

Credentialing Application

CORRECT NUMBERS
AND LETTERS

A

B

C

1

2

3

CORRECT
MARK

X

INCORRECT
MARKS

W

✓

•

CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING,
COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE
MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Instructions

Read all instructions
carefully prior to
submitting your
application.

Tips to avoid processing delays

1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1

Personal Information and Professional IDs

Provider Type

Code list is found on page 36. Enter the
associated 3-digit code in the space
provided.*

☐

YES

☐

NO

DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?*
(E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE
PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name

Do not use nicknames
or initials, unless they
are part of your legal
name.

LAST NAME*

SUFFIX (JR, III)

FIRST NAME*

MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?*

☐

YES

☐

NO

IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME

SUFFIX (JR, III)

OTHER FIRST NAME

OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME

DATE STOPPED USING OTHER NAME

General Information

Only enter a Foreign
National Identification
Number if you do not
have a SSN. Do not
enter National Provider
Identification (NPI)
Number here.

Code lists are found on
pages 36-43. Enter the
associated 3-digit code
in the space provided.

GENDER* ☐ MALE ☐ FEMALE

DATE OF BIRTH*

CITY OF BIRTH

STATE OF
BIRTH

COUNTRY OF
BIRTH

SSN*

FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN)

FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH
LANGUAGES YOU SPEAK

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

Home Address

NUMBER

STREET

APT NUMBER

CITY

STATE

ZIP CODE

TELEPHONE

NOTE: CAQH will use
this method for
application follow-up.

E-MAIL

FAX

PREFERRED METHOD OF CONTACT*

☐

E-MAIL

☐

FAX

3076

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1

Personal Information and Professional IDs (Continued)

Professional IDs

Include all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/certifications.

Non-licensed professionals should enter certification/registration number in the space provided for license number.

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

FEDERAL DEA NUMBER

DEA ISSUE DATE

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE

CDS CERTIFICATE NUMBER

CDS ISSUE DATE

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE

LICENSE STATUS CODE

Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE

Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE

LICENSE STATUS CODE

Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE

Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

Other ID Numbers

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

ARE YOU A PARTICIPATING MEDICARE PROVIDER? ☐ YES ☐ NO

MEDICARE NUMBER

UPIN

ARE YOU A PARTICIPATING MEDICAID PROVIDER? ☐ YES ☐ NO

MEDICAID NUMBER

MEDICAID STATE

NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER

USMLE NUMBER (WITHOUT HYPHENS)

WORKERS COMPENSATION NUMBER

ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)

ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY)

Section 2**Education and Training****Undergraduate School(s)**

Provide the appropriate information for the school that issued your undergraduate degree and all schools attended.

Professional School(s)

Provide the appropriate information for the school that issued your professional degree.

Fifth Pathway Graduates please complete the following sections: U.S. School that issued your certificate, the Non-U.S. School where you attended, and the Fifth Pathway institution where you completed your training on Supplemental Page 20.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Undergraduate or Professional Schools to report, use the Education Supplemental Form on page 20.

UNDERGRADUATE SCHOOL

OFFICIAL NAME OF UNDERGRADUATE SCHOOL

ADDRESS

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

START DATE

END DATE (GRADUATION DATE)

DEGREE AWARDED

DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL?

☐

YES

☐

NO

GRADUATE TYPE*:☐ U.S. OR CANADIAN GRADUATE☐ NON-U.S./CANADIAN GRADUATE☐ FIFTH PATHWAY GRADUATE**U.S. OR CANADIAN SCHOOL**

SCHOOL CODE (U.S./CANADIAN ONLY)

NAME OF U.S./CANADIAN SCHOOL:

START DATE*

END DATE (GRADUATION DATE)*

DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?

☐

YES

☐

NO

NON - U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL

ADDRESS

CITY

COUNTRY CODE

POSTAL CODE

START DATE*

END DATE (GRADUATION DATE)*

DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?

☐

YES

☐

NO

Section 2

Education and Training (Continued)

Training

List all training programs you attended. Use one section per institution.

If you have additional post-graduate training programs, use the Supplemental Training Form on page 21.

Please explain on the Supplemental Professional / Work History Gap Form on page 33 any training gap(s) of three (3) months or greater, or any gap(s) of a shorter duration if required by the organization for which you are being credentialed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

																								SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)		
INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)																										
NUMBER				STREET																SUITE/BUILDING						
CITY												STATE		ZIP/POSTAL CODE												
COUNTRY CODE				TELEPHONE										FAX												
DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? <input type="checkbox"/> YES <input type="checkbox"/> NO																										
(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)																										

List each department separately, if applicable.

List Internship/Residency, Fellowship and Other programs separately.

<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER	M M Y Y Y Y						M M Y Y Y Y																										
												START DATE												END DATE											
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)																																			
NAME OF DIRECTOR																																			
<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER	M M Y Y Y Y						M M Y Y Y Y																										
												START DATE												END DATE											
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)																																			
NAME OF DIRECTOR																																			
<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER	M M Y Y Y Y						M M Y Y Y Y																										
												START DATE												END DATE											
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)																																			
NAME OF DIRECTOR																																			

Professional / Medical Specialty Information

[illegible]

SPECIALTY CODE	<input type="text"/> <input type="text"/> <input type="text"/>	INITIAL CERTIFICATION DATE	<input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO	<input type="text"/>	YES	<input type="text"/>	NO
BOARD CERTIFIED?	<input type="text"/> YES <input type="text"/> NO	RECERTIFICATION DATE (IF APPLICABLE)	<input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y		PPO	<input type="text"/>	YES	<input type="text"/>	NO
CERTIFYING BOARD CODE	<input type="text"/> <input type="text"/> <input type="text"/>	EXPIRATION DATE (IF APPLICABLE)	<input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y		POS	<input type="text"/>	YES	<input type="text"/>	NO

IF NOT BOARD CERTIFIED (SELECT ONE) I HAVE TAKEN EXAM, RESULTS PENDING FOR MONTHS I INTEND TO SIT FOR AN EXAM ON MONTHS MONTHS DAYS DAYS YEARS YEARS YEARS YEARS I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

CERTIFYING BOARD CODE

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

3081

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information

Primary Practice Location

If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 25-29.

NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT QUESTION ABOVE. SECTION 4 MAY BE LEFT BLANK. YOU MAY PROCEED TO SECTION 5 ON PAGE 11.

CURRENTLY PRACTICING AT THIS ADDRESS?*

☐ YES ☐ NO

PREVIOUS OR FUTURE START DATE?

M M D D Y Y Y Y

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?*

☐ YES ☐ NO

TELEPHONE*

FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID GROUP TAX ID PRIMARY TAX ID (ONE ONLY)* USE INDIVIDUAL TAX ID USE GROUP TAX ID

Office Manager or Business Office Staff Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

☐

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Billing Contact.

3083

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information (Continued)

Payment and Remittance

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS PAYEE INFORMATION

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Payee Contact.

ELECTRONIC BILLING CAPABILITIES?*

YES

NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

CHECK PAYABLE TO*

LAST NAME*

FIRST NAME*

M.I.

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE*

FAX

E-MAIL ADDRESS

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

24/7 PHONE COVERAGE?* IF YES

YES NO ANSWERING SERVICE VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?*

YES

NO

ACCEPT ALL NEW PATIENTS?*

YES

NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?*

YES

NO

ACCEPT NEW MEDICARE PATIENTS?*

YES

NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?*

YES

NO

ACCEPT NEW MEDICAID PATIENTS?*

YES

NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN (USE BOTH LINES IF REQUIRED)

ARE THERE ANY PRACTICE LIMITATIONS?*

YES

NO

IF YES

GENDER LIMITATIONS

MALE ONLY

NONE

AGE LIMITATIONS

MINIMUM AGE

MAXIMUM AGE

LIST OTHER LIMITATIONS

3084

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information (Continued)

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

M.I

--	--	--

PROVIDER TYPE (CODE PG 36)

M.I

--	--	--

PROVIDER TYPE (CODE PG 36)

M.I

--	--	--

PROVIDER TYPE (CODE PG 36)

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

M.I.

PROVIDER TYPE (CODE PG 36)

M.I.

PROVIDER TYPE (CODE PG 36)

M.I.

PROVIDER TYPE (CODE PG 36)

Hospital Affiliations

DO YOU HAVE HOSPITAL PRIVILEGES? ☐ YES ☐ NO IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 5

Hospital Affiliations (Continued)

Hospital Privileges

If applicable, list all hospital affiliations. List primary hospital, then other current affiliations, followed by previous affiliations in chronological order.

If you have additional hospital privileges, use the Supplemental Hospital Privileges Form on page 30.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

PRIMARY HOSPITAL

HOSPITAL NAME																															
NUMBER								STREET												SUITE/BUILDING											
CITY														STATE				ZIP CODE													
TELEPHONE														FAX																	
DEPARTMENT NAME																															
DEPARTMENT DIRECTOR'S LAST NAME																															
DEPARTMENT DIRECTOR'S FIRST NAME																											M.I.				
AFFILIATION START DATE								AFFILIATION END DATE								FULL, UNRESTRICTED PRIVILEGES?				YES		NO		ARE PRIVILEGES TEMPORARY?				YES		NO	
OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?																															
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)																															

OTHER HOSPITAL

HOSPITAL NAME																															
NUMBER								STREET												SUITE/BUILDING											
CITY														STATE				ZIP CODE													
TELEPHONE														FAX																	
DEPARTMENT NAME																															
DEPARTMENT DIRECTOR'S LAST NAME																															
DEPARTMENT DIRECTOR'S FIRST NAME																											M.I.				
AFFILIATION START DATE								AFFILIATION END DATE								FULL, UNRESTRICTED PRIVILEGES?				YES		NO		ARE PRIVILEGES TEMPORARY?				YES		NO	
OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?																															
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)																															
PLEASE EXPLAIN TERMINATED AFFILIATION																															

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6

Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

IMPORTANT
IF YOU DO NOT
CARRY
MALPRACTICE
INSURANCE, CHECK
THIS BOX AND SKIP
THIS SECTION.



<input type="text"/>																		SELF-INSURED?*		YES	NO						
CARRIER OR SELF-INSURED NAME*																											
<input type="text"/>				<input type="text"/>														<input type="text"/>									
NUMBER*				STREET*														SUITE/BUILDING									
<input type="text"/>																		<input type="text"/>		<input type="text"/>							
CITY*																		STATE*		ZIP CODE*							
<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>				TYPE OF COVERAGE?*		INDIVIDUAL	SHARED								
ORIGINAL EFFECTIVE DATE*				EFFECTIVE DATE*				EXPIRATION DATE																			
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?*																		YES	NO	\$ <input type="text"/>				\$ <input type="text"/>			
																		AMOUNT OF COVERAGE PER OCCURRENCE				AMOUNT OF COVERAGE AGGREGATE					
POLICY INCLUDES TAIL COVERAGE?																		YES	NO								
<input type="text"/>																											
POLICY NUMBER*																											

Professional Liability Insurance Carrier

List other current, future, or previous carrier(s) if current carrier is less than ten (10) years.

NOTE: A longer period may be required by your healthcare entity.

If you have additional Insurance, use the Supplemental Insurance Form on page 31.

<input type="text"/>																		SELF-INSURED?		YES	NO						
CARRIER OR SELF-INSURED NAME																											
<input type="text"/>				<input type="text"/>														<input type="text"/>									
NUMBER*				STREET*														SUITE/BUILDING									
<input type="text"/>																		<input type="text"/>		<input type="text"/>							
CITY*																		STATE*		ZIP CODE*							
<input type="text"/>				<input type="text"/>				<input type="text"/>				<input type="text"/>				TYPE OF COVERAGE?*		INDIVIDUAL	SHARED								
ORIGINAL EFFECTIVE DATE*				EFFECTIVE DATE*				EXPIRATION DATE																			
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?																		YES	NO	\$ <input type="text"/>				\$ <input type="text"/>			
																		AMOUNT OF COVERAGE PER OCCURRENCE				AMOUNT OF COVERAGE AGGREGATE					
POLICY INCLUDES TAIL COVERAGE?																		YES	NO								
<input type="text"/>																											
POLICY NUMBER*																											

Section 7

Work History and References

Military Duty

Are you currently on active military duty or military reserve?*

☐ YES ☐ NO

Work History

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity.

If you have additional work history, use the Supplemental Work History Form on page 32.

WORK HISTORY																					
<input type="text"/>																					
PRACTICE / EMPLOYER NAME																					
<input type="text"/>				<input type="text"/>														<input type="text"/>			
NUMBER				STREET														SUITE/BUILDING			
<input type="text"/>																		<input type="text"/>		<input type="text"/>	
CITY																		STATE		ZIP/POSTAL CODE	

Section 7

Work History

If you have additional work history, use the Supplemental Work History Form on page 32.

[illegible]

PRACTICE / EMPLOYER NAME

PRACTICE / EMPLOYER NAME																								
NUMBER					STREET															SUITE/BUILDING				
CITY										STATE		ZIP/POSTAL CODE												
TELEPHONE										FAX														
COUNTRY CODE			START DATE						END DATE															
REASON FOR DEPARTURE (IF APPLICABLE)																								

PRACTICE / EMPLOYER NAME

PRACTICE / EMPLOYER NAME																								
NUMBER					STREET															SUITE/BUILDING				
CITY										STATE		ZIP/POSTAL CODE												
TELEPHONE										FAX														
COUNTRY CODE			START DATE			END DATE			REASON FOR DEPARTURE (IF APPLICABLE)															

Work History and References (Continued)

PLEASE EXPLAIN ANY TIME PERIODS OR GAPS IN TRAINING OR WORK HISTORY THAT HAVE OCCURRED SINCE GRADUATION FROM PROFESSIONAL SCHOOL AND ARE LONGER THAN THREE MONTHS IN DURATION OR OF A SHORTER DURATION IF REQUIRED BY THE ORGANIZATION FOR WHICH YOU ARE BEING CREDENTIALLED.

[illegible]

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY*										STATE*				ZIP CODE*		
<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
TELEPHONE										FAX						

LAST NAME*

FIRST NAME*

CITY* STATE* ZIP CODE*

TELEPHONE - -

FAX - -

[illegible][illegible]

FIRST NAME* PROVIDER TYPE (CODE PG 3)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE 3091 FAX

Section 8

Disclosure Questions

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

Allied Health Providers

If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".

LICENSURE

1. ☐ YES ☐ NO 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?*
2. ☐ YES ☐ NO Has there been any challenge to your licensure, registration or certification?*

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. ☐ YES ☐ NO 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?*
4. ☐ YES ☐ NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*
5. ☐ YES ☐ NO 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)?*

EDUCATION, TRAINING AND BOARD CERTIFICATION

6. ☐ YES ☐ NO 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?*
7. ☐ YES ☐ NO 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?*
8. ☐ YES ☐ NO Have any of your board certifications or eligibility ever been revoked?*
9. ☐ YES ☐ NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

10. ☐ YES ☐ NO 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?*

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

11. ☐ YES ☐ NO 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?*

OTHER SANCTIONS OR INVESTIGATIONS

12. ☐ YES ☐ NO 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 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. ☐ YES ☐ NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*
14. ☐ YES ☐ NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*
15. ☐ YES ☐ NO 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?*
16. ☐ YES ☐ NO 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?*

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. ☐ YES ☐ NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*
18. ☐ YES ☐ NO 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?*

Section 8	Disclosure Questions (Continued)
Disclosure Questions Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34. IMPORTANT If you answered "Yes" to question #19 , you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.	MALPRACTICE CLAIMS HISTORY 19. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?*
	If yes, provide information for each case.
	CRIMINAL/CIVIL HISTORY 20. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*
	21. <input type="checkbox"/> YES <input type="checkbox"/> NO 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?*
	22. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever been court-martialed for actions related to your duties as a medical professional?*
	Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.
	ABILITY TO PERFORM JOB 23. <input type="checkbox"/> YES <input type="checkbox"/> NO Are you currently engaged in the illegal use of drugs?*
	("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 by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)
	24. <input type="checkbox"/> YES <input type="checkbox"/> NO 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?*
	25. <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*
	26. <input type="checkbox"/> YES <input type="checkbox"/> NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

Race and Ethnicity

CareFirst does not discriminate or base credentialing decisions on an applicant's race, ethnicity or language, and providing the information is optional.

Race: Please select the applicable value.

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Middle Eastern or North African
- ☐ Prefer not to answer
- ☐ Unknown

Ethnicity: Please select the applicable value.

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefer not to answer
- ☐ Unknown

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

3094

Professional IDs Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1

Personal Information and Professional IDs

Professional IDs

Include all additional state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/certifications.

If you need to report additional Professional IDs, photocopy this page as needed and submit as instructed.

FEDERAL DEA NUMBER

DEA STATE OF REGISTRATION

DEA ISSUE DATE

DEA EXPIRATION DATE

FEDERAL DEA NUMBER

DEA STATE OF REGISTRATION

DEA ISSUE DATE

DEA EXPIRATION DATE

CDS CERTIFICATE NUMBER

CDS STATE OF REGISTRATION

CDS ISSUE DATE

CDS EXPIRATION DATE

CDS CERTIFICATE NUMBER

CDS STATE OF REGISTRATION

CDS ISSUE DATE

CDS EXPIRATION DATE

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE

LICENSE STATUS CODE

Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE

Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE

LICENSE STATUS CODE

Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE

Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

Other Training Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2

Education and Training

Training

List all postgraduate training programs you attended. Use one section per institution.

If you need to report additional Training, photocopy this page as needed and submit as instructed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

															SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)		
INSTITUTION / HOSPITAL NAME (USE BOTH LINES IF REQUIRED)																	
NUMBER				STREET										SUITE/BUILDING			
CITY										STATE		ZIP/POSTAL CODE					
COUNTRY CODE			TELEPHONE						FAX								
DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? <input type="checkbox"/> YES <input type="checkbox"/> NO																	
(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)																	

List each department separately, if applicable.

List Internship/Residency, Fellowship and Other programs separately.

<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER	M M Y Y Y Y						M M Y Y Y Y								
			START DATE						END DATE								
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)																	
NAME OF DIRECTOR																	
<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER	M M Y Y Y Y						M M Y Y Y Y								
			START DATE						END DATE								
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)																	
NAME OF DIRECTOR																	
<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER	M M Y Y Y Y						M M Y Y Y Y								
			START DATE						END DATE								
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)																	
NAME OF DIRECTOR																	

1

If you need to report additional Specialties, photocopy this page as needed and submit as instructed.

[illegible][illegible]

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Std. App. v.5.0
Reprinted on 11/2/2007

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information - Page 1 of 5

Additional Practice Location

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

Office Manager or Business Office Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

Billing Contact

CHECK HERE TO
USE OFFICE
MANAGER AND
OFFICE ADDRESS
AS BILLING
INFORMATION

NOTE:

Even if you checked the boxes above, please provide the e-mail address of the Billing Contact, if available.

LOCATION* #

CURRENTLY
PRACTICING AT
THIS ADDRESS?*

YES

NO

PREVIOUS
OR FUTURE
START DATE?

M M D D Y Y Y Y

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

SEND GENERAL
CORRESPON-
DENCE HERE?*

YES

NO

TELEPHONE*

FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID

GROUP TAX ID

PRIMARY
TAX ID
(ONE ONLY)*

USE INDIVIDUAL
TAX ID

USE GROUP
TAX ID

LAST NAME*

FIRST NAME*

M.I.

TELEPHONE*

FAX

E-MAIL ADDRESS

LAST NAME*

FIRST NAME*

M.I.

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE*

FAX

E-MAIL ADDRESS

3100

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Practice Location Information - Page 2 of 5

Add'l Practice Location (Cont.)

Payment and Remittance

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

NOTE:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

LOCATION* #

ELECTRONIC BILLING CAPABILITIES?* ☐ YES ☐ NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

CHECK PAYABLE TO*

LAST NAME*

FIRST NAME*

M.I.

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE*

FAX

E-MAIL ADDRESS

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	FRIDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
TUESDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	SATURDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
WEDNESDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	SUNDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
THURSDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					

24/7 PHONE COVERAGE?*

IF YES

☐ YES ☐ NO

☐ ANSWERING SERVICE

☐ VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE

☐ VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?*

☐ YES ☐ NO

ACCEPT ALL NEW PATIENTS?*

☐ YES ☐ NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?*

☐ YES ☐ NO

ACCEPT NEW MEDICARE PATIENTS?*

☐ YES ☐ NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?*

☐ YES ☐ NO

ACCEPT NEW MEDICAID PATIENTS?*

☐ YES ☐ NO

IF ANY OF THE ABOVE VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?*

IF YES

☐ YES ☐ NO

GENDER LIMITATIONS

☐ MALE ONLY

☐ NONE

☐ FEMALE ONLY

AGE LIMITATIONS

MINIMUM AGE

MAXIMUM AGE

LIST OTHER LIMITATIONS

3101

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4		Practice Location Information - Page 4 of 5																																												
Additional Practice Location (Continued)	LOCATION* # <input type="text"/> <input type="text"/>																																													
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Important In the box provided, indicate to which practice location this page belongs.																																														
Accessibilities	DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* <input type="text"/> YES <input type="text"/> NO																																													
	<table border="0"><tr><td>DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING</td><td>DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?*</td><td>ACCESSIBLE BY PUBLIC TRANSPORTATION?*</td></tr><tr><td>BUILDING?* <input type="text"/> YES <input type="text"/> NO</td><td>TEXT TELEPHONY (TTY)* <input type="text"/> YES <input type="text"/> NO</td><td>BUS* <input type="text"/> YES <input type="text"/> NO</td></tr><tr><td>PARKING?* <input type="text"/> YES <input type="text"/> NO</td><td>AMERICAN SIGN LANGUAGE* <input type="text"/> YES <input type="text"/> NO</td><td>SUBWAY* <input type="text"/> YES <input type="text"/> NO</td></tr><tr><td>RESTROOM?* <input type="text"/> YES <input type="text"/> NO</td><td>MENTAL/PHYSICAL IMPAIRMENT SERVICES* <input type="text"/> YES <input type="text"/> NO</td><td>REGIONAL TRAIN* <input type="text"/> YES <input type="text"/> NO</td></tr><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>OTHER HANDICAPPED ACCESS</td><td>OTHER DISABILITY SERVICES</td><td>OTHER TRANSPORTATION ACCESS</td></tr></table>			DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING	DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?*	ACCESSIBLE BY PUBLIC TRANSPORTATION?*	BUILDING?* <input type="text"/> YES <input type="text"/> NO	TEXT TELEPHONY (TTY)* <input type="text"/> YES <input type="text"/> NO	BUS* <input type="text"/> YES <input type="text"/> NO	PARKING?* <input type="text"/> YES <input type="text"/> NO	AMERICAN SIGN LANGUAGE* <input type="text"/> YES <input type="text"/> NO	SUBWAY* <input type="text"/> YES <input type="text"/> NO	RESTROOM?* <input type="text"/> YES <input type="text"/> NO	MENTAL/PHYSICAL IMPAIRMENT SERVICES* <input type="text"/> YES <input type="text"/> NO	REGIONAL TRAIN* <input type="text"/> YES <input type="text"/> NO	<input type="text"/>	<input type="text"/>	<input type="text"/>	OTHER HANDICAPPED ACCESS	OTHER DISABILITY SERVICES	OTHER TRANSPORTATION ACCESS																									
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OTHER HANDICAPPED ACCESS	OTHER DISABILITY SERVICES	OTHER TRANSPORTATION ACCESS																																												
Services	Does this location provide any of the following services?																																													
	<table border="0"><tr><td>LABORATORY SERVICES? <input type="text"/> YES <input type="text"/> NO</td><td>IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)</td><td><input type="text"/></td></tr><tr><td>RADIOLOGY SERVICES? <input type="text"/> YES <input type="text"/> NO</td><td>IF YES, PROVIDE X-RAY CERTIFICATION TYPE</td><td><input type="text"/></td></tr><tr><td>EKGs? <input type="text"/> YES <input type="text"/> NO</td><td>ALLERGY INJECTIONS? <input type="text"/> YES <input type="text"/> NO</td><td>ALLERGY SKIN TESTING? <input type="text"/> YES <input type="text"/> NO</td></tr><tr><td>DRAWING BLOOD? <input type="text"/> YES <input type="text"/> NO</td><td>AGE APPROPRIATE IMMUNIZATIONS? <input type="text"/> YES <input type="text"/> NO</td><td>FLEXIBLE SIGMOIDOSCOPY? <input type="text"/> YES <input type="text"/> NO</td></tr><tr><td>ASTHMA TREATMENT? <input type="text"/> YES <input type="text"/> NO</td><td>OSTEOPATHIC MANIPULATION? <input type="text"/> YES <input type="text"/> NO</td><td>IV HYDRATION/ TREATMENT? <input type="text"/> YES <input type="text"/> NO</td></tr><tr><td>PULMONARY FUNCTION TESTING? <input type="text"/> YES <input type="text"/> NO</td><td>PHYSICAL THERAPY? <input type="text"/> YES <input type="text"/> NO</td><td>CARE OF MINOR LACERATIONS? <input type="text"/> YES <input type="text"/> NO</td></tr><tr><td>IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? <input type="text"/> YES <input type="text"/> NO</td><td>IF YES, WHAT CLASS/CATEGORY DO YOU USE?</td><td><input type="text"/></td></tr><tr><td>IF YES, WHO ADMINISTERS IT?</td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td colspan="2">LAST NAME</td><td>FIRST NAME</td></tr><tr><td colspan="3">TYPE OF PRACTICE (SELECT ONE ONLY)* <input type="text"/> SOLO PRACTICE <input type="text"/> SINGLE SPECIALTY GROUP <input type="text"/> MULTI-SPECIALTY GROUP</td></tr><tr><td colspan="3">ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)</td></tr><tr><td colspan="3"><input type="text"/></td></tr><tr><td colspan="3"><input type="text"/></td></tr></table>			LABORATORY SERVICES? <input type="text"/> YES <input type="text"/> NO	IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)	<input type="text"/>	RADIOLOGY SERVICES? <input type="text"/> YES <input type="text"/> NO	IF YES, PROVIDE X-RAY CERTIFICATION TYPE	<input type="text"/>	EKGs? <input type="text"/> YES <input type="text"/> NO	ALLERGY INJECTIONS? <input type="text"/> YES <input type="text"/> NO	ALLERGY SKIN TESTING? <input type="text"/> YES <input type="text"/> NO	DRAWING BLOOD? <input type="text"/> YES <input type="text"/> NO	AGE APPROPRIATE IMMUNIZATIONS? <input type="text"/> YES <input type="text"/> NO	FLEXIBLE SIGMOIDOSCOPY? <input type="text"/> YES <input type="text"/> NO	ASTHMA TREATMENT? <input type="text"/> YES <input type="text"/> NO	OSTEOPATHIC MANIPULATION? <input type="text"/> YES <input type="text"/> NO	IV HYDRATION/ TREATMENT? <input type="text"/> YES <input type="text"/> NO	PULMONARY FUNCTION TESTING? <input type="text"/> YES <input type="text"/> NO	PHYSICAL THERAPY? <input type="text"/> YES <input type="text"/> NO	CARE OF MINOR LACERATIONS? <input type="text"/> YES <input type="text"/> NO	IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? <input type="text"/> YES <input type="text"/> NO	IF YES, WHAT CLASS/CATEGORY DO YOU USE?	<input type="text"/>	IF YES, WHO ADMINISTERS IT?	<input type="text"/>	<input type="text"/>	LAST NAME		FIRST NAME	TYPE OF PRACTICE (SELECT ONE ONLY)* <input type="text"/> SOLO PRACTICE <input type="text"/> SINGLE SPECIALTY GROUP <input type="text"/> MULTI-SPECIALTY GROUP			ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)			<input type="text"/>			<input type="text"/>						
LABORATORY SERVICES? <input type="text"/> YES <input type="text"/> NO	IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)	<input type="text"/>																																												
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IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? <input type="text"/> YES <input type="text"/> NO	IF YES, WHAT CLASS/CATEGORY DO YOU USE?	<input type="text"/>																																												
IF YES, WHO ADMINISTERS IT?	<input type="text"/>	<input type="text"/>																																												
LAST NAME		FIRST NAME																																												
TYPE OF PRACTICE (SELECT ONE ONLY)* <input type="text"/> SOLO PRACTICE <input type="text"/> SINGLE SPECIALTY GROUP <input type="text"/> MULTI-SPECIALTY GROUP																																														
ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)																																														
<input type="text"/>																																														
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3103

