



# APPLICATION and DOCUMENTATION CHECKLIST

For your convenience use the checklist below to prepare your Re-credentialing Application for return. To ensure timely processing, please enclose the required documents listed below in addition to your completed application.

## Checklist:

- Completed and signed Re-Credentialing Application and Attestation**
- Current Professional Liability Face sheet (**must indicate practitioner's name as the insured, policy period and coverage amounts**)
- Current State License/Certification
- Current DEA Certificate (if applicable)
- Current State Controlled Dangerous Substances (CDS) Registration **OR** Rx # (if applicable)
- Current Curriculum Vitae
- Proof of Board Certification

## RE-CREDENTIALING APPLICATION

**ALL HIGHLIGHTED AREAS IN THE APPLICATION MUST BE COMPLETED**

### A. PROVIDER INFORMATION - DEMOGRAPHICS:

Last Name		First Name		Middle Initial	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address Line 1		Mailing Address Line 2		NPI Number	
City	County	State	Zip	Phone FAX	Mail email Preferred Contact Method (Circle One)
Telephone (include area code)	FAX (include area code)	Degree		Highest Level of Licensure	
Social Security Number <b>(REQUIRED)</b>	Tax Identification Number <b>(REQUIRED)</b>	Date of Birth <b>(REQUIRED)</b>	Place of Birth (City, State, Country) <b>(REQUIRED)</b>		
Medicaid Number <b>(REQUIRED)</b>	MEDICARE Number <b>(REQUIRED)</b>	OFFICE Contact Name:	Office Contact Number:		
Indicate any other name you may have used in the past (e.g., maiden name, etc.)			Internet E-mail address (if applicable)		

**LICENSED DISCIPLINE:** Indicate the discipline under which you are LICENSED and/or CERTIFIED at the highest level to practice independently.

- Psychiatrist
- Child Psychiatrist
- Psychologist
- Social Worker
- Registered Nurse or Nurse Practitioner
- Advanced Practice Nurse w/ prescriptive auth.

- CAC, CADS, NCAC, etc.
- Licensed Professional Counselor/Mental Health Counselor
- Marriage & Family Therapist/Marriage Family & Child Counselor
- Pastoral Counselor
- Other (specify): \_\_\_\_\_



## PRIMARY PRACTICE INFORMATION

If Multiple Service Locations enter other location(s) below under "Other Practice Locations".

Practice Name					
Practice Address Line 1 (street address required for referral purposes)			Practice Address Line 2		
City	County	State	Zip	Appointment Telephone (include area code)	
Office Manager (if applicable)			Fax Number		

**Make checks payable to (must match tax ID owner name on file with IRS for the TIN provided)**

Billing Address Line 1			Billing Address Line 2		
City	County	State	Zip	Telephone (include area code)	
Tax Identification Number (TIN) <i>Must submit a substitute W-9 form for each tax ID used</i>			Your Medicare/UPIN Number	Your Medicaid Number	

**Hours of Operation (actual practice hours each day at this location, e.g., 8:00am to 4:30pm):**

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
From	To	From	To	From	To	From	To	From	To	From	To

Is this office handicapped accessible?  Yes  No

Is this office accessible to public transportation?  Yes  No

### Other Practice Location(s)

(If you have **more than two** practice locations **copy this page before completing**)

Practice Name					
Practice Address Line 1 (street address required for referral purposes)			Practice Address Line 2		
City	County	State	Zip	Appointment Telephone (include area code)	
Office Manager (if applicable)			Fax Number		

**Make checks payable to (must match tax ID owner name on file with IRS for the TIN listed below)**

Billing Address Line 1			Billing Address Line 2			
City		County	State	Zip	Telephone (include area code)	
Tax Identification Number (TIN) <i>Must submit a substitute W-9 form for each tax ID used</i>				Your Medicare/UPIN Number		Your Medicaid Number

**Hours of Operation** (actual practice hours each day at this location, e.g., **8:00am to 4:30pm**):

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
From	To	From	To	From	To	From	To	From	To	From	To

