

**Standardized  
Credentialing  
Form  
To Be Used  
By Health Maintenance Organizations  
Licensed in the State of Missouri**

REVISED VERSION EFFECTIVE FEBRUARY 2, 2001  
COMPLETE EACH SECTION AS THOROUGHLY AS POSSIBLE. PLEASE TYPE OR PRINT

**I. GENERAL INFORMATION**

1. \_\_\_\_\_  
Name (Last, First, MI, Degree/Prof. Designation  
M.D./D.O./Ph.D./O.D./M.S.W./D.C./D.P.M./D.D.S./D.M.D./A.P.N./P.A./Other)

2. \_\_\_\_\_  
Home Address/Street

3. \_\_\_\_\_  
City/State/ZIP

4. \_\_\_\_\_  
E-Mail Address

5. \_\_\_\_\_  
Other Names You May Have Used (i.e. Maiden, etc.)

6. \_\_\_\_\_  
Date of Birth (Month/Day/Year)

7. \_\_\_\_\_  
Place of Birth

8. \_\_\_\_\_  
Social Security Number

9. Are You a U.S. Citizen? Yes \_\_\_\_\_ No \_\_\_\_\_

10. Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

If Not a Citizen of the U.S., Indicate the Current Status of Your VISA:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Form Authorized by the Missouri Department of Insurance 1998  
DO NOT SUBMIT COMPLETED FORM TO THE DEPARTMENT OF INSURANCE

## II. OFFICE/PRACTICE INFORMATION

If More Than Two Offices, Check Here  and Attach a Copy of Page 3, Completing Questions 22 - 40 for Each Office.

1. Participation Status For Which You Are Applying: (Indicate Specialty)

Primary Care: \_\_\_\_\_ Specialty: \_\_\_\_\_ Subspecialty: \_\_\_\_\_ Patient Ages: \_\_\_\_\_

2. **PRIMARY OFFICE** ADDRESS/STREET/BUILDING/SUITE \_\_\_\_\_ From: \_\_\_\_\_  
(month/year)

3. City/State/ZIP \_\_\_\_\_

4. Tax ID # Owner/Corporate Name as Appears on SS4 or W-9 Form (or Full Legal Name) \_\_\_\_\_

5. Business Name or Name By Which the Provider Group is Generally Known \_\_\_\_\_

6. Office Phone Number \_\_\_\_\_ 7. After Hours/Emergency Number or Procedure \_\_\_\_\_

8. Office Fax Number \_\_\_\_\_ 9. Office E-Mail Address \_\_\_\_\_

10. Office Manager \_\_\_\_\_ 11. Federal Tax ID# \_\_\_\_\_

12. BILLING ADDRESS/STREET (If Different From Above) \_\_\_\_\_

13. Billing City/State/ZIP \_\_\_\_\_

14. List Routine Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday

15. Evening Hours: Yes  No  If Yes, List Hours After 5:00 P.M.

Monday	Tuesday	Wednesday	Thursday	Friday

16. Weekend Hours: Yes  No

Saturday	Sunday

17(a) Lab Service in Your Office:

Yes  No

17(b) \_\_\_\_\_  
If Yes, specify Waived, Physician Performed Microscopy,  
Moderately Complex, Highly Complex

18. Please check all of the following that you perform IN THIS OFFICE:

EKG  Office gynecology (Routine Pelvic/PAP)  Drawing Blood  Age appropriate immunizations   
X-Rays  Minor Surgery  Tympanometry/audiometry screening  Flexible sigmoidoscopy   
Laceration Repair  Pulmonary Function Studies  Asthma Treatment  Allergy Skin Testing   
Osteopathic manipulation  IV hydration/treatment  Other (please specify) \_\_\_\_\_

19. (a) Languages Spoken (other than English): \_\_\_\_\_

(b) Are Interpreters Available? Yes  No

Health Care Provider \_\_\_\_\_

Staff \_\_\_\_\_

20. Does Your Office: (CIRCLE ONE)

(a) Have 24-Hr. Phone Coverage Service?  Y  N (b) Qualify as a Minority Business Enterprise?  Y  N  
(c) Have Capability for Electronic Billing?  Y  N (d) Provide Child Care Services?  Y  N  
(e) Meet ADA Accessibility Standards?  Y  N (f) Have Public Transportation Accessibility?  Y  N  
(g) Collaborate With an Advanced Nurse Practitioner or Physician Assistant (P.A.)?  Y  N

If Yes, Provide a Copy of Appropriate Collaborative Practice or P.A. Agreement(s) & the Name(s) of the Individual(s).

