Standardized

Credentialing

Form

To Be Used

By Health Maintenance Organizations

Licensed in the State of Missouri

REVISED VERSION EFFECTIVE FEBRUARY 2, 2OO1

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. ______________________________ From: ______________

PRIMARY OFFICE ADDRESS/STREET/BUILDING/SUITE (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. ______________________________ 7. ______________________________

Office Phone Number / After Hours/Emergency Number or Procedure

8. ______________________________ 9. ______________________________

Office Fax Number / Office E-Mail Address

10. ______________________________ 11. ______________________________

Office Manager / 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**

II. OFFICE/PRACTICE INFORMATION (cont'd)

Attach Additional Copies As Necessary.

22. ______________________________
SECONDARY OFFICE ADDRESS/STREET/BUILDING/SUITE

23. ______________________________
City/State/ZIP

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

25. ______________________________
Business Name or Name By Which the Provider Group is Generally Known

26. ______________________________
Office Phone Number

27. ______________________________
After Hours/Emergency Number or Procedure

28. ______________________________
Office Fax Number

29. ______________________________
Office E-Mail Address

30. ______________________________
Office Manager

31. ______________________________
Federal Tax ID#

32. ______________________________
BILLING ADDRESS/STREET (If Different From Above)

33. ______________________________
Billing City/State/ZIP

34. List Routine Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday

35. Evening Hours: Yes_____ No_____ If Yes, List Hours After 5:00 P.M

Monday	Tuesday	Wednesday	Thursday	Friday

36. Weekend Hours: Yes_____ No_____

Saturday	Sunday

37.(a) Lab Service in Your Office:
Yes_______ No_______

37.(b) ______________________________
If Yes, specify Waived, Physician Performed Microscopy, Moderately Complex, Highly Complex

38. 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) ______________________________

39. (a) Languages Spoken (other than English):

____
Health Care Provider

(b) Are Interpreters Available? Yes_____ No_____

____
Staff

40. 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.

41. 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: ______________________________ 5. ______________________________
   Dates Attended (month/year) 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: ______________________________ 5. ______________________________
   Dates Attended (month/year) 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: ______________________________ 5. ______________________________
   Dates Attended (month/year) 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: ______________________________ 5. ______________________________
   Dates Attended (month/year) 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: ____________________ 5. ____________________
Dates Attended (month/year) 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. ____________________ 5. From: To: ____________________
Status of Privileges *(INDICATE BY USING KEY)* Dates Affiliated (month/year)

Status of Privileges Key

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. ____________________ 5a. From: To: ____________________
Status of Privileges *(INDICATE BY USING KEY)* 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)*
____

1b. ____________________
HOSPITAL NAME
2b. ____________________
Address/Street
3b. ____________________
City/State/Zip
4b. ____________________ 5b. From: To: ____________________
Status of Privileges *(INDICATE BY USING KEY)* 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. ______________________ **PRIMARY SPECIALTY / BOARD CERTIFICATION**
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. ______________________ **SECONDARY SPECIALTY / BOARD CERTIFICATION**
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. ______________________ **NAME of PREVIOUS PRACTICE**

2a. ______________________ Address/Street

3a. ______________________ City/State/Zip

4a. ______________________ Phone Number

5a. ______________________ Title or Professional Occupation

6a. From: __________ To __________ Dates of Employment (month/year)

1b. ______________________ **NAME of PREVIOUS PRACTICE**

2b. ______________________ Address/Street

3b. ______________________ City/State/Zip

4b. ______________________ Phone Number

5b. ______________________ Title or Professional Occupation

6b. From: __________ To __________ Dates of Employment (month/year)

1c. ______________________ **NAME of PREVIOUS PRACTICE**

2c. ______________________ Address/Street

3c. ______________________ City/State/Zip

4c. ______________________ Phone Number

5c. ______________________ Title or Professional Occupation

6c. From: __________ To __________ Dates of Employment (month/year)

1d. ______________________ **NAME of PREVIOUS PRACTICE**

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. ______________________ Patient Name
2. ______________________ Plaintiff Name, If Other Than Patient
3. ______________________ Your Involvement in the Case (Attending, Consulting, Etc.)
4. ______________________ Date of Occurrence (month/day/year)
5. ______________________ Your Status in the Case (Primary Defendant, Co-Defendant, Other)
6. ______________________ Date Claim Was Filed (month/day/year)
7. ______________________ Professional Liability Insurance Carrier Involved
8. ______________________ Carrier's Phone Number
9. ______________________ 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. ______________________ State Court Case Number
15. ________ State
16. ______________________ County/Parish
17. ______________________ Federal Court (US District Court) Case Number
18. ______________________ 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.

	Question			
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

(c) ______________________ Address/Street

(d) ______________________ 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.

State of Missouri
M D I
Department of Insurance

REVISED VERSION EFFECTIVE FEBRUARY 2, 2OO1