Is this office handicapped accessible?  Yes  No      Is this office accessible to public transportation?  Yes  No

**Answering Service:** Indicate how you can be reached after hours.

Answering Service Name	Phone #:
Pager or Beeper #	Voice Mail #

**BILLING INFORMATION:**

1. Does your office have electronic billing capacity?  Yes  No

If yes, check one or more of the following:

- Software Vendor      List software: \_\_\_\_\_
- Claims Clearinghouses      List vendor: \_\_\_\_\_
- Billing Service      List vendor: \_\_\_\_\_

2. I will be signing my own claim forms.  Yes  No

3. I belong to an incorporated group/professional association.  Yes  No  
 If yes, my affiliation with incorporated group/professional association began on \_\_\_\_\_ (date).

**C. REFERRAL INFORMATION – NOTE % of Practice should equal 100%**

Identify the percentage of your practice dedicated to the following patient population categories (must total 100%):

Population	% of Practice	Are You Currently Accepting New Patients?	Modality	% of Practice
Young Child (0-5) (YC)		<input type="checkbox"/> Yes <input type="checkbox"/> No	Inpatient	
Child (6-12) (CI)		<input type="checkbox"/> Yes <input type="checkbox"/> No	Day Treatment	
Adolescent (13-17) (AO)		<input type="checkbox"/> Yes <input type="checkbox"/> No	Outpatient	
Adult (18-64) (AU)		<input type="checkbox"/> Yes <input type="checkbox"/> No	Intensive Outpatient Programs	
Geriatric (65+) (GT)		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Identify any language(s) or sign language that you use fluently in treating patients

**CLINICAL EXPERTISE (SPECIALTIES):**



Enclose a copy of your current policy certificate and/or declarations page indicating you as the covered clinician, and showing the coverage limits and dates of coverage.



**ALSO, "LIST BELOW" your current malpractice carrier. Please DO NOT mark "See Policy".**

Current Carrier (Name and Certificate Number)	Dates of Coverage	Coverage Limits



**Has the same carrier covered you for the past five (5) years?**  Yes  No If NO, see below.

If you have not been covered by the same carrier for the past 5 years, list below the name and complete address of any other malpractice carrier who has provided coverage for you for the most recent five (5) year period.

**If there has been more than one carrier, please indicate the dates of coverage with each carrier, and the reason for changing carriers.**

Carrier (Name and Complete Address)	Dates of Coverage	Reason for Changing Carriers



**MALPRACTICE CLAIMS:** Please provide information on pending and/or settled malpractice claims. A separate sheet maybe included if necessary.

If NO CLAIMS, mark NA and advance to Section I.  **NA**

**\*\*Check here if NA.**

Be as specific as possible with regard to procedures, names, dates, and actions. Explanations provided on pending and/or settled malpractice claims must include the minimum information requested below (you may use the space below, or include a separate sheet if necessary).

Patient's name:		Date of occurrence (mm/dd/yy):	
Insurance company defending your claim:			
Hospital name:			
Hospital address:			
Procedures performed:			
Co-defendants:			
Court trial? <input type="checkbox"/> Yes <input type="checkbox"/> No	Settlement out of court? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of settlement (mm/dd/yy):	
Allegations:			
Claim settled for no payment on your behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No		Claim is pending? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Amount in reserve by insurance company:		Total amount paid to claimant on your behalf:	
Total amount paid to claimant for all defendants:			



**E. PROVIDER PROFILE: Please answer ALL provider profile questions.**

**NOTE: If "YES" is checked, please explain fully on a separate sheet. If NA, mark NA.**

**Each box must be addressed.**

**Documentation is required if you have malpractice claims pending or settled in the past five (5) years (include any settlements/adjudications, original complaint and final disposition).**

