

Uniform Credentialing Application

Frequently Asked Questions

May 10, 2016

Managed Care Systems/Health Resources Development Service
1000 N.E. 10th Street, Room 1011
Oklahoma City, OK 73117
Ph. 405.271.6868



Health Resource
Development Service
Oklahoma State
Department of Health

1. *What is the Uniform Credentialing Application?*

The Uniform Credentialing Application was developed by the Oklahoma State Department of Health based on rules promulgated by the Oklahoma State Board of Health. The application form and the rules are required by Title 63 of the Oklahoma Statutes, Section 1-106.2, which reads as follows:

A. By January 1, 1999, the State Board of Health shall promulgate rules necessary to develop a uniform application which shall be used in the credentialing process of health care providers. The State Department of Health shall develop such application form for:

- 1. Initial privileges or membership in a hospital, managed care organization, or other entity requiring credentials verification; and*
- 2. Recredentialing or reappointment in a hospital, managed care organization, or other entity requiring credentials verification.*

B. Any entity requiring credentials verification may require supplemental information. [63 O.S. Section 1-106.2]

2. *Does this form apply only to physicians?*

No. This form is designed for use by all health care providers who request privileges or membership in an entity that requires credentials verification. The application is intended be used by health care providers to request privileges or membership in a hospital, managed care organization, or other entity requiring credentials verification.

3. *Where do I submit the completed form?*

This application may be submitted to hospitals, ambulatory surgery centers, managed care organizations, and other entities requiring credentials verification. **PLEASE DO NOT SEND THE APPLICATION TO THE OKLAHOMA STATE DEPARTMENT OF HEALTH.**

4. *Will I be asked to submit any additional information?*

Credentialing entities may require supplemental information. You may wish to contact the entity to which you plan to apply to determine whether supplemental information may be required.

5. *Does the form have to be filled out completely?*

We encourage applicants to fill out the application completely. Submitting incomplete forms to the credentialing entity may delay processing of the application. If you have questions about the applicability of certain items for an application or renewal with a credentialing

UNIFORM CREDENTIALING APPLICATION FREQUENTLY ASKED QUESTIONS

entity, you may wish to contact that entity. Filling out the application completely and updating it periodically enables the provider to submit just one form to multiple credentialing entities.

6. *What do I enter if an item is not applicable?*

If an item is not applicable, please state “NA”.

7. *May I hand-write my responses on the form?*

We recommend printing legibly or typing.

8. *Do I need to sign and date the application?*

Please sign and the date the application in the appropriate section.

9. *What if I run out of space?*

You may attach additional sheets as needed.

10. *Is a credentialing entity allowed to ask for more information than is requested on the uniform credentialing application?*

Yes. The law authorizes credentialing entities to require supplemental information.

11. *I am applying for recredentialing or reappointment with an entity that has previously approved me for privileges or membership. My information has not changed since I filed my last application with the entity. Am I required to complete and resubmit the entire form?*

The answer will vary depending on the entity to which you are applying. Some hospitals, managed care organizations, or other credentialing entities may require the entire form, while others may require only supplemental information. You should contact the entity to which you are applying to determine if they require resubmittal of the entire uniform credentialing application, only supplemental information, or some combination of the uniform application and supplemental information.

12. *Where can I obtain the form?*

Adobe Acrobat and Word versions of the form are available on the Oklahoma State Department of Health website at:

www.ok.gov/health/Protective_Health/Health_Resources_Development_Service/Uniform_Credentialing_Application/index.html

13. *What if I have other questions about the application?*

If you have questions pertaining to the standards or requirements of the credentialing entity, you should contact that entity. If you have questions about the law, rule, or the form you may contact the Managed Care Systems within the Health Resources Development Service of the Oklahoma State Department of Health by telephone at (405) 271-6868, or via email at this address: HealthResources@health.ok.gov



Health Resources
Development Service
Oklahoma State
Department of Health

Managed Care Systems
1000 NE 10th Street
Oklahoma City, OK 73117-1299
Phone 405.271.6868
<http://hrds.health.ok.gov>

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63 O.S. 2011, Section 1-106.2

This form must be completed in full and typed or printed legibly (i.e. do not state “see CV”), unless the credentialing entity to which you are applying advises you otherwise. Write “N/A” in areas that do not apply to you. All time must be accounted for since entry into medical or other professional school. If additional space is needed to complete information or explanations, use Section 14.

Name of facility/organization this application will be submitted to: _____

Date: _____

SUBMIT THIS FORM TO THE HOSPITAL, MANAGED CARE ORGANIZATION, OR OTHER ENTITY REQUIRING CREDENTIALS VERIFICATION.

The completed application may be submitted to hospitals, ambulatory surgery centers, managed care organizations, and other entities requiring credentials verification.

***PLEASE DO NOT SEND THE APPLICATION TO THE
OKLAHOMA STATE DEPARTMENT OF HEALTH***

Uniform Credentialing Application

SECTION 1: PERSONAL INFORMATION

Name _____			
Last	First	Middle	Suffix
Professional Degree _____		Gender: ___ Male ___ Female	
Other Name By Which You Have Been Known _____			
Dates This Name Was Used: From: ____ - ____ - ____ to ____ - ____ - ____			
Other Name By Which You Have Been Known _____			
Dates This Name Was Used: From: ____ - ____ - ____ to ____ - ____ - ____			
Social Security Number ____ - ____ - ____		NPID (formerly UPIN) _____	
Date of Birth: ____ - ____ - ____			
Place of Birth		Citizenship	
Visa Type	Visa Number (provide copy)	Expiration Date	
Your Personal Medicare Number		Your Personal Medicaid Number	

SECTION 2: DIRECTORY INFORMATION

Mailing Address For All Credentialing Correspondence: _____			
Street Address			
Suite Number	City	State	Zip Code
()	()	()	()
Phone Number	Fax Number	Emergency or Pager Number	
()			
Answering Service Number	E-Mail Address		
Contact Person For Credentialing Correspondence: _____			

This Section continues on next page.

Uniform Credentialing Application

SECTION 3: CURRENT PROFESSIONAL PRACTICE

Primary Specialty (or field of practice)	Subspecialty	% Of Time
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Secondary Specialty	Subspecialty	% Of Time
---------------------	--------------	-----------

Do you wish to be listed as:

Primary Care Provider Specialist Hospitalist On-Call Other (specify) _____

If you are a primary care physician, list special diagnostic or treatment procedures performed in your office(s):

Yes No Are you accepting new patients?

Yes No Are you willing, in the future to accept new patients?

Yes No Do you admit your own patients to hospitals?

If no, please explain how your patients will be admitted, which hospital and who will provide patient care.

Yes No Are you willing to accept current patients if they convert to the healthcare plan to which you are applying?

Yes No Are you a member of an Independent Practice Association or a Physician Hospital Association? If yes, complete the following:

Name: _____

Street Address	Suite Number
----------------	--------------

City	State	Zip Code
------	-------	----------

()	()	()
----------	----------	----------

Phone Number	Fax Number	Answering Service Number
--------------	------------	--------------------------

Name: _____

Street Address	Suite Number
----------------	--------------

City	State	Zip Code
------	-------	----------

()	()	()
----------	----------	----------

Phone Number	Fax Number	Answering Service Number
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List any restrictions on your practice (i.e. patient age and gender): _____

Uniform Credentialing Application

SECTION 4: EDUCATION

Medical/Dental/Graduate Professional Schools

List all, completed or not. Continue in Section 14 if needed.

(1) _____
Institution Degree Awarded

Mailing Address City State Zip Code

Telephone Number: (_____) _____

Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____

Graduation Date ____ - ____ - ____

(2) _____
Institution Degree Awarded

Mailing Address City State Zip Code

Telephone Number: (_____) _____

Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____

Graduation Date ____ - ____ - ____

(3) _____
Institution Degree Awarded

Mailing Address City State Zip Code

Telephone Number: (_____) _____

Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____

Graduation Date ____ - ____ - ____

Foreign Medical Graduates:

ECFMG # _____

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SECTION 5: TRAINING
Internship/Residency/Fellowship/Preceptorship/Other

List all, completed or not. If you require additional space, continue in Section 14, or attach a separate sheet.

(1) Type of Program:
 Internship Residency Fellowship Preceptorship Other (specify) _____

Was program successfully completed: Yes No

Specialty	Institution	Your Program Director		
()				
Address	City	State	Zip Code	Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____				

(2) Type of Program:
 Internship Residency Fellowship Preceptorship Other (specify) _____

Was program successfully completed? Yes No

Specialty	Institution	Your Program Director		
()				
Address	City	State	Zip Code	Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____				

(3) Type of Program:
 Internship Residency Fellowship Preceptorship Other (specify) _____

Was program successfully completed? Yes No

Specialty	Institution	Your Program Director		
()				
Address	City	State	Zip Code	Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____				

(4) Type of Program:
 Internship Residency Fellowship Preceptorship Other (specify) _____

Was program successfully completed? Yes No

Specialty	Institution	Your Program Director		
()				
Address	City	State	Zip Code	Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____				

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SECTION 6: ACADEMIC APPOINTMENTS

List all, past and present. If additional space is needed, copy this sheet or continue in Section 14.

