Ohio Department of Insurance

STANDARDIZED CREDENTIALING FORM

Please complete each section thoroughly.
Attach additional sheets where necessary.
Type or print clearly in black ink.
Sign and date the application.

YOU MUST INCLUDE THE FOLLOWING WITH THIS COMPLETED APPLICATION
(use this checklist as a guide)

- ☐ Copy of State License(s)
- ☐ Copy of DEA Registration
- ☐ Copy of State Controlled Dangerous Substance Certificate
- ☐ Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and provider's name
- ☐ Copy of Board Certification Certificate, if applicable
- ☐ Copy of certificate or letter certifying formal post-graduate training
- ☐ Copy of Curricula Vita/Resume
  Include work history. (**Not accepted as a substitute for completion of application.**)
- ☐ Copy of ECFMG Certificate (if applicable)
- ☐ Copy of W-9 for verification of each tax identification number used
- ☐ Copy of certificates for conducting x-ray and/or laboratory services (if applicable)
- ☐ Copy of Workers Compensation Certificate of Coverage (if applicable)
- ☐ Copy of certificates of Advanced Nurse Practitioners employed by the office (if applicable)
- ☐ Other _____

Provider's Name _____ Date _____

Health Insuring Corporation's Name _____

Note: Submit this form directly to licensed health insuring corporations and other entities that credential providers for participation in their networks. Do not send this form to the Ohio Department of Insurance; the Department does not use the form for any reporting purposes.

Ohio Department of Insurance

STANDARDIZED CREDENTIALING FORM

Please type or print
Fill in all sections - incomplete applications will not be processed.

To be completed by MDs, DOs, DDSs, DPMs, and DCs, and other health care providers.

Date _____

SECTION I
PERSONAL INFORMATION

Name (Last, First, Middle) _____ Degree _____

Home Address/Street _____

City/State/Zip _____

Home Phone Number _____ Cellular Phone Number _____

Date of Birth (for Data Bank Query) _____ Sex: ☐ Male ☐ Female

Place of Birth: (City, State & Country) _____

Languages Spoken _____

Citizenship _____

If not an American citizen, Status & Visa Number _____

SSN # _____

Beeper # _____ Digital: ☐ Yes ☐ No Answering Service # _____

SECTION II
LICENSURE/CERTIFICATIONS/REGISTRATIONS

For all the questions in this section, if you do not have a number but have applied, please indicate "application in process."

Ohio License Number _____ Expiration Date _____

Other State License Number/State of License (list all past and current)

_____ Expiration Date _____

_____ Expiration Date _____

_____ Expiration Date _____

Federal DEA Number _____ Expiration Date _____

Date Issued _____

State Narcotics Registration # or CDS Certification/State of Registration (if applicable) _____ Expiration Date _____

CPR Certifications:

Are you certified in CPR?	☐	Yes (attach copy of certificate(s))	☐	No	Expiration Date _____
Check classification(s):	☐	Basic Life Support (BLS)	☐	No	Expiration Date _____
	☐	Advanced Cardiac Life Support (ACLS)	☐	No	Expiration Date _____
	☐	Health Care Provider (Core C)	☐	No	Expiration Date _____
	☐	Advanced Trauma Life Support (ATLS)	☐	No	Expiration Date _____
	☐	Neonatal Resuscitation Program (NRP)	☐	No	Expiration Date _____
	☐	Pediatric Advanced Life Support (PALS)	☐	No	Expiration Date _____
	☐	Pediatric Emergency Medicine Course (APLS)	☐	No	Expiration Date _____

Other professional certifications or credentials (please include description) _____

_____

Optometrists Only:

Therapeutics Classification Number _____

SECTION III
OFFICE/PRACTICE INFORMATION

Please include all offices/practices. **Copy and complete this sheet for each additional office.**

Is this your primary office? ☐ Yes ☐ No

What type of care do you provide? ☐ Primary Care ☐ Specialty Care

Specialty: _____ Subspecialty: _____

Type of Practice: ☐ Solo ☐ Single Specialty Group ☐ Multi-specialty Group/Other ☐ Hospital Based

Please list other members of your practice and their specialties. _____

_____

Please list the coverage arrangements for your office.