(h) Type of Practice: Solo  Single Specialty Group  Multispecialty Group  Other

If Group Practice, Attach a List of Other Members of Your Practice, Their Specialties, and Coverage Arrangements.

21. Do You Currently: (CIRCLE ONE)

(a) Accept New Patients Into Practice?  Y  N (b) Accept New Patients By Physician Referral Only?  Y  N  
(c) Have Medicare Certification?  Y  N (d) Accept Medicare Assignment?  Y  N  
(e) Provide Inpatient Care?  Y  N (f) Accept Medicaid Assignment?  Y  N





### III A. PROFESSIONAL EDUCATION

List All Medical Schools/Institutions Attended.

Please Explain Any 30 Day or Greater Gap In Your Training. Attach Additional Sheets if Necessary.

1. \_\_\_\_\_  
Medical/Professional School Name
2. \_\_\_\_\_  
Address/Street
3. \_\_\_\_\_  
City/State/Zip/Country
4. From: \_\_\_\_\_ To: \_\_\_\_\_  
Dates Attended (month/year)
5. \_\_\_\_\_  
Degree(s) Awarded
6. If You Are a Graduate of a Foreign Medical School, Are You Certified by the Education Council for Foreign Medical Graduates (ECFMG)? If Yes, Please Enclose a Copy of Your Certificate With This Application.  
Yes \_\_\_\_\_ No \_\_\_\_\_

### III B. POSTGRADUATE TRAINING: INTERNSHIP

1. \_\_\_\_\_  
Institution Name
2. \_\_\_\_\_  
Address/Street
3. \_\_\_\_\_  
City/State/Zip
4. From: \_\_\_\_\_ To: \_\_\_\_\_  
Dates Attended (month/year)
5. \_\_\_\_\_  
Department Chair/Program Director
6. \_\_\_\_\_  
Type of Internship (Rotating/Straight) - If Straight, Please List Specialty.

### III C. POSTGRADUATE TRAINING: FIRST RESIDENCY

1. \_\_\_\_\_  
Institution Name
2. \_\_\_\_\_  
Address/Street
3. \_\_\_\_\_  
City/State/Zip
4. From: \_\_\_\_\_ To: \_\_\_\_\_  
Dates Attended (month/year)
5. \_\_\_\_\_  
Department Chair/Program Director
6. \_\_\_\_\_  
Type of Residency

### III D. POSTGRADUATE TRAINING: SECOND RESIDENCY or FELLOWSHIP

1. \_\_\_\_\_  
Institution Name
2. \_\_\_\_\_  
Address/Street
3. \_\_\_\_\_  
City/State/Zip
4. From: \_\_\_\_\_ To: \_\_\_\_\_  
Dates Attended (month/year)
5. \_\_\_\_\_  
Department Chair/Program Director
6. \_\_\_\_\_  
Type of Residency/Fellowship



**III E. POSTGRADUATE TRAINING: FELLOWSHIP/OTHER**

1. \_\_\_\_\_  
Institution Name

2. \_\_\_\_\_  
Address/Street

3. \_\_\_\_\_  
City/State/Zip

4. From: \_\_\_\_\_ To: \_\_\_\_\_  
Dates Attended (month/year)

5. \_\_\_\_\_  
Department Chair/Program Director

6. \_\_\_\_\_  
Type of Fellowship/Other Explanation

**IV A. HOSPITAL AFFILIATIONS: PRIMARY**

1. \_\_\_\_\_  
**CURRENT PRIMARY HOSPITAL NAME**

2. \_\_\_\_\_  
Address/Street

3. \_\_\_\_\_  
City/State/Zip

4. \_\_\_\_\_  
Status of Privileges (INDICATE BY USING KEY)

5. From: \_\_\_\_\_ To: \_\_\_\_\_  
Dates Affiliated (month/year)

1 Active	4 Associate	7 Courtesy	10 Senior Staff	13 Consulting
2 Courtesy Provisional Staff	5 Visiting	8 Admitting	11 Provisional	14 Pending
3 Active Provisional Staff	6 Temporary	9 CO-Admitting	12 Suspended	15 Other: _____

If CO-Admitting Status, List Other Admitting Physician(s) \_\_\_\_\_

6. Any Past or Present Restriction of Privileges? Yes \_\_\_\_\_ No \_\_\_\_\_ (IF YES, EXPLAIN)

**IV B. HOSPITAL AFFILIATIONS: OTHER**

List All Other Hospitals At Which You Have Or Have Had Privileges.

