GEORGIA UNIFORM ALLIED HEALTHCARE PROFESSIONAL CREDENTIALING APPLICATION FORM

**************PART TWO***************

GEORGIA ASSOCIATION OF HEALTH PLANS

I. Personal Identification

Last Name (include suffix; Jr., Sr., III):	First:	Middle:
Are you eligible to work in the United States?		☐ Yes ☐ No

II. Practice Location Information

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:

III. License and Other Identification Information

National Provider Identifier (NPI) when available.	
Are you a Participating Medicare Provider?	☐ Yes ☐ No
Are you a Participating Medicaid Provider?	☐ Yes ☐ No

IV. Professional/Medical Specialty Information - Primary Specialty:

Based on your contracted agreement do you wish to be listed in the directory under your primary specialty? ☐ Yes ☐ No	Specify: ☐ HMO ☐ PPO ☐ POS

V. Professional/Medical Specialty Information - Secondary Specialty:

Based on your contracted agreement do you wish to be listed in the directory under your secondary specialty? ☐ Yes ☐ No	Specify: ☐ HMO ☐ PPO ☐POS

VI. Professional/Medical Specialty Information - Additional Specialty:

Based on your contracted agreement do you wish to be listed in the directory under an additional specialty? ☐ Yes ☐ No	Specify: ☐HMO ☐ PPO ☐POS
Additional areas of professional/practice interest or focus:	

VII. Hospital/Affiliations

Do you have hospital privileges?	☐ Yes ☐ No
Primary hospital where you have privileges:	
Name:	Address:
Contact:	Phone #: ( ) -
Are privileges temporary?	☐ Yes ☐ No
Other hospital(s) where you have privileges: ***(Use additional sheets if necessary.)***	N/A ☐
Name:	Address:
Contact:	Phone #: ( ) -
Are privileges temporary?	☐ Yes ☐ No

VIII. Work History

Are you currently on active military duty or on military reserve?	☐ Yes ☐ 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: ☐ primary care specialist ☐ 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?	☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.	☐ Yes ☐ No
BILLING INFORMATION:	
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 ☐ Yes ☐ No	Parking ☐ Yes ☐ No	Restroom ☐ Yes ☐ No

Is the site accessible by public transportation? ☐ Yes ☐ No	If yes, indicate types of transportation.
Does your site provide childcare services? (for each site)	☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?	☐ Yes ☐ No
Does your office qualify as a minority business enterprise?	☐ Yes ☐ No

Do you or someone in your office have the following additional certifications? (show expiration dates.)

BLS (Basic Life Support)	☐ Yes ☐ No	Expiration date: /
ACLS (Advanced Cardiac Life Support)	☐ Yes ☐ No	Expiration date: /
ALSO (Advance Life Support in OB)	☐ Yes ☐ No	Expiration date: /
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☐ No	Expiration date: /
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☐ No	Expiration date: /
NALS (Neonatal Advanced Life Support)	☐ Yes ☐ No	Expiration date: /
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☐ No	Expiration date: /
CPR classification	☐ Yes ☐ No	Expiration date: /
Other (Please list on an Explanation Form(s))		

Additional office services provided:

Laboratory services provided	☐ Yes ☐ No	Flexible sigmoidoscopy	☐ Yes ☐ No
Radiology Service	☐ Yes ☐ No	Tympanometry/audiometry screening	☐ Yes ☐ No
EKGs	☐ Yes ☐ No	Asthma treatment	☐ Yes ☐ No
Care of minor lacerations	☐ Yes ☐ No	Osteopathic manipulation	☐ Yes ☐ No
Pulmonary function	☐ Yes ☐ No	IV hydration/treatment	☐ Yes ☐ No
Allergy injections, allergy skin testing	☐ Yes ☐ No	Cardiac stress tests	☐ Yes ☐ No
Office gynecology (routine pelvic/pap)	☐ Yes ☐ No	Physical therapy	☐ Yes ☐ No
Drawing blood	☐ Yes ☐ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☐ No	Surgical procedures	☐ Yes ☐ No
Is anesthesia administered in your office?	☐ Yes ☐ 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:**