_____

Start date with practice: _____

If you have more than one office please indicate the preferred mailing address

Office Address/Street _____

City/State/Zip _____ County _____

Office Phone _____ After-hours number _____

Office Fax _____ Office e-mail address _____

Ohio Medicare PIN (Provider Identification Number) _____

Ohio Medicaid Provider Number _____

National Provider Identification Number (formerly UPIN)) _____

BWC Provider Number _____

Workers' Compensation Employer Risk Number _____

CLIA Certificate ☐ Yes ☐ No

Staff Person responsible for credentialing _____

Phon _____ Fax _____ E-mail _____

Office Manager _____

Phon _____ Fax _____ E-mail _____

Do you use a billing service? ☐ Yes ☐ No

If Yes, list the name and contact _____

Does your billing service bill electronically? ☐ Yes ☐ No

Group or Corporate name (as it appears on W-9) _____ Federal Tax ID # _____

Who should check be payable to? _____ Billing Phone _____

Billing Address/Street (if different from _____

City/State/Zip _____

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Indicate the hours that the doctor(s) is/are available:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Languages spoken by office personnel (other than _____

Based on your individual practice, do you currently: (check appropriate box for each item)

Accept new patients into your practice?	☐ Yes	☐ No	Accept new Medicare patients?	☐ Yes	☐ No
Accept new patients from phys. referral only?	☐ Yes	☐ No	Accept new Medicaid patients?	☐ Yes	☐ No
Provide inpatient care?	☐ Yes	☐ No	Accept new BWC patients?	☐ Yes	☐ No
Have any age restrictions?	☐ Yes	☐ No			

If YES, what are they? _____

Does the office: (check appropriate box for each item)

Make 24-hour phone coverage available?	☐ Yes	☐ No	Provide childcare services?	☐ Yes	☐ No
Have capability for electronic billing?	☐ Yes	☐ No	Meet ADA accessibility standards?	☐ Yes	☐ No
Have internet access?	☐ Yes	☐ No	Communicate with health plans via the Internet?	☐ Yes	☐ No
Offer patients Internet access to obtain medical, billing, and appointment information?	☐ Yes	☐ No	Have public transportation access?	☐ Yes	☐ No
Have other services for the disabled? (TTY, American Sign Language, mental/physical impairments, etc.)	☐ Yes	☐ No	Employ or contract with allied health professionals including physician assistants and Advanced Nurse Practitioners?	☐ Yes	☐ No

Please list services

_____
_____
_____
_____

If Yes, please list all names

_____
_____
_____
_____

SECTION IV
PROFESSIONAL / MEDICAL EDUCATION & TRAINING/WORK HISTORY

Provide history (since medical school) of ***all*** work, education and training including but not limited to medical military services, public health or business training. Provide an explanation for any gaps of more than two months.

MEDICAL EDUCATION:

University _____

Address/Street _____

City/State/Zip _____ Telephone Number _____

Degree _____ Month/Year Started _____ Month/Year Completed _____

University _____

Address/Street _____

City/State/Zip _____ Telephone Number _____

Degree _____ Month/Year Started _____ Month/Year Completed _____

INTERNSHIP

Facility _____

Address/Street _____

City/State/Zip _____ Telephone Number _____

Type _____ Month/Year Started _____ Month/Year Completed _____

Name of Department Head or Chief of Service _____

Was this program successfully completed? ☐ Yes ☐ No

RESIDENCIES

Facility _____

Program Name _____

Address/Street _____

City/State/Zip _____ Telephone Number _____

Specialty _____ Month/Year Started _____ Month/Year Completed _____

Name of Department Head or Chief of Service _____

Was this program successfully completed? ☐ Yes ☐ No

Facility _____

Program Name _____

Address/Street _____

City/State/Zip _____ Telephone Number _____

Specialty _____ Month/Year Started _____ Month/Year Completed _____

Name of Department Head or Chief of Service _____

Was this program successfully completed? ☐ Yes ☐ No

FELLOWSHIPS

Facility _____

Program Name _____

Address/Street _____

City/State/Zip _____

Specialty _____ Month/Year Started _____ Month/Year Completed _____

Name of Department Head or Chief of Service _____

Was this program successfully completed? ☐ Yes ☐ No

Facility _____

Program Name _____

Address/Street _____

City/State/Zip _____ Telephone Number: _____

Specialty _____ Month/Year Started _____ Month/Year Completed _____

Name of Department Head or Chief of Service _____

Was this program successfully completed? ☐ Yes ☐ No

Other Graduate Level Education for which a degree was obtained

Degree(s) obtained _____

Institution _____

Address/Street _____

City/State/Zip _____

Telephone Number _____

Dates (from/to) _____

Program Director _____

International Medical Graduates

Are you certified by the Educational Council for Foreign Medical Graduates? ☐ Yes ☐ No

ECFMG # _____

Date Issued _____

ADDITIONAL QUALIFICATIONS/TRAINING

List below in chronological order, any and all additional training and places of practice, including medical military services, subspecialty training programs, or public health or business training. If more space is needed, please include an attachment. Include the following information: Dates of the training (from/to), program/training name, location (address), telephone number, contact person, and relevant comments

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WORK HISTORY

Practice/Employer _____

Contact Name _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____

Dates of employment Month/Year Started _____ Month/Year Ended _____

Reason for leaving _____

_____

Practice/Employer _____

Contact Name _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____

Dates of employment Month/Year Started _____ Month/Year Ended _____

Reason for leaving _____

_____

Practice/Employer

Contact Name _____

Address/Street _____

City/State/Zip _____

Phone _____

Dates of employment Month/Year Started _____ Month/Year Ended _____

Reason for leaving _____

_____

SECTION V
PROFESSIONAL / MEDICAL SPECIALTY INFORMATION

For each specialty below, please indicate if you are qualified or board certified:

PRIMARY SPECIALTY _____ ☐ Qualified ☐ Certified ☐ Not certified ☐ No board available

Certifying Board _____ Date _____

Is certification current? ☐ Yes ☐ No

Dates of current certification From (month/year) _____ To (month/year) _____

Have you been recertified? ☐ Yes ☐ No Date _____

If status is qualified, give date status expires. Date _____

If qualified, date exam scheduled. Date _____

Board certification results pending? ☐ Yes ☐ No

Do you wish to be listed in the organization directory under this specialty? ☐ Yes ☐ No

SECONDARY SPECIALTY (Secondary area of practice) _____ ☐ Qualified ☐ Certified ☐ Not certified ☐ No board available

Certifying Board _____ Date of initial certification _____

Is certification current? ☐ Yes ☐ No

Dates of current certification From (month/year) _____ To (month/year) _____

Have you been recertified? ☐ Yes ☐ No Date _____

If status is qualified, give date status expires. Date _____

If qualified, date exam scheduled. Date _____

Board certification results pending? ☐ Yes ☐ No

Do you wish to be listed in the organization directory under this specialty? ☐ Yes ☐ No

If you have applied to a specialty board for examination, give the name of the board and the date of application.

Board _____ Date _____

Board _____ Date _____

Board _____ Date _____

**Note: Submit copies of all certificates with application including copies of letters attesting to board eligibility.*

PROFESSIONAL AFFILIATIONS (e.g. AMA, AOA) _____

SECTION VI
HEALTH CARE AFFILIATIONS

List all health care facilities at which you have privileges. (Copy this page for additional facilities.)

Status of Privileges Key

1 Active	4 Associate	7 Courtesy	10 Provisional	13 Pending
2 Courtesy Provisional Staff	5 Visiting	8 Admitting	11 Suspended	14 Other
3 Active Provisional Staff	6 Temporary	9 Senior Staff	12 Consulting	

PRIMARY FACILITY _____

Date affiliation started _____ Date affiliation ended (if applicable) _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Status of privileges (*indicate by using key*); explain coverage arrangements. _____

_____

Any past or present restriction of privileges? ☐ Yes ☐ No
(*If Yes, explain. Attach additional pages if necessary.*)

