



Instructions:

Penn Highlands Health Plan accepts this Pennsylvania Standard Application developed and endorsed by the Pennsylvania Medical Society.

Please print and complete this application, and return it to:

Penn Highlands Health Plan
Attention: PHO Administrator
1086 Franklin Street
Johnstown, PA 15905

Pennsylvania Standard Application

This form should be typed or legibly printed in black or blue ink. Please answer all questions completely and fully. If more space is needed than provided on this application, attach additional sheets and reference the question being answered. If a question is not applicable to you, please respond with N/A. Incomplete applications cannot be processed and this will delay the credentialing process. Refer to instructions from each managed care insurance company for copies of documents that must be submitted with this application. **Please hand initial and date the bottom of each page of the application.**

I. PERSONAL INFORMATION

Last Name: _____ First: _____ Middle: _____

Degree and/or Title: _____ Social Security Number: _____

Any other name under which you have been known: _____

Birth Date: _____ Gender: (Optional) Male: _____ Female: _____ Ethnicity (Optional): _____

If you are not a US Citizen, do you have authorization to work in the US? Yes: _____ No: _____ N/A: _____

Primary Office Address

Name of Practice: _____ Street Address: _____

Suite/Bldg#: _____ City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Federal Tax ID of Group: _____

Are you applying for affiliation as:

Primary Care Physician: _____ Specialist: _____ Both: _____

Non-physician Practitioner: _____ (Please specify: _____)

If you are applying as a **PRIMARY CARE PHYSICIAN**, please mark which specialty:

Family Practice: _____ General Practice: _____ Internal Medicine: _____ Pediatrics: _____ Med Pediatrics: _____ Other: _____

If you have a subspecialty, please identify: _____

If you are applying as a **SPECIALIST**, please indicate which specialty: _____

If you have one or more subspecialties, please identify: _____

Medical Licensure/Registration

Medical License Number:	Issue Date:	Expiration Date:
CDS/BNDD Number (If Applicable):		Expiration Date:
Federal DEA Reg. Number (s):		Expiration Date:
EPSDT Provider Number:		Expiration Date:
Medicare Provider Number:		Expiration Date:
Medicaid Provider Number:		Expiration Date:
UPIN/NPI Number:		Expiration Date:

Additional State Licenses and Numbers

State: _____	License Number: _____	Expiration Date: _____
State: _____	License Number: _____	Expiration Date: _____
State: _____	License Number: _____	Expiration Date: _____

II. EDUCATION / TRAINING / HOSPITAL PRIVILEGES

Undergraduate/Professional Training

Institution: _____ Degree: _____ Graduation Date: _____
 City: _____ State: _____ Country: _____ Dates of Attendance: _____

Medical School

Institution: _____ Degree: _____ Date of Entry: _____
 City: _____ State: _____ Country: _____ Graduation Date: _____

International Medical Graduates

ECFMG Number: _____ Issue Date: _____

Internship/Residency

Institution: _____ Type of Training: _____
 City: _____ State: _____ Country: _____ Date of Entry: _____
 Program Completed: Yes: _____ Date: _____ Specialty: _____
 No: _____ Explain: _____

Residency/Fellowship

Institution: _____ Type of Training: _____
 City: _____ State: _____ Country: _____ Date of Entry: _____
 Program Completed: Yes: _____ Date: _____ Specialty: _____
 No: _____ Explain: _____

Residency/Fellowship

Institution: _____ Type of Training: _____
 City: _____ State: _____ Country: _____ Date of Entry: _____
 Program Completed: Yes: _____ Date: _____ Specialty: _____
 No: _____ Explain: _____

Other Experience or Training (i.e., allied health, public service, or military)

Institution: _____ Type of Training Program: _____

City: _____ State: _____ Country: _____ Dates of Attendance: _____

Program Completed: Yes: _____ No: _____ Supervised Clinical Hours: _____

Additional Information: _____

Work History

Starting with your current practice, list all employment since completion of post-graduate training. Explain any gaps in the chronology.

Employer/Practice	Location: City and State	Dates (inclusive): Month and Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have no current hospital admitting privileges, please provide your coverage arrangements for admitting patients.

