Last Name First Name Middle Name Suffix Professional Degree Birth Date Gender

Email Address (For correspondence and credentialing application status)

Physical Address of Office City State Zip Telephone Fax

Billing Address of Office City State Zip Telephone Fax

Office Hours: Monday Tuesday Wednesday Thursday Friday Saturday

Are you applying to Allegiance Provider Direct as a member of a group or as a partner to a current Allegiance Provider Direct member? If so, please identify:

Group Name/Member Name Telephone Number

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SPECIALTIES:

	Board Certified? (circle one)	Specialty Board Name	American Board Certification #	Certification Date	Expiration Date
Primary	Y / N				
Secondary	Y / N				

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STATISTICAL INFORMATION:

MT Professional License # / Exp. Date / Federal Tax Identification # / Social Security #

NPI – National Provider ID / DEA Number / CAQH Number / Medicare/Medicaid Number

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EDUCATION & TRAINING:

School Degree City State Month/Year of Graduation

TRAINING	LOCATION	MONTH/YEAR	COMPLETED Yes/No
Internship	Institution	From To	
Residency	Institution	From To	
Fellowship	Institution	From To	

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***HOSPITAL STAFF PRIVILEGES**:* List all area hospitals where you hold privileges

	Hospital / City	Start Date	End Date	Staff Category	Admitting Priveledges? (Yes/No/NA)
1.					
2.					
3.					

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ADDITIONAL INFORMATION:

If you answer YES to any of the questions # 3 - 10 below, an explanation and a copy of any related order or settlement must be attached to the application.

1. How many years have you practiced ? _____ Years

2. Malpractice carrier: Please include declarations page.

3. Has your license to practice in any jurisdiction ever been revoked, suspended, or subject to probation or any conditions or limitations? Y / N

4. Have any complaints been filed against you with any Board? Y / N

5. Has your professional liability insurance cancelled, restricted, declined or not renewed in the past five years?Y / N

6. Have you ever been named as a defendant in a malpractice action that resulted in a settlement of more than $10,000? Y / N

7. Have your privileges at any facility ever been denied, revoked, suspended or restricted? If yes, name the facility _____ Y / N

8. Has your DEA or other license ever been suspended or revoked? Y / N

9. Do you presently have any physical or mental health problems which would interfere with your ability to provide high quality professional services? Y / N

10. Are you unable to perform the essential functions involved in delivering safe, efficient, quality care due to chemical dependency, substance abuse, or current mental or physical health conditions? Y / N

11. Have you ever been convicted of, or plead no contest to, or are you currently under investigation for any felony charges brought against you? Y / N

12. Do you use physician assistants or nurse practitioners in the office? Y / N

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CURRICULUM VITAE

The National Committee for Quality Assurance requires Allegiance Provider Direct to have work history in provider files. **Please return a CV or resume** with at least 5 years of work history, explaining gaps of 6 months or more.

AUTHORIZATION FOR RELEASE OF INFORMATION

All information provided in or in connection with my Allegiance Provider Direct Credentialing application is correct and complete to the best of my knowledge and belief. I fully understand that any misleading statement or material omissions in this application may constitute cause for denial of eligibility. I authorize Allegiance Provider Direct Network, its affiliates and designees to verify and supplement this information and I authorize any and all of the following persons and organizations to provide information to Allegiance Provider Direct Network: The National Practitioner Data Bank; the American Medical Association; the Federation of State Medical Boards; the American Board of Medical Specialties or any of its member boards; any applicable state licensing board(s); the Drug Enforcement Agency; any malpractice insurance carrier; any hospital, HMO, medical facility where I have practiced and any other health delivery system or entities; any state or federal government agency; any other person or organization having knowledge of my professional qualifications or credentials. The information to be provided hereunder includes, without limitation, favorable or unfavorable information, including any state hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and settlements, licensing and certification information, DEA registration, medical training, hospital affiliations, performance records, quality assurance data or other related confidential and/or peer review information. I hereby release each person and organization described above from and against any and all liability caused or related to any good faith communication or information pursuant to this authorization.

I understand that my Allegiance Provider Direct application does not entitle me to status as an Allegiance Provider Direct participating physician. If my application is accepted and approved by Allegiance Provider Direct, however, I agree to promptly notify Allegiance of any changes in the application information.

This authorization shall remain valid (with respect to processing my APD application for a period not to exceed three hundred sixty-five (365) days) for as long as I maintain a professional relationship with Allegiance Provider Direct Network. Any party furnishing information pursuant to this authorization is entitled to rely on the representation of APD, its affiliates or its designee that this authorization is currently valid. A photocopy of this authorization is as valid as the original.

ONLY MY ORIGINAL SIGNATURE ON THIS AUTHORIZATION IS VALID; NO STAMPED, COMPUTER-GENERATED OR BY-PROXY SIGNATURES ARE ACCEPTABLE.

_____

Provider Name (Please print)

_____ _____

Provider Signature Date Signed

_____

Any other name possibly in records