Attach Additional Pages If Necessary.

1a. \_\_\_\_\_  
HOSPITAL NAME

2a. \_\_\_\_\_  
Address/Street

3a. \_\_\_\_\_  
City/State/Zip

4a. \_\_\_\_\_  
Status of Privileges (INDICATE BY USING KEY)

5a. From: \_\_\_\_\_ To: \_\_\_\_\_  
Dates Affiliated (month/year)

If CO-Admitting Status, List Other Admitting Physician(s) \_\_\_\_\_

6a. Any Past or Present Restriction of Privileges? Yes \_\_\_\_\_ No \_\_\_\_\_ (IF YES, EXPLAIN)

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1b. \_\_\_\_\_  
HOSPITAL NAME

2b. \_\_\_\_\_  
Address/Street

3b. \_\_\_\_\_  
City/State/Zip

4b. \_\_\_\_\_  
Status of Privileges (INDICATE BY USING KEY)

5b. From: \_\_\_\_\_ To: \_\_\_\_\_  
Dates Affiliated (month/year)

If CO-Admitting Status, List Other Admitting Physician(s) \_\_\_\_\_

6b. Any Past or Present Restriction of Privileges? Yes \_\_\_\_\_ No \_\_\_\_\_ (IF YES, EXPLAIN)



**IV B. HOSPITAL AFFILIATIONS: OTHER (CONT'D)**

1c. \_\_\_\_\_  
HOSPITAL NAME

2c. \_\_\_\_\_  
Address/Street

3c. \_\_\_\_\_  
City/State/Zip

4c. \_\_\_\_\_ 5c. From: \_\_\_\_\_ To: \_\_\_\_\_  
Status of Privileges (INDICATE BY USING KEY, Dates Affiliated (month/year)  
If CO-Admitting Status, List Other Admitting Physician(s)

6c. Any Past or Present Restriction of Privileges? Yes \_\_\_\_\_ No \_\_\_\_\_ (IF YES, EXPLAIN)

\_\_\_\_\_

**IV C. OTHER PRACTICE AFFILIATIONS (e.g. HMOs, PPOs, IPAs, PHOs, etc.)**

Attach Additional Pages If Necessary

1a. \_\_\_\_\_  
Institution/Organization Name

2a. \_\_\_\_\_  
Address/Street

3a. \_\_\_\_\_  
City/State/Zip

4a. \_\_\_\_\_ 5a. From: \_\_\_\_\_ To: \_\_\_\_\_  
Type of Affiliation Dates Affiliated (month/year)

1b. \_\_\_\_\_  
Institution/Organization Name

2b. \_\_\_\_\_  
Address/Street

3b. \_\_\_\_\_  
City/State/Zip

4b. \_\_\_\_\_ 5b. From: \_\_\_\_\_ To: \_\_\_\_\_  
Type of Affiliation Dates Affiliated (month/year)

1c. \_\_\_\_\_  
Institution/Organization Name

2c. \_\_\_\_\_  
Address/Street

3c. \_\_\_\_\_  
City/State/Zip

4c. \_\_\_\_\_ 5c. From: \_\_\_\_\_ To: \_\_\_\_\_  
Type of Affiliation Dates Affiliated (month/year)

1d. \_\_\_\_\_  
Institution/Organization Name

2d. \_\_\_\_\_  
Address/Street

3d. \_\_\_\_\_  
City/State/Zip

4d. \_\_\_\_\_ 5d. From: \_\_\_\_\_ To: \_\_\_\_\_  
Type of Affiliation Dates Affiliated (month/year)

1e. \_\_\_\_\_  
Institution/Organization Name

2e. \_\_\_\_\_  
Address/Street

3e. \_\_\_\_\_  
City/State/Zip

4e. \_\_\_\_\_ 5e. From: \_\_\_\_\_ To: \_\_\_\_\_  
Type of Affiliation Dates Affiliated (month/year)



## V. PRACTICE SPECIALTY

Attach Copy of Certificate(s). If Not Applicable to Your Profession/Specialty, Complete With N/A.

