

## Credentialing Application

### I. DEMOGRAPHIC INFORMATION

Name: \_\_\_\_\_  
(Last) (First) (Degree) (Title)

Home Address: \_\_\_\_\_ Email: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Tel #: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Birthplace: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Ethnicity (Optional): \_\_\_\_\_  Male  Female

Individual or Group Practice Name: \_\_\_\_\_

Primary Office Address: \_\_\_\_\_  
(Street) (Suite #)

\_\_\_\_\_  
(City) (State) (Zip)  
( ) ( )  
(Office Phone) (Office Fax) (Email)

Accessibility/Accommodation :  Handicap Accessible  Evening Hours  Saturday Hours

Individual or Group Practice Name: \_\_\_\_\_

Secondary Office Address: \_\_\_\_\_  
(Street) (Suite #)

\_\_\_\_\_  
(City) (State) (Zip)  
( ) ( )  
(Office Phone) (Office Fax) (Email)

Accessibility/Accommodation :  Handicap Accessible  Evening Hours  Saturday Hours

NPI Provider Number: \_\_\_\_\_ Aetna Provider Number \_\_\_\_\_

#### CREDENTIALLED AND ACCEPTING INSURANCE:

COMPANY	YES	NO	COMPANY	YES	NO	COMPANY	YES	NO
Aetna	<input type="checkbox"/>	<input type="checkbox"/>	Tri-State Health & Welfare	<input type="checkbox"/>	<input type="checkbox"/>	Magellan	<input type="checkbox"/>	<input type="checkbox"/>
CIGNA	<input type="checkbox"/>	<input type="checkbox"/>	Carpenters Health & Welfare	<input type="checkbox"/>	<input type="checkbox"/>	Humana	<input type="checkbox"/>	<input type="checkbox"/>
Keystone Health Plan East	<input type="checkbox"/>	<input type="checkbox"/>	American Behavioral	<input type="checkbox"/>	<input type="checkbox"/>	Carebridge	<input type="checkbox"/>	<input type="checkbox"/>
BC/BS Personal Choice	<input type="checkbox"/>	<input type="checkbox"/>	Preferential Care Network	<input type="checkbox"/>	<input type="checkbox"/>	Ullicare	<input type="checkbox"/>	<input type="checkbox"/>
United Behavioral Health	<input type="checkbox"/>	<input type="checkbox"/>	Total Care Network	<input type="checkbox"/>	<input type="checkbox"/>	UBH/Americhoice	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify): \_\_\_\_\_

Other BC/BS (please specify): \_\_\_\_\_

## Languages Spoken (in addition to English):

Spanish  French  German  Italian  Russian  Arabic  Other: \_\_\_\_\_

## II. LICENSING, REGISTRATION AND CERTIFICATION(S)

[Please complete all which apply, use additional sheets if necessary]

License Type \_\_\_\_\_  
License # \_\_\_\_\_  
State: \_\_\_\_\_  
Date of Issue: \_\_\_\_\_  
License Renewal Date: \_\_\_\_\_

Certification Type \_\_\_\_\_  
Certification # \_\_\_\_\_  
State of Certification: \_\_\_\_\_  
Date of Certification: \_\_\_\_\_  
Certification Renewal Date: \_\_\_\_\_

License Type \_\_\_\_\_  
License # \_\_\_\_\_  
State: \_\_\_\_\_  
Date of Issue: \_\_\_\_\_  
License Renewal Date: \_\_\_\_\_

Certification Type \_\_\_\_\_  
Certification # \_\_\_\_\_  
State of Certification: \_\_\_\_\_  
Date of Certification: \_\_\_\_\_  
Certification Renewal Date: \_\_\_\_\_

## III. QUALIFYING INFORMATION

Have you ever been denied **initial** or **renewal** coverage by any professional liability insurance carrier? If yes, please explain on a separate sheet of papers

Yes  No

Have you had any malpractice judgments against you, made any settlements or have any cases pending against you at this time? If **yes**, please provide detailed information of all judgments, settlements and cases on a separate sheet of paper including the state, court and jurisdiction of any claims.

Yes  No

Have any of the following ever been or are any of the following currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, voluntarily relinquished, or have you ever withdrawn or failed to proceed with an application for any of the following?