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Professional Liability Insurance Carrier Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6

Professional Liability Insurance Carrier

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

<input type="text"/>										SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
CARRIER OR SELF-INSURED NAME											
<input type="text"/>		<input type="text"/>								<input type="text"/>	
NUMBER*		STREET*								SUITE/BUILDING	
<input type="text"/>		<input type="text"/>								<input type="text"/>	
CITY*										STATE*	
<input type="text"/>										<input type="text"/>	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		ZIP CODE*	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
ORIGINAL EFFECTIVE DATE*		EFFECTIVE DATE*		EXPIRATION DATE		TYPE OF COVERAGE?*		INDIVIDUAL		SHARED	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?		<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ <input type="text"/>		\$ <input type="text"/>					
				AMOUNT OF COVERAGE PER OCCURRENCE		AMOUNT OF COVERAGE AGGREGATE					
POLICY INCLUDES TAIL COVERAGE?		<input type="checkbox"/> YES <input type="checkbox"/> NO									
POLICY NUMBER*											

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.

<input type="text"/>										SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
CARRIER OR SELF-INSURED NAME											
<input type="text"/>		<input type="text"/>								<input type="text"/>	
NUMBER*		STREET*								SUITE/BUILDING	
<input type="text"/>		<input type="text"/>								<input type="text"/>	
CITY*										STATE*	
<input type="text"/>										<input type="text"/>	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		ZIP CODE*	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
ORIGINAL EFFECTIVE DATE*		EFFECTIVE DATE*		EXPIRATION DATE		TYPE OF COVERAGE?*		INDIVIDUAL		SHARED	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?		<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ <input type="text"/>		\$ <input type="text"/>					
				AMOUNT OF COVERAGE PER OCCURRENCE		AMOUNT OF COVERAGE AGGREGATE					
POLICY INCLUDES TAIL COVERAGE?		<input type="checkbox"/> YES <input type="checkbox"/> NO									
POLICY NUMBER*											

Professional Training / Work History Gaps Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7

Professional Training / Work History Gaps

Professional Training / Work History Gaps

Please explain any time periods or gaps in training or work history that have occurred since graduation from professional school and are longer than three month in duration or of a shorter duration if required by the organization for which you are being credentialed.

GAP START DATE	M	M	Y	Y	Y	Y	GAP END DATE	M	M	Y	Y	Y	Y

GAP START DATE	M	M	Y	Y	Y	Y	GAP END DATE	M	M	Y	Y	Y	Y

GAP START DATE	M	M	Y	Y	Y	Y	GAP END DATE	M	M	Y	Y	Y	Y

GAP START DATE	M	M	Y	Y	Y	Y	GAP END DATE	M	M	Y	Y	Y	Y

GAP START DATE	M	M	Y	Y	Y	Y	GAP END DATE	M	M	Y	Y	Y	Y

Malpractice Claims Explanation

Malpractice Claims Explanation

Use this form to report any "Yes" response to Disclosure Question #19.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

[illegible]

Code Lists

Provider Type Codes

001	Medical Doctor (MD)	030	Licensed Practical Nurse	041	Optometrist
002	Doctor of Dental Surgery (DDS)	031	Marriage/Family Therapist	042	Pharmacist
003	Doctor of Dental Medicine (DMD)	032	Massage Therapist	043	Physical Therapist
004	Doctor of Podiatric Medicine (DPM)	033	Naturopath	044	Physician Assistant
005	Doctor of Chiropractic (DC)	034	Neuropsychologist	045	Professional Counselor
007	Osteopathic Doctor (DO)	035	Midwife	046	Registered Nurse
020	Acupuncturist	036	Nurse Midwife	047	Registered Nurse First Assistant
021	Alcohol/Drug Counselor	037	Nurse Practitioner	048	Respiratory Therapist
022	Audiologist	038	Nutritionist	049	Speech Pathologist
023	Biofeedback Technician	039	Occupational Therapist		
024	Certified Registered Nurse Anesthetist	040	Optician		
025	Christian Science Practitioner				
026	Clinical Nurse Specialist				
027	Clinical Psychologist				
028	Clinical Social Worker				
029	Dietician				

License Status Codes

001	Active	008	Pending	015	Temporary
002	Canceled	009	Probation	016	Terminated
003	Denied	010	Provisional	017	Time Limited
004	Expired	011	Restricted	018	Unrestricted
005	Inactive	012	Revoked	019	Other
006	Lapsed	013	Suspended		
007	Limited	014	Surrendered		

