

## CREENTIALING REQUEST FORM

Please fax completed form along with a current CV or resume to: 215-573-6465. The Office of Provider Relations will contact you. If you have questions, please feel free to contact us at 215-746-7906.

DATE:

NAME:

LICENSE TYPE:

PRACTICE ADDRESS:

MAILING ADDRESS:  
(if different)

TELEPHONE NUMBER:

FAX NUMBER:

EMAIL ADDRESS:

# CREDENTIALING REQUEST FORM

NAME:

## SPECIALTY AREAS

**Ages:**

- Child (0 – 12)
- Adolescent (13 – 18)
- Adult (19 – 60)
- Older Adult (60 +)
- Medicare Approved

- Anxiety
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder
- Domestic Violence
- Behavioral Therapy
- Bereavement
- Physical Pain/Stress Disorder
- Physical Disability
- Infertility
- Employee Assistance Program

**LOC Specialties:**

- Psychopharmacology
- Individual Psychotherapy
- Group Psychotherapy
- Family Psychotherapy
- Couples/Marital Psychotherapy
- Emergent Care
- Urgent Care

**Languages (in addition to English):**

- Sign -Deaf
- Spanish
- French
- Italian
- German
- Hebrew
- Russian
- Arabic
- Other: \_\_\_\_\_

**Special Areas of Interest:**

- Cognitive Behavioral Health
- Diagnosis/Treatment of Chemical Abuse/Dependency
- Diagnosis/Treatment of Eating Disorders
- Attention Deficit Disorder
- Hypertension Disorder
- Sexuality
- Dissociative Disorder

*For Office Use Only*

Provider Rates:

CPT Code	<input style="width: 95%; height: 20px;" type="text"/>	Rate:	<input style="width: 95%; height: 20px;" type="text"/>
CPT Code	<input style="width: 95%; height: 20px;" type="text"/>	Rate:	<input style="width: 95%; height: 20px;" type="text"/>
CPT Code	<input style="width: 95%; height: 20px;" type="text"/>	Rate:	<input style="width: 95%; height: 20px;" type="text"/>
CPT Code	<input style="width: 95%; height: 20px;" type="text"/>	Rate:	<input style="width: 95%; height: 20px;" type="text"/>

Credentialing Application Mailed:  Received: