" to any of the questions in this section, please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)</i>			
①	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		
②	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?		
③	Are there any such claims being asserted against you now?		
④	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?		
⑤	Are any of the privileges that you are requesting <u>not</u> covered by your current malpractice coverage?		
E. ATTESTATION			
I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.			
<div style="display: flex; justify-content: space-between;"> _____ _____ _____ </div>			
<div style="display: flex; justify-content: space-between;"> Typed or printed name Signature Date </div>			

Provider Credentials Verification Addendum

Supplemental Provider Authorization and Release of Information

XXII. PROVIDER AUTHORIZATION TO RELEASE INFORMATION	<p>I hereby authorize the presenter of this Release and/or its representatives to consult with others who have information bearing on my professional competence, character, professional practice or ethical qualifications. I authorize all malpractice carriers to release coverage and/or claims history information which may exclude direct patient identification including name, address or telephone numbers to the presenter of this Release and/or its representatives. I hereby further consent to the inspection by the presenter, and/or its representatives, of all documents, including medical records, which may be relevant to evaluation of my professional competence, character, professional practice or ethical qualifications. <i>The presenter complies with the Health Insurance Portability and Accountability Act of 1996 "HIPAA" (as defined in 45 CFR § 160 et seq.) as well as other state and federal statutes, rules and regulations relating to confidentiality and privacy.</i> I understand that I have the right to review any information submitted in support of this Provider Application.</p> <p>I hereby release from liability any and all individuals and organizations that provide information to the presenter concerning my professional competence, practices, ethics, character or ethical qualifications for participating provider status, and hereby consent to the release of such information. I further agree to release and hold harmless from any liability the presenter and/or its representatives who participate within the scope of their duties in review of any information obtained under this Release. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, professional practice or ethical qualifications for resolving any doubts regarding such qualifications. A copy of any portion/section of the Authorization and Release, Criteria Sheet and or Application has the same force and effect as the original.</p> <p>I also understand that to participate, this application must be verified and I must be notified in writing whether this application has been approved or denied. I agree to immediately notify the entity to which this authorization has been given, in accordance with executed Agreements, of any change in submitted information. Failure to notify the entity of changes in the information contained in this application may result in immediate termination from participation with the entity to which this Release is given.</p>
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XXIII. ATTESTATION	<p>I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.</p>
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Print Name Here _____

Signature _____
(Stamped signature is not acceptable)

Date _____

Application Addendum: Behavioral Health Provider Expertise

_____ Provider Name	_____ NPI
_____ Clinic Name	_____ Tax ID

Which population do you specialize in providing services to? (Please mark all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Adults | <input type="checkbox"/> Racial or Ethnic Minorities |
| <input type="checkbox"/> Children (ages 0-12) | <input type="checkbox"/> Teenagers (ages 13-17) |
| <input type="checkbox"/> Elderly (65+) | <input type="checkbox"/> Veterans |
| <input type="checkbox"/> Immigrants and/or Refugees | <input type="checkbox"/> Women |
| <input type="checkbox"/> LGBTQ+ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Men | |

Do you provide any of the following? (Please mark all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Couples Counseling | <input type="checkbox"/> Individual Counseling |
| <input type="checkbox"/> Family Counseling | <input type="checkbox"/> Psychiatric Medication Management |
| <input type="checkbox"/> Group Counseling | |

Which therapeutic models, theories or practices are you trained to provide? (Please mark all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Acceptance and Commitment Therapy (ACT) | <input type="checkbox"/> Mindfulness-Based (MBCT) |
| <input type="checkbox"/> Attachment-based Therapy | <input type="checkbox"/> Motivational Interviewing |
| <input type="checkbox"/> Cognitive Behavioral Therapy (CBT) | <input type="checkbox"/> Psychodynamic |
| <input type="checkbox"/> Dialectical Behavioral Therapy (DBT) | <input type="checkbox"/> Solution Focused Brief Therapy (SFBT) |
| <input type="checkbox"/> EMDR | <input type="checkbox"/> Trauma Focused Therapy |

Which do you specialize in? (Please mark all that apply)

- | | |
|---|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Borderline Personality Disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Chronic Illness |

Continued: Which do you specialize in? (Please mark all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Self Esteem |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Self-Harming |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sex Therapy |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Spirituality |
| <input type="checkbox"/> Domestic Abuse | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Dual Diagnosis | <input type="checkbox"/> Substance Use |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Suicidal Ideation |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Testing and Evaluations |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Thought Disorders |
| <input type="checkbox"/> Life Transitions | <input type="checkbox"/> Trauma and PTSD |
| <input type="checkbox"/> Obsessive Compulsive Disorder | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Pregnancy, Prenatal or Postpartum | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Racial Identity | |