Country Codes

004	Afghanistan	174	Comoros	334	Heard Island and McDonald Islands	498	Moldova
008	Albania	178	Congo	340	Honduras	492	Monaco
012	Algeria	180	Congo, Democratic Republic of the	344	Hong Kong	496	Mongolia
016	American Samoa	184	Cook Islands	348	Hungary	500	Montserrat
020	Andorra	188	Costa Rica	352	Iceland	504	Morocco
024	Angola	191	Croatia	356	India	508	Mozambique
660	Anguilla	192	Cuba	360	Indonesia	104	Myanmar
010	Antarctica	196	Cyprus	364	Iran	516	Namibia
028	Antigua and Barbuda	203	Czech Republic	368	Iraq	520	Nauru
032	Argentina	208	Denmark	372	Ireland	524	Nepal
051	Armenia	262	Djibouti	376	Israel	528	Netherlands
533	Aruba	212	Dominica	380	Italy	530	Netherlands Antilles
036	Australia	214	Dominican Republic	388	Jamaica	540	New Caledonia
040	Austria	626	East Timor (provisional)	392	Japan	554	New Zealand
031	Azerbaijan	218	Ecuador	400	Jordan	558	Nicaragua
044	Bahamas	818	Egypt	398	Kazakhstan	562	Niger
048	Bahrain	222	El Salvador	404	Kenya	566	Nigeria
050	Bangladesh	226	Equatorial Guinea	296	Kiribati	570	Niue
052	Barbados	232	Eritrea	408	Korea, North	574	Norfolk Island
112	Belarus	233	Estonia	410	Korea, South	580	Northern Mariana Islands
056	Belgium	231	Ethiopia	414	Kuwait	578	Norway
084	Belize	238	Falkland Islands (Malvinas)	417	Kyrgyzstan	512	Oman
204	Benin	234	Faroe Islands	418	Laos	586	Pakistan
060	Bermuda	242	Fiji	422	Lebanon	585	Palau
064	Bhutan	246	Finland	426	Lesotho	591	Panama
068	Bolivia	250	France	430	Liberia	598	Papua New Guinea
070	Bosnia and Herzegovina	249	France, Metropolitan	434	Libya	600	Paraguay
072	Botswana	254	French Guiana	438	Liechtenstein	604	Peru
074	Bouvet Island	258	French Polynesia	440	Lithuania	608	Philippines
076	Brazil	260	French Southern Territories	442	Luxembourg	612	Pitcairn
086	British Indian Ocean Territory	266	Gabon	446	Macau	616	Poland
096	Brunei Darussalam	270	Gambia	807	Macedonia	620	Portugal
100	Bulgaria	276	Georgia	450	Madagascar	630	Puerto Rico
854	Burkina Faso	288	Ghana	454	Malawi	634	Qatar
108	Burundi	292	Gibraltar	458	Malaysia	638	Réunion
116	Cambodia	300	Greece	462	Maldives	642	Romania
120	Cameroon	304	Greenland	466	Mali	643	Russian Federation
136	Cayman Islands	308	Grenada	470	Malta	646	Rwanda
140	Central African Republic	312	Guadaloupe	584	Marshall Islands	654	Saint Helena
148	Chad	316	Guam	474	Martinique	659	Saint Kitts and Nevis
152	Chile	320	Guatemala	478	Mauritania	662	Saint Lucia
156	China	324	Guinea	480	Mauritius	666	Saint Pierre and Miquelon
162	Christmas Island	624	Guinea-Bissau	175	Mayotte	670	Saint Vincent and the Grenadines
166	Cocos (Keeling) Islands	328	Guyana	484	Mexico		
170	Colombia	332	Haiti	583	Micronesia		

Code Lists

Country Codes (continued)

882	Samoa			772	Tokelau	548	Vanuatu
674	San Marino	724	Spain	776	Tonga	336	Vatican City State (Holy See)
678	São Tomé and Príncipe	144	Sri Lanka	780	Trinidad and Tobago	862	Venezuela
682	Saudi Arabia	736	Sudan	788	Tunisia	704	Viet Nam
683	Scotland	740	Suriname	792	Turkey795 Turkmenistan	092	Virgin Islands, British
686	Senegal	744	Svalbard and Jan Mayen	796	Turks and Caicos Islands	850	Virgin Islands, U.S.
690	Seychelles	748	Swaziland	798	Tuvalu	876	Wallis and Fortuna Islands
694	Sierra Leone	752	Sweden	800	Uganda	732	Western Sahara (provisional)
702	Singapore	756	Switzerland	804	Ukraine	887	Yemen
703	Slovakia	760	Syria	784	United Arab Emirates	891	Yugoslavia
705	Slovenia	158	Taiwan	826	United Kingdom	894	Zambia
090	Solomon Islands	762	Tajikistan	840	United States	716	Zimbabwe
706	Somalia	834	Tanzania	581	U.S. Minor Outlying Islands		
710	South Africa	764	Thailand	858	Uruguay		
239	South Georgia and the South	768	Togo	860	Uzbekistan		

Language Codes

001	Abkhazian	061	Kinyarwanda	121	Tonga
002	Afan (Oromo)	062	Kirghiz	122	Tsonga
003	Afar	063	Kurundi	123	Turkish
004	Afrikaans	064	Korean	124	Turkmen
005	Albanian	065	Kurdish	125	Twi
006	Amharic	066	Laothian	126	Uigur
007	Arabic	067	Latin	127	Ukrainian
008	Armenian	068	Latvian;Lettish	128	Urdu
009	Assamese	069	Lingala	129	Uzbek
010	Zerbajjani	070	Lithuanian	130	Vietnamese
011	Bashkir	071	Macedonian	131	Volapuk
012	Basque	072	Malagasy	132	Welsh
013	Bengali;Bangla	073	Malay	133	Wolof
014	Bhutani	074	Malayalam	134	Xhosa
015	Bihari	075	Maltese	135	Yiddish
016	Bislama	076	Maori	136	Yoruba
017	Breton	077	Marathi	10	Zerbajjani
018	Bulgarian	078	Moldavian	137	Zhuang
019	Burmese	079	Mongolian	138	Zulu
020	Byelorussian	080	Nauru		
021	Cambodian	081	Nepali		
022	Catalan	082	Norwegian		
023	Chinese	083	Occitan		
024	Corsican	084	Oriya		
025	Croatian	085	Pashto;Pushto		
026	Czech	086	Persian (Farsi)		
027	Danish	087	Polish		
028	Dutch	088	Portuguese		
140	English	089	Punjabi		
030	Esperanto	090	Quechua		
031	Estonian	091	Rhaeto-Romance		
032	Faroese	092	Romanian		
033	Fiji	093	Russian		
034	Finnish	094	Samoan		
035	French	095	Sangho		
036	Frisian	096	Sanskrit		
037	Galician	097	Scot Gaelic		
038	Georgian	098	Serbian		
039	German	099	Serbo-Croatian		
040	Greek	100	Sesotho		
041	Greenlandic	101	Setswana		
042	Guarani	102	Shona		
043	Gujarati	103	Sindhi		
044	Hausa	104	Singhalese		
045	Hebrew	105	Siswati		
046	Hindi	106	Slovak		
047	Hungarian	107	Slovenian		
048	Icelandic	108	Somali		
049	Indonesian	109	Spanish		
050	Interlingua	110	Sundanese		
051	Interlingue	111	Swahili		
052	Inuktitut	112	Swedish		
053	Inupiak	113	Tagalog		
054	Irish	114	Tajik		
055	Italian	115	Tamil		
056	Japanese	116	Tatar		
057	Javanese	117	Telugu		
058	Kannada	118	Thai		
059	Kashmiri	119	Tibetan		
060	Kazakh	120	Tigrinya		

Code Lists

U.S. / Canadian Professional School Codes

Alabama

300 University of Alabama School of Dentistry
001 University of Alabama School of Medicine
002 University of South Alabama College of Medicine

Arkansas

003 University of Arkansas College of Medicine

Arizona

500 Arizona College of Osteopathic Medicine
004 University of Arizona College of Medicine

California

801 California College of Podiatric Medicine
400 Cleveland Chiropractic College of Los Angeles
005 Keck School of Medicine
401 Life Chiropractic College West
301 Loma Linda University School of Dentistry
006 Loma Linda University School of Medicine
402 Los Angeles College of Chiropractic
403 Palmer College of Chiropractic West
404 Quantum University/SCCC
007 Stanford University School of Medicine
501 Touro University College of Osteopathic Medicine
008 UCLA School of Medicine
009 University of California
010 University of California, Irvine, College of Medicine
302 University of California, Los Angeles School of Dentistry
011 University of California, San Diego, School of Medicine
303 University of California, San Francisco, School of Dentistry
012 University of California, San Francisco, School of Medicine
304 University of Southern California School of Dentistry
305 University of the Pacific School of Dentistry
502 Western University of Health Sciences, College of Osteopathic Medicine of the Pacific

Colorado

306 University of Colorado School of Dentistry
013 University of Colorado School of Medicine

Connecticut

405 University of Bridgeport College of Chiropractic
307 University of Connecticut School of Dental Medicine
014 University of Connecticut School of Medicine
015 Yale University School of Medicine

District of Columbia

016 George Washington University
017 Georgetown University School of Medicine
308 Howard University College of Dentistry
018 Howard University College of Medicine

