# CAQH Form for NEW Providers

*Below is a list of information that we will need to complete your initial application. If you already have a CAQH ID or are unsure if you do, please contact us first to make sure your initial application has not already been completed. Should have any questions or concerns please contact us at CAQH@drcred.com.*

**ATTACHMENTS NEEDED**

- DEA Certificate
- CDS (Controlled and Dangerous Substances Certificate) – if applicable
- State Medical License(s)
- Malpractice Insurance Face Sheet (if available)
- CV- If applicable (see above introduction)
- Signature on the Attestation Page – Once your application is complete we will send a review and attestation page for your signature.

## Part I- General Information

| **PERSONAL INFORMATION** | | |
|---|---|---|
| \ | Full Name | |
| | Home Address | |
| | Home Phone | |
| | Provider Type | |
| | Gender | |
| | DOB | |
| | SS# | |
| | State of Birth | |
| | State Practicing | |
| | Other Names Used | |
| | Email Address | |
| | Fax | |
| | Preferred Method of Contact | ☐ Email ☐ Fax |
| | Languages Spoken | English |
| | Which insurance plans would you like to participate with: | ☐ HMO ☐ PPO ☐POS |
| **LICENSES AND CERTIFICATES - (Please provide all Certificates and we will gather information for the application)** | | |
| | DEA | |
| | State License (all states which you hold a license) | Are you currently practicing (if not start date) |
| | CDS-Controlled & Dangerous Substances Certificate | |
| | Participating Medicare Provider | ☐ YES # ☐ NO |
| | Participating Medicaid Provider | ☐ YES # ☐ NO |
| | NPI # | |
| | Workers Compensation # | |
| | USMLE # | |
| | ECFMG # | |
| **SPECIALITIES AND BOARD CERTIFICATION** | | |
| | Specialty | |
| | Name of Certifying Board | |
| | Date of Certification | |
| | Date of Re-Certification (if applicable) | |
| | Expiration Date (if applicable) | |
| | If you are not certified | Date you plan on sitting for the exam |

| | | Why you don't plan to sit for the exam |
|---|---|---|
| | | |

| EDUCATION AND TRAINING | | |
|---|---|---|
| **Medical School** | | |
| | Address | |
| | Start Date (MM/YYYY) | |
| | End Date (MM/YYYY) | |
| | Degree Earned | |
| | Did you complete training here | |
| | Phone | |
| | Fax | |
| **Graduate Type** | | ☐ US/Canadian ☐ Non US/ Canadian<br>☐Fifth Pathway Graduate |

# Part II- Residency, Post Graduate Training, & Practice Information

| **Internships and Residencies** | | | |
|---|---|---|---|
| | Address | | |
| | Start Date (MM/YYYY) | | |
| | End Date (MM/YYYY) | | |
| | Did you complete training here | ☐ yes | ☐ no |
| | Specialty | | |
| | Phone | | |
| | Fax | | |
| | Directors Name | | |
| **Fellowships** | | | |
| | Address | | |
| | Start Date (MM/YYYY) | | |
| | End Date (MM/YYYY) | | |
| | Did you complete training here | ☐ yes | ☐ no |
| | Specialty | | |
| | Phone | | |
| | Fax | | |
| | Directors Name | | |

| PRACTICE INFORMATION | | |
|---|---|---|
| | Practice Name | |
| | Are you currently practicing here (if not what is your anticipated start date) | |
| | Can general correspondence be sent here | |
| | Address | |
| | Phone | |
| | Fax | |
| **Billing Manager** | | |
| | Name | |
| | Address | |
| | Phone | |
| | Email | |
| | Do you have electronic billing capabilities | |
| | Checks should be made out to | |
| | Tax ID | |

| | | |
|---|---|---|
| **Office Manager** | | |
| | Name | |
| | Address | |
| | Phone | |
| | Email | |
| **Credentialing Contact** | | |
| | Name | |
| | Phone | |
| | Email | |
| **Other Practice Questions** | | |
| | Services Provided | |
| | Practice Interest | |
| | Limitations | ☐ none<br>☐ age limitation<br>☐ gender limitation |
| | Days and Hours of Operation | |
| | 24/7 phone coverage | ☐ yes ☐ no<br>☐ Answering Service<br>☐ Voice Mail with instructions to call service<br>☐ Voice Mail with other instructions |
| | Partners in Practice | |
| | Covering Colleagues | |
| | Mid Level Practitioners | |
| | Do you accept New Patients | ☐ yes ☐ no – please explain |
| | Do you accept existing patients with change of payor | ☐ yes ☐ no – please explain |
| | Do you accept new patients with referral | ☐ yes ☐ no – please explain |
| | Languages spoken by office personnel | |
| | Interpreters available | ☐ yes – please list available languages ☐ no |
| | Do you meet ADA Requirements | ☐ yes ☐ no |
| | Handicapped Access for | ☐ Building<br>☐ Restroom<br>☐ Parking<br>☐ Other |
| | Other Services | ☐ TTY Text Telephone<br>☐ American Sign Language<br>☐ Mental/Physical Impairment<br>☐ Other |
| | Accessible by Public Transportation | ☐ Bus<br>☐ Subway<br>☐ Regional Train<br>☐ Other |
| | Services Provided | ☐ Lab (certifying program CLIA, COLA, etc)<br>☐ Radiology Services (certification type)<br>☐ EKG<br>☐ Allergy Injections<br>☐ Allergy Skin Testing<br>☐ Routine Office GYN (pelvic/pap)<br>☐ Drawing Blood<br>☐ Age Appropriate Immunizations<br>☐ Flexible Sigmoidoscopy<br>☐ Tympanometry/Audiometry Screening<br>☐ Asthma Treatment<br>☐ Osteopathic Manipulation |