1. _____ <b>PRIMARY SPECIALTY / BOARD CERTIFICATION</b>	2. _____ Certification Number
3. _____ Name of Board	4. _____ Date of Certification
5. _____ Expiration Date	6. _____ Date of Recertification (If Applicable)
7. _____ If Not Certified, Indicate Current Status and/or Date Intending to Sit For Boards.	
8. _____ <b>SECONDARY SPECIALTY / BOARD CERTIFICATION</b>	9. _____ Certification Number
10. _____ Name of Board	11. _____ Date of Certification
12. _____ Expiration Date	13. _____ Date of Recertification (If Applicable)
14. _____ If Not Certified, Indicate Current Status and/or Date Intending to Sit For Boards.	

## VI. WORK /PRACTICE HISTORY

List Chronologically All Employment, Including Self Employment, For the Last Ten (10) Years. For Any Gap in Chronology, Explain On a Separate Sheet. Leave No Time Period Unaccounted For Within the Last Ten Years, Excluding Previously Stated Training. Attach Additional Sheets If Necessary.

1a. _____ <b>NAME of PREVIOUS PRACTICE</b>	
2a. _____ Address/Street	
3a. _____ City/State/Zip	4a. _____ Phone Number
5a. _____ Title or Professional Occupation	6a. From: _____ To _____ Dates of Employment (month/year)

1b. _____ <b>NAME of PREVIOUS PRACTICE</b>	
2b. _____ Address/Street	
3b. _____ City/State/Zip	4b. _____ Phone Number
5b. _____ Title or Professional Occupation	6b. From: _____ To _____ Dates of Employment (month/year)

1c. _____ <b>NAME of PREVIOUS PRACTICE</b>	
2c. _____ Address/Street	
3c. _____ City/State/Zip	4c. _____ Phone Number
5c. _____ Title or Professional Occupation	6c. From: _____ To _____ Dates of Employment (month/year)

1d. _____ <b>NAME of PREVIOUS PRACTICE</b>	
2d. _____ Address/Street	
3d. _____ City/State/Zip	4d. _____ Phone Number
5d. _____ Title or Professional Occupation	6d. From: _____ To _____ Dates of Employment (month/year)



## VII. PROFESSIONAL CERTIFICATES / LICENSE NUMBERS

List All States In Which You Have Held, or Currently Hold a License to Practice Your Profession. Please Attach Copies.

1. _____ License/Certification/Registration Number; Licensing State	2. _____ Expiration Date
3. _____ Other License/Certification/Registration Number; Licensing State	4. _____ Expiration Date
5. _____ Other License/Certification/Registration Number; Licensing State	6. _____ Expiration Date
7. _____ Federal Drug Enforcement Agency (DEA) Number(s)	8. _____ Expiration Date(s)
9. _____ CDS Certification Number (BNDD Number for Missouri)	10. _____ Expiration Date
11. _____ Medicare/Unique Provide ID Number (UPIN)	12. _____ National Provider ID Number (NPI)
13. _____ State Medicaid Number(s); Licensing State(s)	14. _____ ECFMG Number

## VIII. PROFESSIONAL LIABILITY INSURANCE INFORMATION

Please Attach a Copy of Your Current Certificate(s) or Declaration(s) of Insurance, Including HCSF for Kansas Practitioners.

1a. \_\_\_\_\_  
**CURRENT CARRIER NAME**

2a. \_\_\_\_\_  
Address/Street

3a. \_\_\_\_\_  
City/State/Zip

4a. \_\_\_\_\_  
Phone Number

5a. \_\_\_\_\_  
Policy Number

6a. From: \_\_\_\_\_ To \_\_\_\_\_  
Dates of Coverage (month/year)

7. Indicate Coverage Type: Claims Based \_\_\_\_\_ Occurrence Based \_\_\_\_\_

8. Policy Limits: Per Occurrence \$ \_\_\_\_\_ Aggregate \$ \_\_\_\_\_

Prior Carriers Within the Last Ten (10) Years. Attach Additional Sheets if Necessary.