Florida

800 Barry University School of Graduate Medical Sciences
309 Nova Southeastern University College of Dentistry
503 Nova Southeastern University College of Osteopathic Medicine
310 University of Florida College of Dentistry
019 University of Florida College of Medicine
020 University of Miami School of Medicine
021 University of South Florida College of Medicine

Georgia

022 Emory University School of Medicine
406 Life Chiropractic College
311 Medical College of Georgia School of Dentistry
023 Medical College of Georgia School of Medicine
024 Mercer University School of Medicine
025 Morehouse School of Medicine

Hawaii

026 John A. Burns School of Medicine

Iowa

802 College of Podiatric Medicine and Surgery Des Moines University
504 Des Moines University, Osteopathic Medical Center, College of Osteopathic Medicine and Surgery
407 Palmer College of Chiropractic
312 University of Iowa College of Dentistry
027 University of Iowa College of Medicine

Illinois

028 Chicago Medical School, Finch University of Health Sciences
029 Loyola University Chicago, Stritch School of Medicine
505 Midwestern University, Chicago College of Osteopathic Medicine
408 National College of Chiropractic
313 Northwestern University Dental School
030 Northwestern University Medical School
031 Rush Medical College of Rush University
804 Scholl College of Podiatric Medicine at Finch University
314 Southern Illinois University School of Dental Medicine
032 Southern Illinois University School of Medicine
033 University of Chicago, The Pritzker School of Medicine
315 University of Illinois at Chicago College of Dentistry
034 University of Illinois College of Medicine

Indiana

316 Indiana University School of Dentistry
035 Indiana University School of Medicine

Kansas

036 University of Kansas School of Medicine

Kentucky

506 Pikeville College, School of Osteopathic Medicine
317 University of Kentucky College of Dentistry
037 University of Kentucky College of Medicine
318 University of Louisville School of Dentistry
038 University of Louisville School of Medicine

Louisiana

319 Louisiana State University School of Dentistry
039 Louisiana State University School of Medicine in New Orleans
040 Louisiana State University School of Medicine in Shreveport
041 Tulane University School of Medicine

Massachusetts

042 Boston University School of Medicine
320 Boston University, Goldman School of Dental Medicine
043 Harvard Medical School
321 Harvard School of Dental Medicine
322 Tufts University School of Dental Medicine
044 Tufts University School of Medicine
045 University of Massachusetts Medical School

Maryland

046 Johns Hopkins University School of Medicine
047 Uniformed Services University of the Health Sciences
048 University of Maryland School of Medicine
323 University of Maryland, Baltimore, College of Dental Surgery

Maine

507 University of New England, College of Osteopathic Medicine

Michigan

049 Michigan State University College of Human Medicine
508 Michigan State University, College of Osteopathic Medicine
324 University of Detroit Mercy School of Dentistry
050 University of Michigan Medical School
325 University of Michigan School of Dentistry
051 Wayne State University School of Medicine

Minnesota

052 Mayo Medical School
409 Northwestern College of Chiropractic
053 University of Minnesota, Duluth School of Medicine
054 University of Minnesota Medical School, Twin Cities
326 University of Minnesota School of Dentistry

Missouri

410 Cleveland Chiropractic College of Kansas City
509 Kirksville College of Osteopathic Medicine
411 Logan Chiropractic College
055 Saint Louis University School of Medicine
510 University of Health Sciences, College of Osteopathic Medicine

056 University of Missouri, Columbia School of Medicine
327 University of Missouri Kansas City School of Dentistry
057 University of Missouri Kansas City School of Medicine
058 Washington University in St. Louis School of Medicine

Code Lists

U.S. / Canadian Professional School Codes (continued)

Mississippi

328 University of Mississippi School of Dentistry
059 University of Mississippi School of Medicine

North Carolina

060 Duke University School of Medicine
061 The Brody School of Medicine at East Carolina University
329 University of North Carolina at Chapel Hill School of Dentistry
062 University of North Carolina at Chapel Hill School of Medicine
063 Wake Forest University School of Medicine

North Dakota

064 University of North Dakota School of Medicine and Health Sciences

Nebraska

330 Creighton University School of Dentistry
065 Creighton University School of Medicine
066 University of Nebraska College of Medicine
331 University of Nebraska Medical Center, College of Dentistry

New Hampshire

067 Dartmouth Medical School

New Jersey

068 Robert Wood Johnson Medical School
069 University of Medicine and Dentistry of New Jersey (UMDNJ)
332 UMDNJ, New Jersey Dental School
511 UMDNJ, School of Osteopathic Medicine

New Mexico

070 University of New Mexico School of Medicine

Nevada

071 University of Nevada School of Medicine

New York

072 Albany Medical College
073 Albert Einstein College of Medicine
074 Columbia University College of Physicians and Surgeons
333 Columbia University School of Dental and Oral Surgery
075 Joan & Sanford I. Weill Medical College of Cornell University
076 Mount Sinai School of Medicine of New York University
412 New York Chiropractic College
512 NY College of Osteopathic Medicine of the NY Institute of Technology
077 New York Medical College
334 New York University Kriser Dental Center
078 New York University School of Medicine
335 State University of New York at Buffalo School of Dental Medicine
082 State University of New York at Buffalo School of Medicine
336 State University of New York at Stony Brook School of Dental Medicine
081 State University of New York at Stony Brook School of Medicine
079 State University of New York College of Medicine
080 State University of New York Upstate Medical University
083 University of Rochester School of Medicine and Dentistry

Ohio

337 Case Western Reserve University School of Dentistry
084 Case Western Reserve University School of Medicine
085 Medical College of Ohio
086 Northeastern Ohio Universities College of Medicine
803 Ohio College of Podiatric Medicine
338 Ohio State University College of Dentistry
087 Ohio State University College of Medicine and Public Health
513 Ohio University College of Osteopathic Medicine
088 University of Cincinnati College of Medicine
089 Wright State University School of Medicine

Oklahoma

514 Oklahoma State University, College of Osteopathic Medicine
339 University of Oklahoma College of Dentistry
090 University of Oklahoma College of Medicine

Oregon

091 Oregon Health & Science University School of Medicine
340 Oregon Health Sciences University School of Dentistry
413 Western States Chiropractic College

Pennsylvania

092 Jefferson Medical College of Thomas Jefferson University

515 Lake Erie College of Osteopathic Medicine
093 MCP Hahnemann University School of Medicine
094 Pennsylvania State University College of Medicine
516 Philadelphia College of Osteopathic Medicine
341 Temple University School of Dentistry
095 Temple University School of Medicine
805 Temple University School of Podiatric Medicine
342 University of Pennsylvania School of Dental Medicine
096 University of Pennsylvania School of Medicine
343 University of Pittsburgh School of Dental Medicine
097 University of Pittsburgh School of Medicine

Puerto Rico

098 Ponce School of Medicine
099 Universidad Central del Caribe School of Medicine
100 University of Puerto Rico School of Medicine
344 University of Puerto Rico School of Dentistry

Rhode Island

101 Brown Medical School

South Carolina

345 Medical University of South Carolina College of Dental Medicine
102 Medical University of South Carolina College of Medicine
414 Sherman College of Chiropractic
103 University of South Carolina School of Medicine

South Dakota

104 University of South Dakota School of Medicine

Tennessee

105 East Tennessee State University
346 Meharry Medical College School of Dentistry
106 Meharry Medical College School of Medicine
347 University of Tennessee College of Dentistry
107 University of Tennessee College of Medicine
108 Vanderbilt University School of Medicine

Texas

348 Baylor College of Dentistry
109 Baylor College of Medicine
415 Parker College of Chiropractic
416 Texas Chiropractic College
110 Texas Tech University Health Sciences Center School of Medicine
111 The Texas A & M University System College of Medicine
517 UNT Health Sciences Center, Texas College of Osteopathic Medicine
349 University of Texas Health Science Center at Houston Dental School
350 University of Texas Health Science Center at San Antonio Dental School
112 University of Texas Medical Branch at Galveston
113 University of Texas Medical School at Houston
114 University of Texas Medical School at San Antonio
115 UT Southwestern Medical Center at Dallas Southwestern Medical School

Utah

116 University of Utah School of Medicine

Virginia

117 Eastern VA Medical School of the Medical College of Hampton Roads
118 University of Virginia School of Medicine Health System
351 Virginia Commonwealth University School of Dentistry
119 Virginia Commonwealth University School of Medicine

Vermont

120 University of Vermont College of Medicine

Washington

352 University of Washington School of Dentistry
121 University of Washington School of Medicine

Wisconsin

353 Marquette University School of Dentistry
122 Medical College of Wisconsin
123 University of Wisconsin Medical School

West Virginia

124 Joan C. Edwards School of Medicine at Marshall University
518 West Virginia School of Osteopathic Medicine
354 West Virginia University School of Dentistry
125 West Virginia University School of Medicine

