



# GEORGIA UNIFORM ALLIED HEALTHCARE PROFESSIONAL CREDENTIALING APPLICATION FORM

\*\*\*\*\*PART TWO\*\*\*\*\*

## GEORGIA ASSOCIATION OF HEALTH PLANS

<b>I. Personal Identification</b>		
Last Name (include suffix; Jr., Sr., III):	First:	Middle:
Are you eligible to work in the United States?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>II. Practice Location Information</b>		
Physician group name/practice name to appear in directory (if applicable):		
Group/Corporate name as it appears on W-9, if different from Physician group/practice name:		
<b>III. License and Other Identification Information</b>		
National Provider Identifier (NPI) when available:		
Are you a Participating Medicare Provider?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a Participating Medicaid Provider?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>IV. Professional/Medical Specialty Information - Primary Specialty:</b>		
Based on your contracted agreement do you wish to be listed in the directory under your primary specialty? <input type="checkbox"/> Yes <input type="checkbox"/> No	Specify: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS	
<b>V. Professional/Medical Specialty Information - Secondary Specialty:</b>		
Based on your contracted agreement do you wish to be listed in the directory under your secondary specialty? <input type="checkbox"/> Yes <input type="checkbox"/> No	Specify: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS	
<b>VI. Professional/Medical Specialty Information - Additional Specialty:</b>		
Based on your contracted agreement do you wish to be listed in the directory under an additional specialty? <input type="checkbox"/> Yes <input type="checkbox"/> No	Specify: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS	
Additional areas of professional/practice interest or focus:		
<b>VII. Hospital/Affiliations</b>		
Do you have hospital privileges?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Primary hospital where you have privileges:</b>		
Name:	Address:	
Contact:	Phone #: ( ) -	
Are privileges temporary?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Other hospital(s) where you have privileges: (Use additional sheets if necessary.)</b>		N/A <input type="checkbox"/>
Name:	Address:	
Contact:	Phone #: ( ) -	
Are privileges temporary?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>VIII. Work History</b>		
Are you currently on active military duty or on military reserve?		<input type="checkbox"/> Yes <input type="checkbox"/> No

**IX. Other Practice Information** *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address:	Type of service provided:	<input type="checkbox"/> primary care specialist
		<input type="checkbox"/> non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements:		
After hours, back office phone number for health plan business use only:		
Office business hours, hours that patients are seen:		
Evening or weekend hours:		
Do you want to list site in the directory?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you make 24-hour/7 day a week phone coverage available?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Indicate type of coverage arrangements.		
<b>BILLING INFORMATION:</b>		
E-mail for billing contact: @	Department name if hospital based:	
Who check should be payable to:	Billing representative's name:	
Practice limitations: (patient ages, sex)		
Availability of interpreters (specify languages):		
Do you provide handicap accessibility for each of the following areas:		
Building	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parking <input type="checkbox"/> Yes <input type="checkbox"/> No Restroom <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the site accessible by public transportation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your office qualify as a minority business enterprise?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you or someone in your office have the following additional certifications? (show expiration dates.)		
BLS (Basic Life Support)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration date: /
ACLS (Advanced Cardiac Life Support)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration date: /
ALSO (Advance Life Support in OB)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration date: /
PALS (Pediatriac Advanced Life Support) Classification	<input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration date: /
ATLS (Advanced Trauma Life Support) Certified	<input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration date: /
NALS (Neonatal Advanced Life Support)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration date: /
NRS (Neonatal Resuscitation Program) Classification	<input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration date: /
CPR classification	<input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration date: /
Other (Please list on an Explanation Form(s))		
<b>Additional office services provided:</b>		
Laboratory services provided	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flexible sigmoidoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No
Radiology Service	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tympanometry/audiometry screening <input type="checkbox"/> Yes <input type="checkbox"/> No
EKGs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Care of minor lacerations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteopathic manipulation <input type="checkbox"/> Yes <input type="checkbox"/> No
Pulmonary function	<input type="checkbox"/> Yes <input type="checkbox"/> No	IV hydration/treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy injections, allergy skin testing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac stress tests <input type="checkbox"/> Yes <input type="checkbox"/> No
Office gynecology (routine pelvic/pap)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical therapy <input type="checkbox"/> Yes <input type="checkbox"/> No
Drawing blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Additional office procedures provided <input type="checkbox"/> Yes <input type="checkbox"/> No
Age appropriate immunizations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgical procedures <input type="checkbox"/> Yes <input type="checkbox"/> No
Is anesthesia administered in your office?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what category of anesthesia do you use?
Specify the class or category:	Who administers it?	

**X. Required Attachments or Supplemental Information – Hard Copy or Scanned**

Copy of state controlled dangerous substance (CDS) certificate (if applicable).  
Copy(ies) of W-9 for verification of each tax identification number used.  
Copy of workers compensation certificate of coverage, if applicable.

Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, preceptorship, or other clinical education program?  Yes  No

**XI. Attestation and Signature – Part II** *By signing this application, I certify, agree, understand and acknowledge the following:*

1. The information in this entire application is complete, current, correct, and not misleading
2. Any misstatements or omissions (whether intentional or unintentional) on this application may constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement.
3. A photocopy of this application, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.
4. I have reviewed the information in this application on the most recent date indicated below and it continues to be true and complete.
5. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.
6. No action will be taken on this application until it is complete and all outstanding questions with respect to the application have been resolved.
7. This attestation statement and application must be signed no more than 180 days prior to the credentialing decision date..

**Signature:**

**Printed Name:**

**Date:**