1b. \_\_\_\_\_  
**PREVIOUS CARRIER NAME**

2b. \_\_\_\_\_  
Address/Street

3b. \_\_\_\_\_  
City/State/Zip

4b. \_\_\_\_\_  
Phone Number

5b. \_\_\_\_\_  
Policy Number

6b. From: \_\_\_\_\_ To \_\_\_\_\_  
Dates of Coverage (month/year)

1c. \_\_\_\_\_  
**PREVIOUS CARRIER NAME**

2c. \_\_\_\_\_  
Address/Street

3c. \_\_\_\_\_  
City/State/Zip

4c. \_\_\_\_\_  
Phone Number

5c. \_\_\_\_\_  
Policy Number

6c. From: \_\_\_\_\_ To \_\_\_\_\_  
Dates of Coverage (month/year)

1d. \_\_\_\_\_  
**PREVIOUS CARRIER NAME**

2d. \_\_\_\_\_  
Address/Street

3d. \_\_\_\_\_  
City/State/Zip

4d. \_\_\_\_\_  
Phone Number

5d. \_\_\_\_\_  
Policy Number

6d. From: \_\_\_\_\_ To \_\_\_\_\_  
Dates of Coverage (month/year)



**IX. MALPRACTICE CLAIMS HISTORY**

**\*A SIGNATURE IS REQUIRED AT THE BOTTOM OF THIS PAGE, EVEN IF THERE IS NO HISTORY TO REPORT**

Are you currently or have you within the last ten (10) years been involved in a malpractice suit or other suit or claim in which your care and treatment of a patient was at issue, including pending or dismissed cases or claims settled before or during trial, or settled to avoid a lawsuit? Yes \_\_\_ No \_\_\_

If yes, answer the following questions for EACH such claim. Duplicate this page as necessary.

- 1. \_\_\_\_\_ 2. \_\_\_\_\_  
Patient Name Plaintiff Name, If Other Than Patient
- 3. \_\_\_\_\_ 4. \_\_\_\_\_  
Your Involvement in the Case (Attending, Consulting, Etc.) Date of Occurrence (month/day/year)
- 5. \_\_\_\_\_ 6. \_\_\_\_\_  
Your Status in the Case Date Claim Was Filed (month/day/year)  
(Primary Defendant, Co-Defendant, Other)
- 7. \_\_\_\_\_  
Professional Liability Insurance Carrier Involved
- 8. \_\_\_\_\_ 9. \_\_\_\_\_  
Carrier's Phone Number Policy Number
- 10. \_\_\_\_\_  
Additional Defendants
- 11. Describe the Allegations Against You:  
\_\_\_\_\_  
\_\_\_\_\_
- 12. Describe the Alleged Injury to the Patient:  
\_\_\_\_\_  
\_\_\_\_\_
- 13. Claimant/Plaintiff Filed Suit in Court? Yes \_\_\_ No \_\_\_
- 14. \_\_\_\_\_ 15. \_\_\_\_\_ 16. \_\_\_\_\_  
State Court Case Number State County/Parish
- 17. \_\_\_\_\_ 18. \_\_\_\_\_  
Federal Court (US District Court) Case Number District
- 19. Present Status of Claim: Open \_\_\_ Closed \_\_\_ Pending \_\_\_

**If PENDING, DO NOT Complete the Rest of This Page Except For Signature and Date.**

- 20. If Closed, Indicate the Method of Resolution:
 

Dismissed _____	Date: _____
Settled (With Prejudice) _____	Date: _____
Settled (Without Prejudice) _____	Date: _____
Judgment for Defendant(s) _____	Date: _____
Judgment for Plaintiff(s) _____	Date: _____
Other _____	Date: _____
- 21. Settlement Amount Paid On Your Behalf (If Any) \_\_\_\_\_
- 22. Additional Information/Explanation:  
(e.g. Patient condition and diagnosis at time of incident, description of treatment, subsequent patient outcome, etc.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_

Date (month/day/year) \_\_\_\_\_

**IF YOU HAVE NO HISTORY TO REPORT, PLEASE INDICATE THAT AND SIGN.**



## X. ADDITIONAL INFORMATION

Please Answer the Following Questions By Circling "Y" (Yes), "N" (No), or "N/A" (Not Applicable).

Please Provide an Explanation For Any "Yes" Responses on a Separate Page.