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|---|---|---|
| | | ☐ IV Hydration Treatment<br>☐ Cardiac Stress Test<br>☐ Pulmonary Function Test<br>☐ Physical Therapy<br>☐ Care of Minor Laceration<br>☐ Is Anesthesia Administered<br>(class/category<br>(who administers anesthesia)<br>☐ Other Office Procedures (i.e. surgical) |
| | Type of Practice | ☐ Solo<br>☐ Single Specialty<br>☐ Multi-Specialty |
| **HOSPITAL AFFILIATIONS (list all hospitals)** | | |
| | Name | |
| | Address | |
| | Phone | |
| | Type of Privileges | ☐ Full<br>☐ Unrestricted<br>☐ Provisional<br>☐ Temporary<br>☐ If you don't have privileges who admits your patients |
| | Date of Privileges | |
| | Affiliation Start Date | |
| | Affiliation End Date and Reason | |
| | Fax | |
| | Department Director | |
| | % of Admissions | |

| | | |
|---|---|---|
| **MALPRACTICE INSURANCE** | | |
| | Carrier Name (please note if self insured) | |
| | Address | |
| | Phone | |
| | Fax | |
| | Policy Number | |
| | Original Effective Date MM/YYYY | |
| | Effective Date MM/YYYY | |
| | Expiration Date MM/YYYY | |
| | Type of Coverage | ☐ individual<br>☐ shared |
| | Do you have unlimited coverage | ☐ yes ☐ no |
| | Amount per occurrence | |
| | Amount per aggregate | |
| | Does this include tail coverage | ☐ yes ☐ no |
| **WORK HISTORIES (past 10 years)** | | |
| | Name | |
| | Address | |
| | Start Date MM/YYYY | |
| | End Date MM/YYYY (reason for Departure) | |
| | Phone | |
| | Fax | |
| | If you have any gaps in work histories please explain | |

| Professional References | | |
|---|---|---|
| **REFERENCE – 1** | | |
| | Name | |
| | Address | |
| | Phone | |
| **REFERENCE – 2** | | |
| | Name | |
| | Address | |
| | Phone | |
| **REFERENCE – 3** | | |
| | Name | |
| | Address | |
| | Phone | |

## Part III- Certification of Information

| | | |
|---|---|---|
| 1. | Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? | ☐ yes<br>☐ no |
| 2. | Has there been any challenge to your licensure, registration or certification? | ☐ yes<br>☐ no |
| 3. | Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? | ☐ yes<br>☐ no |
| 4. | Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? | ☐ yes<br>☐ no |
| 5. | Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? | ☐ yes<br>☐ no |
| 6. | Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? | ☐ yes<br>☐ no |
| 7. | Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? | ☐ yes<br>☐ no |
| 8. | Have any of your board certifications or eligibility ever been revoked? | ☐ yes<br>☐ no |
| 9. | Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? | ☐ yes<br>☐ no |
| 10. | Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished? | ☐ yes<br>☐ no |
| 11. | Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs? | ☐ yes<br>☐ no |
| 12. | Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other | ☐ yes<br>☐ no |

| | | |
|---|---|---|
| | private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? | |
| 13. | To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? | ☐ yes<br>☐ no |
| 14. | Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? | ☐ yes<br>☐ no |
| 15. | Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct? | ☐ yes<br>☐ no |
| 16. | Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency? | ☐ yes<br>☐ no |
| 17. | Has your professional liability coverage ever been canceled, restricted, declined or not renewed by the carrier based on your individual liability history? | ☐ yes<br>☐ no |
| 18. | Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history? | ☐ yes<br>☐ no |
| 19. | Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?<br>If yes, provide information for each case. | ☐ yes<br>☐ no |
| 20. | Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony? | ☐ yes<br>☐ no |

| | | |
|---|---|---|
| 21. | In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? | ☐ yes<br>☐ no |
| 22. | Have you ever been court-martialed for actions related to your duties as a medical professional? | ☐ yes<br>☐ no |
| 23. | Are you currently engaged in the illegal use of drugs?<br>("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized<br>by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.) | ☐ yes<br>☐ no |
| 24. | Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? | ☐ yes<br>☐ no |
| 25. | Do you have any reason to believe that you would pose a risk to the safety or well being of your patients? | ☐ yes<br>☐ no |
| 26. | Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation? | ☐ yes<br>☐ no |