LICENSE IN ANY STATE	Yes _____	No _____
OTHER HEALTH SERVICES RELATED PROFESSIONAL LICENSE	Yes _____	No _____
CERTIFICATION, REGISTRATION (I.E. DEA)	Yes _____	No _____
ACADEMIC APPOINTMENT	Yes _____	No _____
OTHER CLINICAL PRIVILEGES, INSTITUTIONAL AFFILIATIONS OR STATUS	Yes _____	No _____
SPECIALTY OR SUBSPECIALTY BOARD CERTIFICATION OF ADMISSIBILITY	Yes _____	No _____
PROFESSIONAL SOCIETY MEMBERSHIP OR FELLOWSHIP CERTIFICATION	Yes _____	No _____
ANY OTHER TYPE OF PROFESSIONAL SANCTION	Yes _____	No _____
MEDICARE, MEDICAID OR OTHER THIRD PARTY PAYERS	Yes _____	No _____
HAVE YOU EVER BEEN CONVICTED OF OR PLEADED NO CONTEST TO A FELONY, DRUG OR ALCOHOL RELATED OFFENSE?	Yes _____	No _____
HAVE ANY CRIMINAL CHARGES EVER BEEN BROUGHT AGAINST YOU (EXCLUDING MINOR MOTOR VEHICLE VIOLATIONS)?	Yes _____	No _____

## IV. EDUCATIONAL BACKGROUND

Highest Degree Earned in your discipline: \_\_\_\_\_ College/University: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Years Attended: From: \_\_\_\_\_ To: \_\_\_\_\_ Date of Graduation: \_\_\_\_\_

Name while attending school (if different): \_\_\_\_\_

**V. HOSPITAL AFFILIATION (MD's/DO's Only)** (List chronologically, all present and previous hospital affiliations)

Hospital Name	Address	City	State	Zip	Dates: From	To	Y or N Admitting Privileges
							Y or N Admitting Privileges

**VI. PROFESSIONAL WORK EXPERIENCE**

List Chronologically, All Present and Previous Professional Clinical Work Experience. Please do not say "see resume" [Use additional sheets if necessary]

1. **Dates:** From \_\_\_\_\_ To \_\_\_\_\_

Name of Institution/Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Your Title: \_\_\_\_\_  Full Time  Part Time

Department: \_\_\_\_\_ Name of Immediate Supervisor: \_\_\_\_\_

Briefly Describe the Nature of your Work/Duties: \_\_\_\_\_

\_\_\_\_\_

2. **Dates:** From \_\_\_\_\_ To \_\_\_\_\_

Name of Institution/Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Your Title: \_\_\_\_\_  Full Time  Part Time

Department: \_\_\_\_\_ Name of Immediate Supervisor: \_\_\_\_\_

Briefly Describe the Nature of your Work/Duties: \_\_\_\_\_

\_\_\_\_\_

3. **Dates:** From \_\_\_\_\_ To \_\_\_\_\_

Name of Institution/Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Your Title: \_\_\_\_\_  Full Time  Part Time

Department: \_\_\_\_\_ Name of Immediate Supervisor: \_\_\_\_\_

Briefly Describe the Nature of your Work/Duties: \_\_\_\_\_

\_\_\_\_\_

**VII. PROFESSIONAL LIABILITY INSURANCE INFORMATION**

Enclose a copy of your current policy declaration page. List the name of your current malpractice carrier and the names of all malpractice insurance carriers for the past five years.

Name of Insurance Carrier: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Has your professional liability insurance coverage ever been terminated by action of the insurance company? Yes  No

Have you ever been denied professional liability coverage? Yes  No

Has your professional liability carrier excluded any specific procedures from your coverage? Yes  No

**VIII. CLINICAL EXPERIENCE AND PRIVILEGING**

Based on your description of your formal education, training and professional experiences provided in this application, for which of the following Age Populations and Psychotherapeutic Modalities are you requesting clinical privileges? A mandatory child abuse clearance is required if age population is 0-12. This also includes Family Psychotherapy.

- |                            |  |
|----------------------------|--|
| _____ Child (0 - 12)       | _____ Psychopharmacology (Physicians Only) |
| _____ Adolescent (13 - 18) | _____ Couple Marital Psychotherapy         |
| _____ Adult (19 – 65)      | _____ Group Psychotherapy                  |
| _____ Geriatric (65+)      | _____ Family Psychotherapy                 |
|                            | _____ Individual Psychotherapy             |

**Areas of Clinical Interest(s) or specialties with appropriate documentation as necessary**

Based on your description of your formal education, training and professional experiences provided in this application, for which of the following **CLINICAL INTEREST(s)** are you requesting privileges? You understand that you are bound by applicable policies by the state and each respective specialty, that you meet the threshold criteria for each clinical interest(s) requested.