1. Have any of your board certifications ever been suspended, revoked, not renewed, denied renewal, voluntarily or involuntarily surrendered?	Y	N	N/A
2. Have you ever been named as a defendant in any criminal case?	Y	N	N/A
3. Have you ever been convicted, pled guilty, or pled nolo contendere to any felony, any offense reasonably related to your qualifications, functions, or duties as a medical professional, or any offense an essential element of which is fraud, dishonesty, or an act of violence?	Y	N	N/A
4. Has your malpractice insurance ever been canceled, suspended, not renewed, special rated, or restricted by the exclusion of any specific procedures from coverage?	Y	N	N/A
5. Have you ever been denied participation, suspended from, or denied renewal from the Medicare or Medicaid program, or had participation status modified?	Y	N	N/A
6. Has your authority to practice in any state been suspended, revoked, voluntarily or involuntarily surrendered, been subject to a consent or stipulation order, not renewed, denied renewal, or has probation ever been invoked?	Y	N	N/A
7. Has your federal or state controlled substance license ever been suspended, revoked, voluntarily or involuntarily surrendered, restricted, not renewed, denied renewal, or has probation ever been invoked?	Y	N	N/A
8. Have your privileges at any hospital or other health care setting ever been suspended, revoked, voluntarily or involuntarily surrendered, reduced, restricted, not renewed, denied renewal, or has probation ever been invoked?	Y	N	N/A
9. Within the last five years, have you ever been a participating provider of another HMO, PPO, PHO, or MSO, etc. with which you are not affiliated at this time?	Y	N	N/A
10. Have you ever received sanctions from a regulatory agency (e.g., CLIA, OSHA, etc.)?	Y	N	N/A
11. Has any information on you ever been reported to the National Practitioner Data Bank?	Y	N	N/A
12. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application. Rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)	Y	N	N/A
13. Within the last five years, have you ever been reprimanded or disciplined in any manner by any state licensing authority or other professional board or peer review committee for conduct related to the use of alcohol or the use of any drug?	Y	N	N/A
14. Have you discontinued practice for any reason (other than for routine vacation) for one month (30 days) or more?	Y	N	N/A



## X. ADDITIONAL INFORMATION (continued)

15. Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital ambulatory surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies? Y      N      N/A
- If so, please provide the following information, attaching additional copies as necessary.

(a) _____ Organization Name	(b) _____ Type of Organization
_____	
Address/Street	
_____	
City/State/Zip	
(e) _____ Phone Number	(f) _____ Federal Tax ID#
(g) _____ Percent of Business Owned/Invested by Applicant	(h) _____ Nature of Business Interest (owner, partner, investor)

## XI. ADDITIONAL DOCUMENTATION / ATTACHMENTS

### Please Attach Copies of the Following Documents (If Applicable):

1. W9 Form For Each Entity the Applicant Expects Will Receive Payments or Reimbursements.
2. Collaborative Practice and/or Physician Assistant Verification of Supervision Agreement(s).
3. A List of Other Members of Your Practice, Their Specialties, and Coverage Arrangements.
4. Education Council for Foreign Medical Graduates (ECFMG) Certificate.
5. Board Certification Certificate(s).
6. Copies of Professional Diplomas, Internship, Residency, and Fellowship Certificates, As Applicable.
7. Current State Licenses (For All States Practicing).
8. Federal DEA Certificate.
9. State Controlled Substance Certificate(s) For All States Practicing (i.e. BNDD for Missouri).
10. Current Certificate(s) or Declaration(s) of Insurance, Including HCSF for Kansas Practitioners.
11. Curriculum Vitae (If Required By Health Carrier)
12. Professional References (If Required By Health Carrier)
13. Signed Copy of an Affirmation and Release of Information Document (Attestation Page) As Stipulated By the Health Carrier to Which the Applicant is Seeking to Become a Participating Provider.
14. Attach a copy of all postgraduate (CME) activities which you have attended and for which you have received credit in the past 2 years.
15. Include a list of societies of which you are currently a member.
16. Include copies of United States Military discharge papers/DD214 if discharged from U.S. Military, or status if currently serving.
17. Include a copy of certificate showing CLIA waiver number and identification number.
18. Provide a statement regarding the reasons for any inability to perform the essential functions, with or without accommodations, for the practice in which you are seeking to become a participating provider.