(1) _____ ()
 Institution and Address City State Zip Code Phone Number

 From: ____ - ____ - ____ to ____ - ____ - ____
 Position/Rank Inclusive Dates (mo/day/year)

(2) _____ ()
 Institution and Address City State Zip Code Phone Number

 From: ____ - ____ - ____ to ____ - ____ - ____
 Position/Rank Inclusive Dates (mo/day/year)

(3) _____ ()
 Institution and Address City State Zip Code Phone Number

 From: ____ - ____ - ____ to ____ - ____ - ____
 Position/Rank Inclusive Dates (mo/day/year)

SECTION 7: HEALTH CARE AFFILIATIONS

List, in chronological order, all hospital/health system affiliations where you have ever been employed, practiced, associated, or privileged for the purpose of providing patient care. Do not list affiliations that were part of your training (Section 5). If additional space is required, copy this sheet or continue in Section 14.

Indicate which of these is your "current primary and secondary admitting facility" (where you currently spend the greatest portion of your time).

(1) _____ Primary ___ Secondary
 Facility Name
 _____ ()
 Complete Mailing Address City State Zip Code Telephone Number
 From: ____ - ____ - ____ to ____ - ____ - ____
 Dates of Appointment (mo/day/year) Staff Category

Reason for Discontinuance Department or Service

(2) _____ Primary ___ Secondary
 Facility Name
 _____ ()
 Complete Mailing Address City State Zip Code Telephone Number
 From: ____ - ____ - ____ to ____ - ____ - ____
 Dates of Appointment (mo/day/year) Staff Category

Reason for Discontinuance Department or Service

This section continues on next page.

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-Section 7 Continued-

(3) _____ Facility Name	___ Primary ___ Secondary
Complete Mailing Address	_____ () City State Zip Code Telephone Number
From: _____ - _____ - _____ to _____ - _____ - _____ Dates of Appointment (mo/day/year)	_____ Staff Category
Reason for Discontinuance	Department or Service

SECTION 8: OTHER PROFESSIONAL WORK HISTORY

List, chronologically, **all** professional work history (i.e. clinics, partnerships, solo/group practices, employment). Include secondary agencies or clinics such as public health and family planning where you perform duties. Account for all time gaps of thirty (30) days or more. If additional space is needed, copy this page or continue in Section 14.

(1)	Name and Nature of Affiliation
Mailing Address	_____ () City State Zip Code Telephone Number
From: _____ - _____ - _____ to _____ - _____ - _____ Dates of Affiliation (mo/day/year)	_____ Reason for Discontinuance
(2)	Name and Nature of Affiliation
Mailing Address	_____ () City State Zip Code Telephone Number
From: _____ - _____ - _____ to _____ - _____ - _____ Dates of Affiliation (mo/day/year)	_____ Reason for Discontinuance
(3)	Name and Nature of Affiliation
Mailing Address	_____ () City State Zip Code Telephone Number
From: _____ - _____ - _____ to _____ - _____ - _____ Dates of Affiliation (mo/day/year)	_____ Reason for Discontinuance

US Military/Public Health Service

List all medical and surgical locations and dates.

From: _____ - _____ - _____ to _____ - _____ - _____	
Location	Branch of Service
From: _____ - _____ - _____ to _____ - _____ - _____	
Location	Branch of Service

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-Section 10 Continued-

SUBSPECIALTY CERTIFICATION AND ADDED QUALIFICATIONS

Subspecialty or Added Qualification	Name of Board
_____ - _____ - _____	_____ - _____ - _____
Date Initially Certified	Date Most Recently Recertified
_____ - _____ - _____	_____ - _____ - _____
	Date Certification Expires
	_____ - _____ - _____

Subspecialty or Added Qualification	Name of Board
_____ - _____ - _____	_____ - _____ - _____
Date Initially Certified	Date Most Recently Recertified
_____ - _____ - _____	_____ - _____ - _____
	Date Certification Expires
	_____ - _____ - _____

BOARD QUALIFICATIONS

___ Yes ___ No If you are not certified, are you qualified to sit for the exam in a primary or subspecialty board or added qualification?
 ___ Yes ___ No Are you planning to take the exam?
 ___ Yes ___ No Are you scheduled to take the exam? If yes, attach confirmation letter.

Date Scheduled:

Oral _____ - _____ - _____
 Written _____ - _____ - _____
 Other _____ - _____ - _____

Subspecialty or Added Qualification	Name of Board
_____ - _____ - _____	_____ - _____ - _____
Date Qualified	Date Qualification Expires
_____ - _____ - _____	_____ - _____ - _____

Classifications:

___ Yes ___ No Are you certified in CPR?	Expires _____ - _____ - _____
___ Yes ___ No Basic Life Support (BLS)	Expires _____ - _____ - _____
___ Yes ___ No Advanced Cardiac Life Support (ACLS)	Expires _____ - _____ - _____
___ Yes ___ No Health Care Provider (CoreC)	Expires _____ - _____ - _____
___ Yes ___ No Advanced Trauma Life Support (ATLS)	Expires _____ - _____ - _____
___ Yes ___ No Neonatal Advanced Life Support (NALS)	Expires _____ - _____ - _____
___ Yes ___ No Pediatric Advanced Life Support (PALS)	Expires _____ - _____ - _____
___ Yes ___ No Other _____	Expires _____ - _____ - _____