Code Lists

U.S. / Canadian Professional School Codes (continued)

Canada

355	Dalhousie University Faculty of Dentistry
126	Dalhousie University Faculty of Medicine
357	Laval University Faculty of Dentistry
127	Laval University Faculty of Medicine
356	McGill University Faculty of Dentistry
128	McGill University Faculty of Medicine
129	McMaster University School of Medicine
130	Memorial University of Newfoundland Faculty of Medicine
131	Queen's University Faculty of Health Sciences
132	The University of Western Ontario Faculty of Medicine & Dentistry
133	Universite de Montreal Faculty of Medicine
134	Universite de Sherbrooke Faculty of Medicine
358	University of Alberta Faculty of Dentistry
135	University of Alberta Faculty of Medicine
359	University of British Columbia Faculty of Dentistry
136	University of British Columbia Faculty of Medicine
137	University of Calgary Faculty of Medicine
360	University of Manitoba Faculty of Dentistry
138	University of Manitoba Faculty of Medicine
361	University of Montreal Faculty of Dentistry
139	University of Ottawa Faculty of Medicine
362	University of Saskatchewan College of Dentistry
140	University of Saskatchewan College of Medicine
363	University of Toronto Faculty of Dentistry
141	University of Toronto Faculty of Medicine
364	University of Western Ontario Faculty of Dentistry

Specialty Codes - MD / DO Only

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

247	Allergy & Immunology	832	Internal Medicine, Bariatric Medicine	260	Obstetrics & Gynecology, Critical Care Medicine
246	Allergy & Immunology, Allergy		Specialization	326	Obstetrics & Gynecology, Gynecologic Oncology
291	Allergy & Immunology, Clinical & Laboratory Immunology	255	Internal Medicine, Cardiovascular Disease	286	Obstetrics & Gynecology, Gynecology
		294	Internal Medicine, Clinical & Laboratory Immunology	817	Obstetrics & Gynecology, Hospice and Palliative Medicine
249	Anesthesiology	253	Internal Medicine, Clinical Cardiac Electrophysiology	303	Obstetrics & Gynecology, Maternal & Fetal Medicine
235	Anesthesiology, Addiction Medicine	257	Internal Medicine, Critical Care Medicine	320	Obstetrics & Gynecology, Obstetrics
258	Anesthesiology, Critical Care Medicine	267	Internal Medicine, Endocrinology, Diabetes & Metabolism	271	Obstetrics & Gynecology, Reproductive Endocrinology
812	Anesthesiology, Hospice and Palliative Medicine	275	Internal Medicine, Gastroenterology	328	Ophthalmology
126	Anesthesiology, Pain Medicine	285	Internal Medicine, Geriatric Medicine	441	Oral & Maxillofacial Surgery
363	Clinical Pharmacology	287	Internal Medicine, Hematology	411	Orthopaedic Surgery
367	Colon & Rectal Surgery	288	Internal Medicine, Hematology & Oncology	412	Orthopaedic Surgery, Adult Reconstructive Orthopaedic Surgery
263	Dermatology	450	Internal Medicine, Hepatology	456	Orthopaedic Surgery, Foot and Ankle Surgery
292	Dermatology, Clinical & Laboratory Dermatological Immunology	816	Internal Medicine, Hospice and Palliative Medicine	406	Orthopaedic Surgery, Hand Surgery
444	Dermatology, Dermatological Surgery	299	Internal Medicine, Infectious Disease	415	Orthopaedic Surgery, Orthopaedic Surgery of the Spine
266	Dermatology, Dermatopathology	451	Internal Medicine, Interventional Cardiology	416	Orthopaedic Surgery, Orthopaedic Trauma
264	Dermatology, MOHS-Micrographic Surgery	453	Internal Medicine, Magnetic Resonance Imaging (MRI)	803	Orthopaedic Surgery, Pediatric Orthopaedic Surgery
443	Dermatology, Pediatric Dermatology	325	Internal Medicine, Medical Oncology	457	Orthopaedic Surgery, Sports Medicine
268	Emergency Medicine	309	Internal Medicine, Nephrology	119	Orthopedic
445	Emergency Medicine, Emergency Medical Services	378	Internal Medicine, Pulmonary Disease	331	Otolaryngology
813	Emergency Medicine, Hospice and Palliative Medicine	390	Internal Medicine, Rheumatology	458	Otolaryngology, Otolaryngic Allergy
427	Emergency Medicine, Medical Toxicology	802	Internal Medicine, Sleep Medicine	459	Otolaryngology, Otolaryngology/ Facial Plastic Surgery
348	Emergency Medicine, Pediatric Emergency Medicine	397	Internal Medicine, Sports Medicine	332	Otolaryngology, Otolology & Neurotology
395	Emergency Medicine, Sports Medicine	833	Internal Medicine, Transplant Hepatology	357	Otolaryngology, Pediatric Otolaryngology
446	Emergency Medicine, Undersea and Hyperbaric Medicine	433	Laboratories, Clinical Medical Laboratory	417	Otolaryngology, Plastic Surgery within the Head & Neck
391	Facial Plastic Surgery	481	Legal Medicine	804	Otolaryngology, Sleep Medicine
272	Family Medicine	278	Medical Genetics, Clinical Biochemical Genetics	480	Pain Medicine, Interventional Pain Medicine
447	Family Medicine, Addiction Medicine	261	Medical Genetics, Clinical Cytogenetic	337	Pain Medicine
237	Family Medicine, Adolescent Medicine	277	Medical Genetics, Clinical Genetics (M.D.)	338	Pathology, Anatomic Pathology
448	Family Medicine, Adult Medicine	280	Medical Genetics, Clinical Molecular Genetics	340	Pathology, Anatomic Pathology & Clinical Pathology
831	Family Medicine, Bariatric Medicine	455	Medical Genetics, Molecular Genetic Pathology	250	Pathology, Blood Banking & Transfusion Medicine
	Specialization	454	Medical Genetics, Ph.D. Medical Genetics	344	Pathology, Chemical Pathology
282	Family Medicine, Geriatric Medicine	306	Neonatal-Perinatal Medicine	835	Pathology, Clinical Pathology
814	Family Medicine, Hospice and Palliative Medicine	308	Neopathology	302	Pathology, Clinical Pathology/Laboratory Medicine
396	Family Medicine, Sports Medicine	409	Neurological Surgery	262	Pathology, Cytopathology
225	General Practice	330	Neuromusculoskeletal Medicine & OMM	265	Pathology, Dermatopathology
479	Hospitalist	440	Neuromusculoskeletal Medicine, Sports Medicine	273	Pathology, Forensic Pathology
815	Independent Medical Examiner	317	Nuclear Medicine	290	Pathology, Hematology
301	Internal Medicine	318	Nuclear Medicine, In Vivo & In Vitro Nuclear Medicine		
449	Internal Medicine, Addiction Medicine	315	Nuclear Medicine, Nuclear Cardiology		
236	Internal Medicine, Adolescent Medicine	316	Nuclear Medicine, Nuclear Imaging & Therapy		
248	Internal Medicine, Allergy & Immunology	321	Obstetrics & Gynecology		
		834	Obstetrics & Gynecology, Bariatric Medicine Specialization		