**The documentation must be from an attorney or the entity that issued the judgment.**

1. <b>Health Status:</b> Do you have any physical, mental, or emotional condition, including but not limited to any history of drug or alcohol abuse, which currently impairs your ability to render the professional services which are the subject of this application? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to safely and competently render the professional services which are the subject of this application.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. <b>Insurance Coverage:</b> Has your professional liability insurance coverage ever been denied, canceled, or non-renewed or initially refused upon application?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. <b>License:</b> Has your medical or professional license in any state ever been revoked, suspended, placed on probation, conditional status, or limited?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Have you ever voluntarily surrendered your license?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Are formal charges pending against you at this time? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. <b>DEA:</b> Has your DEA Registration Certificate ever been suspended, revoked, subjected to probation, placed on conditional status, or limited?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
5. <b>Hospital Privileges:</b> Has any hospital ever dismissed you from its staff?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
a. Has any hospital ever revoked, suspended, or limited your privileges?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
b. Has any hospital initiated either type of the aforementioned action by formal notice to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
c. Has any hospital refused or denied you privileges?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
d. Have you ever voluntarily surrendered your hospital privileges?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
6. <b>Hospital Sanctions:</b> Have you ever surrendered your clinical privileges upon threat of censure, restriction, suspension or revocation of such privileges?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
7. <b>Professional Membership(s):</b> Has your membership in any professional society or association ever been canceled, revoked, or censured?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. <b>Medicare/Medicaid/TRICARE:</b> Have you ever been fined, had an arrangement suspended, been expelled from participation or had criminal charges brought against you by any Medicare, Medicaid or TRICARE program?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. <b>Criminal Offenses:</b> Have you ever been arrested, charged with or convicted of a felony or involved in charges relating to moral or ethical turpitude, including crimes with children?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Have you ever been named as a defendant in any criminal proceeding?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. <b>Board Discipline:</b> Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board; county, state or national professional society; hospital medical or clinical staff)?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. <b>Malpractice Action:</b> Has any malpractice action against you been brought or settled in the past 5 years or has there been any unfavorable judgment (s) against you in a malpractice action?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. To your knowledge, is any malpractice action against you currently pending?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Please give a number of malpractice claims pending and closed: <b>CHECK "0" if NO CLAIMS</b> <input type="checkbox"/> None (0) <input type="checkbox"/> One (1) <input type="checkbox"/> Two (2) <input type="checkbox"/> More than 2 (please give number:_____)	<b>Please check one box – do not leave blank.</b>
c. Have you ever been a defendant in any lawsuit involving your practice where there has been an award or payment of \$50,000 or more?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Have you had any malpractice claims where there has been an award or payment of \$50,000 or more?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No

# PROVIDER ATTESTATION STATEMENT

## *Signature and Date Required*

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I understand that this application does not entitle me to participation in the Advantage Behavioral Health Network

I release Advantage Behavioral Health(Advantage), its representatives, and any individuals or entities providing information to Advantage from liability for any act or omission related to the evaluation or verification contained in this application provided Advantage, its representatives and individuals providing information to Advantage act in good faith and without malice. I further agree to notify Advantage of any change to the information provided in this application within 30 days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by Advantage.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify Advantage immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation, limitation, restriction or nonrenewal of my license to practice in any state; (ii) any suspension, revocation, limitation, restriction or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation, limitation, restriction or nonrenewal of my professional liability insurance coverage.

I further agree to notify Advantage in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the applicable State Regulation and Licensing or the applicable State Medical Examining Board taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a report with the applicable State Regulation and Licensing or the applicable State Medical Examining Board, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, restriction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I authorize Advantage Behavioral Health and its agents and any individual or entity providing information to Advantage to investigate and evaluate my provider application, and consult with any person, organization, or entity that has, or could have any information, data, or documents regarding my background, competence, and credentials.

Date (mm/dd/yy) \_\_\_\_\_

\_\_\_\_\_  
Provider Signature (Sign in script/cursive)

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Degree

### RETURN COMPLETED APPLICATION TO:

Advantage Behavioral Health  
1101 Sixth Avenue North  
Nashville, TN 37208

Or

Fax to: 615-460-4107

Or

E-mail to: [kathy.campbell@advantagebehavioral.org](mailto:kathy.campbell@advantagebehavioral.org)