_____

SECONDARY FACILITY _____

Date affiliation started _____ Date affiliation ended (if applicable) _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Status of privileges (*indicate by using key*); explain coverage arrangements. _____

_____

Any past or present restriction of privileges? ☐ Yes ☐ No
(*If Yes, explain. Attach additional pages if necessary.*)

_____

SECONDARY FACILITY _____

Date affiliation started _____ Date affiliation ended (if applicable) _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Status of privileges (*indicate by using key*); explain coverage arrangements. _____

_____

Any past or present restriction of privileges? ☐ Yes ☐ No
(*If Yes, explain. Attach additional pages if necessary.*)

_____

OTHER FACILITIES

List all other health care facilities or practices where you have had privileges and indicate whether your privileges were restricted in any way at any of the facilities. (*Attach additional pages if necessary*)

OTHER FACILITY _____

Date affiliation started _____ Date affiliation ended (if applicable) _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Status of privileges (*indicate by using key*); explain coverage arrangements. _____

_____

Any past or present restriction of privileges? ☐ Yes ☐ No
(*If Yes, explain. Attach additional pages if necessary.*)

_____

SECTION VII
PROFESSIONAL REFERENCES

List three (3) professional/medical references from individuals who have worked extensively with you or who have been responsible for professional observation of your work within the past three years. Only one reference can be a current partner or associate. Do not include relatives.

Name _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____

Relationship _____

Name _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____

Relationship _____

Name _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____

Relationship _____

SECTION VIII
PROFESSIONAL LIABILITY INSURANCE COVERAGE

Provide professional liability insurance coverage information for the previous ten (10) years.

☐ Not Applicable Reason _____

MALPRACTICE CARRIER

Carrier Name _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Policy number _____

Length of time with this carrier _____

If coverage with this carrier is less than ten (10) years, please list your previous carrier(s). (Attach additional pages if necessary)

Amount of coverage (Per claim/Aggregate) _____

Type of coverage ☐ Occurrence ☐ Claims made

Effective dates (from/to) _____

Renewal date _____

Agent Name _____

Address/Street _____

City/State/Zip _____

PREVIOUS CARRIER

Carrier Name _____

Address/Street _____

City/State/Zip _____

Phone _____ Fax _____ Website _____

Policy number _____

Amount of coverage
(Per claim/Aggregate) _____

Type of coverage ☐ Occurrence ☐ Claims made

Effective dates (from/to) _____

Agent Name _____

Address/Street _____

City/State/Zip _____

SECTION IX
MALPRACTICE CLAIMS HISTORY

Provide information for all cases occurring in previous ten (10) years. Attach additional sheets if necessary. This sheet may be photocopied.

☐ No claims to date

Date of occurrence _____ Date claim was filed with malpractice carrier _____

Professional liability carrier involved _____

Address (if different from Section VII _____

Patient name _____ Age _____ Sex _____

Name of Plaintiff, if other than patient _____

You were (Check one): ☐ Primary Defendant ☐ Co-Defendant

Other Defendants (if any) _____

Describe the allegations against you _____

_____

_____

Describe the alleged injury to the patient _____

_____

Claimant/Plaintiff filed suit in court ☐ Yes ☐ No If yes, date filed _____

State Court Case Number _____ State _____ County/Parish _____

Federal Court (U.S. District Court) Case Number _____ District _____

Present status of the Claim/Case (Include amount awarded/attributed/settlement)

☐ Pending ☐ Settled ☐ Arbitrated ☐ Award

☐ In Appeal ☐ Adjudicated ☐ Withdrawn Date _____

Other, please specify _____

If pending, amount being sought $ _____

Amount of award or settlement $ _____

Amount paid on your behalf $ _____

Amount paid by all parties $ _____

Additional information/explanation (*e.g. the condition/diagnosis of the patient at the time of the incident, treatment rendered, and the condition of the patient subsequent to treatment*)

_____

SECTION X
DISCLOSURE INFORMATION

Please answer the following questions "yes" or "no". If your answer to questions 1-18 is "yes" or if your answer to question 19 is "no", please provide a written explanation on a separate sheet.