Primary Hospital Affiliation

Primary Hospital: _____ Street Address: _____

Department: _____ City: _____ State: _____ Zip: _____

Staff Category: _____ % of Admissions: _____ Dates of Affiliation: From: _____ To: _____

Do you currently admit and care for patients on your own hospital service? Yes _____ No _____

If yes: Adult _____ Child _____ Infant _____ If no, please explain: _____

Additional Hospital Affiliation

Hospital: _____ Street Address: _____

Department: _____ City: _____ State: _____ Zip: _____

Staff Category: _____ % of Admissions: _____ Dates of Affiliation: From: _____ To: _____

Additional Hospital Affiliation

Hospital: _____ Street Address: _____

Department: _____ City: _____ State: _____ Zip: _____

Staff Category: _____ % of Admissions: _____ Dates of Affiliation: From: _____ To: _____

Previous Hospital Affiliations (within the last 10 years)

Hospital: _____
City, State: _____
Hospital: _____
City, State: _____
Hospital: _____
City, State: _____

Dates of Affiliation:
From: _____ To: _____
Dates of Affiliation:
From: _____ To: _____
Dates of Affiliation:
From: _____ To: _____

Board Certification

Board Certified: Yes: _____ No: _____
Certificate Number: _____
Most Recent Recertification Date: _____

Certifying Board: _____
Original Certification Date: _____
Certification Expiration Date: _____

Additional Board Certifications / Other Certifications

Board Certified: Yes: _____ No: _____
Certificate Number: _____
Most Recent Recertification Date: _____

Certifying Board: _____
Original Certification Date: _____
Certification Expiration Date: _____

Are you pursuing Board Certification? Yes: _____ No: _____
If yes, give details of plans to take Board exam:

III. OFFICE PRACTICE INFORMATION

Type of Practice

Corporation: _____ Partnership: _____ Solo: _____ Institution: _____ FQHC: _____

Give a narrative description of your practice, including the type of medicine that comprises the majority of your practice, special interests, and procedures performed in your office: _____

Do you receive vaccines purchased by the city/county through public funding? Yes: _____ No: _____ N/A: _____

Individual Tax ID Number of Applicant: _____

Define age restrictions or other practice limitations: _____

Please list HMOs, POs, PHOs and other managed care programs in which you are participating: _____

Primary Office Site

List Associates (If more space required, attach roster)

Specialties

Office Hours

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday: _____

Office Manager's Name: _____

Handicap Access? Yes: _____

No: _____

List all languages (other than English) including sign, in which you are fluent.

Provider _____

Staff _____

Other arrangements for translating _____

TDD No. _____

Billing Information for Primary Office

(Check here: _____ if billing address is the same as the Primary Office Address listed on page 1)

Street: _____ City: _____ State: _____ Zip: _____

Suite/Bldg#: _____ Phone: _____ Fax: _____

Billing Manager: _____

Claims payable to: _____

Submit electronic claims? Yes: _____ No: _____

Electronic Mail Code: _____

Preferred Mailing Address

Please indicate contact person and address you would prefer to receive correspondence related to the status of this application:

Contact Person _____ Tel No. _____

Primary Office Site: _____

Primary Office Billing Address: _____

Other: _____

If other, please provide complete address:

Additional Office Sites

 Check here if there are no additional office sites

Photocopy this page and complete one sheet for each additional office associated with the applicant's practice.

Name of Practice: _____ Street Address: _____

Suite/Bldg#: _____ City: _____ State: _____ Zip: _____

County: _____ Phone: _____ Fax: _____

List Associates (If more space required, attach roster)

Specialties

Office Hours

Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

Saturday:

Sunday:

Office Manager's Name: _____

Handicap Access? Yes: _____ No: _____

List all languages (other than English) including sign, in which you are fluent.

Provider: _____

Staff: _____

Other arrangements for translating _____

TDD No. _____

Billing Information for Additional Office

(Check here: if billing address is the same as the address above)

Street: _____ City: _____ State: _____ Zip: _____

Suite/Bldg#: _____ Phone: _____ Fax: _____

Billing Manager: _____ Claims payable to: _____

Submit electronic claims? Yes: _____ No: _____ Electronic Mail Code: _____

Federal Tax ID of Group: _____

Cross Coverage Please list covering practitioners. If additional names and information, please attach.

Practitioner: _____	Practitioner: _____	Practitioner: _____
Address: _____ _____	Address: _____ _____	Address: _____ _____
Phone: _____	Phone: _____	Phone: _____
Specialty: _____	Specialty: _____	Specialty: _____
Hospital Affiliations: _____ _____	Hospital Affiliations: _____ _____	Hospital Affiliations: _____ _____
Office Patients: _____	Office Patients: _____	Office Patients: _____
Hospital Patients: _____	Hospital Patients: _____	Hospital Patients: _____

If you utilize practitioners in addition to those listed above for 24 hour, 7 day a week coverage, list them.

Practitioner (Attach roster, if more space required)

Phone Number with Area Code

Do you use physician extenders?

Yes: _____ No: _____

If yes, list names and license numbers.