- |  |           |          |
|--|-----------|----------|
| Employee Assistance Program                                    | Yes _____ | No _____ |
| Diagnosis and Treatment of Chemical Abuse/Dependency Disorders | Yes _____ | No _____ |
| Diagnosis and Treatment of Eating Disorders                    | Yes _____ | No _____ |
| Attention Deficit Disorder                                     | Yes _____ | No _____ |
| Obsessive Compulsive Disorder                                  | Yes _____ | No _____ |
| Sexuality  | Yes _____ | No _____ |
| Gay/Lesbians   | Yes _____ | No _____ |
| Dissociative Disorder  | Yes _____ | No _____ |
| Anxiety  | Yes _____ | No _____ |
| Post Traumatic Stress Disorder                                 | Yes _____ | No _____ |
| Domestic Violence  | Yes _____ | No _____ |
| Behavioral Therapy   | Yes _____ | No _____ |
| Bereavement  | Yes _____ | No _____ |
| Physical Pain/Stress Disorder                                  | Yes _____ | No _____ |
| Depression   | Yes _____ | No _____ |
| Marital/Relationship Issues                                    | Yes _____ | No _____ |
| Panic Disorder   | Yes _____ | No _____ |
| Phobias  | Yes _____ | No _____ |

**IX. LETTER OF REFERENCE**

Please request one peer reference (form attached), who have worked with you and directly observed your professional performance. This reference may not be from an individual personally related to applicant.

Name: \_\_\_\_\_ Degree: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**X. CERTIFICATION, CONDITIONS AND RELEASE**

By applying for appointment as a PENN Behavioral Health Network Provider, I hereby:

1. acknowledge that I, as an applicant for provider membership in PBH, need to produce adequate information for a proper evaluation of my professional, ethical and other qualifications, for membership and for resolving any doubts about such qualifications;
2. acknowledge adherence to Federal and State regulations and laws that pertain to the maintenance of confidential information/records. Pledge to not discuss participants outside of PBH. Pledge to not divulge or release confidential information or records concerning any participant without proper authorization in accordance with PBH policies and Federal and State law. Should I disclose confidential information without the proper authorization, I understand that I will be terminated from the Provider network and that I may be subject to other remediation.
3. pledge to maintain an ethical practice and to provide for continuous care for my patients.
4. authorize PBH, its Medical Director and their representatives to consult with prior and current associates and others who may have information bearing on my professional competence, character, health status as it relates directly to the performance of my contracted duties, ethical qualifications, ability to work cooperatively with others, and other qualifications to become, and continue to be, a Participating Provider in the PBH Network;
5. consent to inspection by PBH, its Medical Director and their representatives of all documents that may be material to an evaluation of my qualifications and competence and consent to the release of such information. I hereby release from liability PBHS, its officers, directors, employees and agents for their acts performed and statements made, in good faith and without malice, in connection with evaluating my application, my credentials and qualifications. In addition, I hereby release from liability, any and all individuals and organizations who provide information to PBH, its Medical Director and their representatives, in good faith and without malice, concerning my professional competence, background, education and training, experience, ethics, character, utilization practice patterns, health status and other qualifications to be a Participating provider in PBH. I am aware that the release from liability is an express condition to my application for and acceptance of membership in PBH, and for continuation as a Participating Provider in PBH.
6. acknowledge that my credentials, including but not limited to professional licensure [including current status and history], professional liability insurance [including current coverage and history], educational degrees and certifications, continuing education credits, and employment history are subject to primary source verification;
7. signify my willingness, if necessary, to appear for interviews in regard to my application;
8. signify my willingness to permit and cooperate with on-site physical inspection of my clinical practice office location(s) and record keeping practices;
9. acknowledge that any false or misleading representations or omissions from this application may disqualify me from further consideration and may result in termination of privileges if discovered subsequent to acceptance;
10. recognize that I may be notified of any information obtained during the credentialing process that significantly varies from information I have provided and that I am permitted to then submit corrected information to PBHS and to request reconsideration of such information;
11. recognize that the application process is a continuous process, that PBH will credential and continuously recredential me, and that the authorizations, acknowledgments, consents, pledges and releases provided in this application will remain in effect for one (1) year for purposes of credentialing and recredentialing or until revoked by me in writing;
12. recognize that the submission of this application is not an assurance of acceptance to PBH and, if I am not accepted, it is not a reflection on the quality of my professional practice.
13. affirm that I will have completed the minimum amount of CEU/CME required by the State Licensing Board and PBH for my license. I also agree that PBH may audit these records at random upon written request. Non-compliance with a requested audit will deem my provider status as resigned.

I hereby certify that the information provided on this application is true and complete to the best of my knowledge and belief.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_