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SECTION 11: OFFICE INFORMATION Primary Office

Group Name	Name As It Appears On Your W-9 (if applicable)	Business Owned By
Type of Practice:		
<input type="checkbox"/> Solo <input type="checkbox"/> Partnership <input type="checkbox"/> Single-Specialty Group <input type="checkbox"/> Multi-Specialty Group Other (specify) _____		

Office Manager	Nurse Coordinator
----------------	-------------------

Group Medicare Number	Group Medicaid Number	IRS Tax ID Number
-----------------------	-----------------------	-------------------

Does this office have lab service? Yes No Reference Lab? Yes No On Site? Yes No

CLIA ID # _____ CLIA Waiver # _____

Does your office have the following:

Yes No Radiology

Yes No EKG

Yes No Audiology

Yes No Treadmill

Yes No Sigmoidoscopy

Yes No Wheelchair/handicapped access?

Yes No Other services for the disabled?

If yes, please list: _____

Yes No Other: _____

List all independent licensed non-physicians working in this office.

<u>Name</u>	<u>Provider Type</u>	<u>License Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Fluent Languages:

You _____

Your Staff _____

Other Resources _____

Yes No Does this office meet all state and local fire, safety and sanitation requirements?

Yes No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	_____	_____	_____	_____	_____	_____	_____
To:	_____	_____	_____	_____	_____	_____	_____

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.

Note: These practitioners must be affiliated with the organization to which you are applying.

Name _____	Specialty _____	Telephone (____) _____
Name _____	Specialty _____	Telephone (____) _____
Name _____	Specialty _____	Telephone (____) _____
Name _____	Specialty _____	Telephone (____) _____

Yes No Do you or your business own, operate, manage or participate in any medical enterprise or business?
If yes, explain on a separate attachment.

Uniform Credentialing Application

**SECTION 11: OFFICE INFORMATION
Secondary Office**

Group Name _____ Name As It Appears On Your W-9 (if applicable) _____ Business Owned By _____
 Type of Practice:
 Solo Partnership Single-Specialty Group Multi-Specialty Group Other (specify) _____

Office Manager _____ Nurse Coordinator _____

Group Medicare Number _____ Group Medicaid Number _____ IRS Tax ID Number _____
 Does this office have lab service? Yes No Reference Lab? Yes No On Site? Yes No

CLIA ID # _____ CLIA Waiver # _____

Does your office have the following:
 Yes No Radiology
 Yes No EKG
 Yes No Audiology
 Yes No Treadmill
 Yes No Sigmoidoscopy
 Yes No Wheelchair/handicapped access?
 Yes No Other services for the disabled?

List all independent licensed non-physicians working in this office.

<u>Name</u>	<u>Provider Type</u>	<u>License Number</u>
-------------	----------------------	-----------------------

_____	_____	_____
_____	_____	_____
_____	_____	_____

Fluent Languages:

You _____

Your Staff _____

Other Resources _____

If yes, please list: _____
 Yes No Other: _____

Yes No Does this office meet all state and local fire, safety and sanitation requirements?

Yes No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	_____	_____	_____	_____	_____	_____	_____
To:	_____	_____	_____	_____	_____	_____	_____

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.

Note: These practitioners must be affiliated with the organization to which you are applying.

Name _____ Specialty _____ Telephone (____) _____

Yes No Do you or your business own, operate, manage or participate in any medical enterprise or business?
 If yes, explain on a separate attachment.

Uniform Credentialing Application

SECTION 12: COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following with this application. Practitioner should check off needed items that are being attached to this application.

<u>Attached</u>	<u>Item</u>
_____	Oklahoma Bureau of Narcotics and Dangerous Drugs Registration (BNDD)
_____	Current Federal DEA Registration Certificate
_____	Emergency Care Training Certificates (CPR, etc., if certified)
_____	Photo Identification
_____	Curriculum Vitae
_____	Tax Identification Information Form W-9

SECTION 13: ATTESTATION

All information and documentation contained in this application is true, correct and complete to my best knowledge and belief. I further acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for staff membership, privileges, or participation.

Name (printed) _____

Signature _____ Date _____

NOTE:
Practitioners are reminded that each organization will require submission of additional information.

SECTION 14: ADDITIONAL INFORMATION

This page is furnished for your convenience in completing questions or providing additional information. Please make as many copies of this page as you require to fully answer all questions.

As appropriate, note section number and question number that you are addressing.