INSTRUCTION NOTE: A voluntary surrender or non-renewal is for reasons related to professional competence or conduct when the surrender or non-renewal is done to avoid an adverse action, preclude an investigation or is done while the licensee is under investigation related to professional competence or conduct.

1. Have any of your board certifications or equivalents ever been suspended, revoked, voluntarily surrendered or have you failed to recertify? ☐ Yes ☐ No

2. Has your professional license, in any jurisdiction, ever been voluntarily or involuntarily suspended, limited, revoked, denied, or surrendered or subjected to probationary conditions or are any such actions pending? ☐ Yes ☐ No

3. Has your DEA license or state narcotics registration ever been voluntarily or involuntarily suspended, limited, revoked, denied, or restricted for reasons other than non-completion of medical records or are any such actions pending? ☐ Yes ☐ No

4. Has your hospital or facility medical staff membership or have your hospital or facility professional privileges ever been voluntarily or involuntarily suspended, limited, revoked, denied or surrendered for reasons related to professional competence or conduct, other than non-completion of medical records or are any such actions pending? ☐ Yes ☐ No

5. Have you ever been placed on probation or asked to resign an internship or residency training program? ☐ Yes ☐ No

6. Has Medicare, Medicaid, or any other medical reimbursement plan ever voluntarily or involuntarily suspended, limited, revoked, denied, not renewed or terminated your participation for reasons related to professional competence or conduct? ☐ Yes ☐ No

7. Have you ever been or are you currently excluded from participation with Medicare or any other federally funded health care program? ☐ Yes ☐ No

8. Has your professional liability coverage ever been restricted, limited, denied, not renewed, or special rated (for reasons other than the carrier's termination of operations in your state)? ☐ Yes ☐ No

9. Have you ever been named as a defendant in any criminal case? (excluding minor traffic infractions, but not DUIs) ☐ Yes ☐ No

10. Have you ever been convicted of a felony? ☐ Yes ☐ No

11. Have you ever been disciplined for a violation of ethical standards by a professional organization? ☐ Yes ☐ No

12. To your knowledge has information pertaining to you ever been reported to the National Practitioner Data Bank? ☐ Yes ☐ No

13. Do you have a history of engaging in the illegal use of drugs? ("Illegal use of drugs" means the use of any controlled substances illegally obtained, i.e. not obtained pursuant to a valid prescription and not taken in accordance with the direction of a licensed health care practitioner.) ☐ Yes ☐ No

14. Are you currently engaged in the illegal use of drugs? ("Currently" does not mean on the day of or even the weeks preceding the completion of this application. Rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.) ☐ Yes ☐ No

15. Are you currently in treatment for addiction to drugs or alcohol? ☐ Yes ☐ No

16. Within the last five years, have you been reprimanded or disciplined in any manner by any state licensing authority or other professional board for conduct related to the use of alcohol or the use of any drug? ☐ Yes ☐ No

17. Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital, ambulatory surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies? ☐ Yes ☐ No

18. Do you have any emotional or physical disabilities that may limit your ability to practice? ☐ Yes ☐ No

19. Are you able to perform the procedures and the essential functions of the position for which you have applied or requested privileges, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients? ☐ Yes ☐ No

SECTION XI
AFFIRMATION OF INFORMATION

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I understand that this application does not entitle me to participation in the network of any health plan using this application.

I release _____ "the Health Plan," its representatives, and any individuals or entities providing information to the Health Plan from liability for any act or omission related to the evaluation or verification contained in this application provided the Health Plan, its representatives and individuals providing information to the Health Plan act in good faith and without malice. I further agree to notify the Health Plan of any change to the information provided in this application within 30 days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by the Health Plan.

I authorize _____ and its agents and any individual or entity providing information to the Health Plan to investigate and evaluate my provider application, and consult with any person, organization, or entity that has, or could have any information, data, or documents regarding my background, competence, and credentials.

_____
Applicant Signature

_____
Print Name

_____ _____
Print Degree Date

Note: Providers submitting completed credentialing forms to a health plan must complete and submit Section XI as shown. Health plans may, however, substitute their own release and affirmation page in place of this form.