Name: _____

Title/Degree: _____

License Number: _____

Name: _____

Title/Degree: _____

License Number: _____

Name: _____

Title/Degree: _____

License Number: _____

Name: _____

Title/Degree: _____

License Number: _____

IV. CONFIDENTIAL INFORMATION

IF YOU HAVE ANY YES ANSWERS TO ANY QUESTIONS IN THE SECTIONS BELOW AND THOSE ON PAGE 9, REFERENCE THE QUESTIONS ON A SEPARATE SHEET, GIVE FULL DETAILS AND ATTACH.

Have any of the following at any time been, or are they currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state?

Medical or professional license	Yes: _____	No: _____
DEA or CDS/BNDD registration	Yes: _____	No: _____
Hospital medical staff membership	Yes: _____	No: _____
Clinical privileges or other rights on any hospital medical staff	Yes: _____	No: _____
Employment by any hospital, institution, or the military	Yes: _____	No: _____
Professional society memberships	Yes: _____	No: _____
Participation in any private, federal, or state health insurance program (i.e., Medicare, CHAMPUS, Medicaid)	Yes: _____	No: _____
Participation in an HMO, PPO, or any other managed care organization	Yes: _____	No: _____
Board Certification	Yes: _____	No: _____

At any time, have you ever been:

Convicted of a criminal offense	Yes: _____	No: _____
Convicted of a felony	Yes: _____	No: _____
Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of trial, or an accelerated rehabilitation disposition in the disposition of felony charges in any state, territory or country	Yes: _____	No: _____

Have you ever at any time or are you currently:

Under indictment for any crime	Yes: _____	No: _____
The subject of an investigation by any private, federal or state health insurance program or state licensing board	Yes: _____	No: _____
Under investigation by any state licensing board or federal agency	Yes: _____	No: _____
The subject of any adverse action reports to a state or federal databank	Yes: _____	No: _____

Have you ever either voluntarily or involuntarily:

Withdrawn your application for medical staff membership at any facility	Yes:_____	No:_____
Withdrawn your request for any clinical privileges at any facility	Yes:_____	No:_____

Applicant's Signature: _____

Health Status

Are you able to perform the professional duties of the position with or without reasonable accommodation?	Yes:_____	No:_____
Are you currently using illegal substances or illegally using substances?	Yes:_____	No:_____

V. PROFESSIONAL LIABILITY CARRIER INFORMATION

Current Insurance Carrier: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Suite/Bldg #: _____ Date of Coverage: _____ Coverage expiration: _____

Coverage Amount _____ Policy Number: _____ Type of coverage: _____

Individual: _____ Procedures excluded from coverage: _____

Aggregate: _____

Previous Insurance Carrier(s) (For the last 5 years, if you have not been with your current carrier for 5 years.)

Previous Insurance Carrier: _____ Type of coverage: _____

Street Address: _____ Suite/Bldg#: _____ City: _____ State: _____

Policy Number: _____ Coverage: To: _____ From: _____

Procedures excluded from coverage: _____

Previous Insurance Carrier: _____ Type of coverage: _____

Street Address: _____ Suite/Bldg#: _____ City: _____ State: _____

Policy Number: _____ Coverage: To: _____ From: _____

Procedures excluded from coverage: _____

Applicant's Signature: _____

Professional Liability History

In the past 10 years, has your liability insurance ever been canceled or denied?	Yes:_____	No:_____
Do you have any malpractice judgments against you including arbitration in the last 10 years?	Yes:_____	No:_____
Have you had any claim settlements not involving litigation or arbitration paid by you or on your behalf in the last 10 years?	Yes:_____	No:_____
Are you now a defendant in a pending malpractice suit?	Yes:_____	No:_____

IF YOU ANSWER YES TO ANY OF THE QUESTIONS ABOVE, PROVIDE THE FOLLOWING INFORMATION FOR EACH CASE/SITUATION:

Date of occurrence of alleged malpractice:_____ Plaintiff name:_____

Name of the insurance carrier involved:_____

Status of the case: Your status is/was in this case: Primary Defendant:_____ CoDefendant:_____

Pending:_____

If pending, list carrier:_____

Found for plaintiff:_____

Found for defendant:_____

Dismissed / dropped:_____

Settled:_____

If settled, give the amount:_____

Professional relationship to patient:_____

Alleged harm to patient:_____

Circumstances of patient's illness:_____

Any other pertinent details:_____

Applicant's Signature:_____

REQUIRED COPIES

REFER TO INSTRUCTIONS FROM EACH MANAGED CARE ORGANIZATION FOR DOCUMENTS REQUIRED FOR CREDENTIALS THAT ARE IN ADDITION TO THE INFORMATION YOU ATTACH TO PROPERLY RESPOND TO QUESTIONS ON THIS APPLICATION