Code Lists

Specialty Codes - MD/DO Only

298 Pathology, Immunopathology	836 Pediatrics, Pediatric Transplant Hepatology	370 Psychiatry & Neurology, Addiction Medicine	476 Psychiatry & Neurology, Vascular Neurology
305 Pathology, Medical Microbiology	806 Pediatrics, Sleep Medicine	473 Psychiatry & Neurology, Addiction Psychiatry	366 Public Health & General Preventive Medicine
461 Pathology, Molecular Genetic Pathology	398 Pediatrics, Sports Medicine	838 Psychiatry & Neurology, Bariatric Medicine	252 Radiology, Body Imaging
312 Pathology, Neuropathology	819 Phlebology	371 Psychiatry & Neurology, Child & Adolescent Psychiatry	824 Radiology, Diagnostic Neurolmaging
358 Pathology, Pediatric Pathology	365 Physical Medicine & Rehabilitation	313 Psychiatry & Neurology, Clinical Neurophysiology	173 Radiology, Diagnostic Radiology
244 Pediatrics	820 Physical Medicine & Rehabilitation, Hospice and Palliative Medicine	821 Psychiatry & Neurology, Diagnostic Neurolmaging	430 Radiology, Diagnostic Ultrasound
805 Pediatric Anesthesiology	837 Physical Medicine & Rehabilitation, Neuromuscular Medicine	274 Psychiatry & Neurology, Forensic Psychiatry	825 Radiology, Hospice and Palliative Medicine
239 Pediatrics, Adolescent Medicine	468 Physical Medicine & Rehabilitation, Pain Medicine	373 Psychiatry & Neurology, Geriatric Psychiatry	314 Radiology, Neuroradiology
295 Pediatrics, Clinical & Laboratory Immunology	389 Physical Medicine & Rehabilitation, Pediatric Rehabilitation Medicine	822 Psychiatry & Neurology, Hospice and Palliative Medicine	319 Radiology, Nuclear Radiology
462 Pediatrics, Developmental – Behavioral Pediatrics	466 Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine	472 Psychiatry & Neurology, Neurodevelopmental Disabilities	360 Radiology, Pediatric Radiology
818 Pediatrics, Hospice and Palliative Medicine	469 Physical Medicine & Rehabilitation, Sports Medicine	100 Psychiatry & Neurology, Neurology	380 Radiology, Radiation Oncology
354 Pediatrics, Medical Toxicology	419 Plastic Surgery	311 Psychiatry & Neurology, Neurology with Special Qualifications in Child Neurology	477 Radiology, Radiological Physics
356 Pediatrics, Neurodevelopmental Disabilities	470 Plastic Surgery, Plastic Surgery Within the Head and Neck	839 Psychiatry & Neurology, Neuromuscular Medicine	381 Radiology, Therapeutic Radiology
345 Pediatrics, Pediatric Allergy & Immunology	407 Plastic Surgery, Surgery of the Hand	474 Psychiatry & Neurology, Pain Medicine	384 Radiology, Vascular & Interventional Radiology
346 Pediatrics, Pediatric Cardiology	242 Preventive Medicine, Aerospace Medicine	368 Psychiatry & Neurology, Psychiatry	434 Supplier
347 Pediatrics, Pediatric Critical Care Medicine	429 Preventive Medicine, Medical Toxicology	823 Psychiatry & Neurology, Psychosomatic Medicine	399 Surgery
463 Pediatrics, Pediatric Emergency Medicine	112 Preventive Medicine, Occupational Medicine	809 Psychiatry & Neurology, Sleep Medicine	826 Surgery, Hospice and Palliative Medicine
349 Pediatrics, Pediatric Endocrinology	471 Preventive Medicine, Sports Medicine	475 Psychiatry & Neurology, Sports Medicine	418 Surgery, Pediatric Surgery
350 Pediatrics, Pediatric Gastroenterology	431 Preventive Medicine, Undersea and Hyperbaric Medicine		420 Surgery, Plastic and Reconstructive Surgery
351 Pediatrics, Pediatric Hematology-Oncology	114 Preventive Medicine/Occupational Environmental Medicine		405 Surgery, Surgery of the Hand
352 Pediatrics, Pediatric Infectious Diseases			425 Surgery, Surgical Critical Care
355 Pediatrics, Pediatric Nephrology			413 Surgery, Surgical Oncology
359 Pediatrics, Pediatric Pulmonology			423 Surgery, Trauma Surgery
361 Pediatrics, Pediatric Rheumatology			400 Surgery, Vascular Surgery
			421 Thoracic Surgery (Cardiothoracic Vascular Surgery)
			442 Transplant Surgery
			424 Urology
			811 Urology, Pediatric Urology

Specialty Codes - DDS / DMD / DPM / DC

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

DDS / DMD	DPM	DC
2 Dentist	3 Podiatrist	1 Chiropractor
13 Dentist, Dental Public Health	231 Podiatrist, Foot & Ankle Surgery	827 Chiropractor, Independent Medical Examiner
14 Dentist, Endodontics	230 Podiatrist, Foot Surgery	5 Chiropractor, Internist
438 Dentist, General Practice	227 Podiatrist, Primary Podiatric Medicine	6 Chiropractor, Neurology
16 Dentist, Oral and Maxillofacial Pathology	226 Podiatrist, Public Medicine	7 Chiropractor, Nutrition
439 Dentist, Oral and Maxillofacial Radiology	228 Podiatrist, Radiology	8 Chiropractor, Occupational Medicine
20 Dentist, Oral and Maxillofacial Surgery	229 Podiatrist, Sports Medicine	9 Chiropractor, Orthopedic
15 Dentist, Orthodontics and Dentofacial Orthopedics		10 Chiropractor, Radiology
17 Dentist, Pediatric Dentistry		801 Chiropractor, Rehabilitation Specialization
18 Dentist, Periodontics		11 Chiropractor, Sports Physician
19 Dentist, Prosthodontics		12 Chiropractor, Thermography

Specialty Codes - Allied Providers

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

501 Acupuncturist	751 Clinical Nurse Specialist, Psychiatric/Mental Health, Adult
503 Audiologist	752 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent
504 Audiologist, Assistive Technology Practitioner	753 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family
505 Audiologist, Assistive Technology Supplier	754 Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill
841 Certified First Assistant	755 Clinical Nurse Specialist, Psychiatric/Mental Health, Community
531 Christian Science Practitioner	756 Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric
727 Clinical Nurse Specialist	757 Clinical Nurse Specialist, Rehabilitation
728 Clinical Nurse Specialist, Acute Care	759 Clinical Nurse Specialist, School
729 Clinical Nurse Specialist, Adult Health	758 Clinical Nurse Specialist, Transplantation
730 Clinical Nurse Specialist, Chronic Care	760 Clinical Nurse Specialist, Women's Health
731 Clinical Nurse Specialist, Community Health/Public Health	513 Counselor
732 Clinical Nurse Specialist, Critical Care Medicine	514 Counselor, Addiction (Substance Use Disorder)
733 Clinical Nurse Specialist, Emergency	515 Counselor, Mental Health
734 Clinical Nurse Specialist, Ethics	516 Counselor, Professional
735 Clinical Nurse Specialist, Family Health	533 Dietitian, Registered
736 Clinical Nurse Specialist, Gerontology	536 Dietitian, Registered, Nutrition, Metabolic
737 Clinical Nurse Specialist, Holistic	534 Dietitian, Registered, Nutrition, Pediatric
738 Clinical Nurse Specialist, Home Health	535 Dietitian, Registered, Nutrition, Renal
739 Clinical Nurse Specialist, Informatics	651 Licensed Practical Nurse
740 Clinical Nurse Specialist, Long-Term Care	517 Marriage & Family Therapist
741 Clinical Nurse Specialist, Medical-Surgical	547 Massage Therapist
742 Clinical Nurse Specialist, Neonatal	549 Midwife, Certified
743 Clinical Nurse Specialist, Neuroscience	652 Midwife, Certified Nurse
744 Clinical Nurse Specialist, Occupational Health	551 Naturopath
745 Clinical Nurse Specialist, Oncology	553 Clinical Neuropsychologist
746 Clinical Nurse Specialist, Oncology, Pediatrics	653 Nurse Anesthetist, Certified Registered
747 Clinical Nurse Specialist, Pediatrics	654 Nurse Practitioner
748 Clinical Nurse Specialist, Perinatal	655 Nurse Practitioner, Acute Care
749 Clinical Nurse Specialist, Perioperative	656 Nurse Practitioner, Adult Health
750 Clinical Nurse Specialist, Psychiatric/Mental Health	657 Nurse Practitioner, Critical Care Medicine

Code Lists

Specialty Codes - Allied Providers (continued)

658	Nurse Practitioner, Community Health	679	Registered Nurse, Continuing Education/Staff Development
659	Nurse Practitioner, Family	675	Registered Nurse, Critical Care Medicine
660	Nurse Practitioner, Gerontology	682	Registered Nurse, Diabetes Educator
661	Nurse Practitioner, Neonatal	683	Registered Nurse, Dialysis, Peritoneal
662	Nurse Practitioner, Neonatal, Critical Care	684	Registered Nurse, Emergency
670	Nurse Practitioner, Obstetrics & Gynecology	685	Registered Nurse, Enterostomal Therapy
671	Nurse Practitioner, Occupational Health	686	Registered Nurse, Flight
663	Nurse Practitioner, Pediatrics	688	Registered Nurse, Gastroenterology
664	Nurse Practitioner, Pediatrics, Critical Care	687	Registered Nurse, General Practice
666	Nurse Practitioner, Perinatal	689	Registered Nurse, Gerontology
667	Nurse Practitioner, Primary Care	691	Registered Nurse, Hemodialysis
665	Nurse Practitioner, Psych/Mental Health	690	Registered Nurse, Home Health
668	Nurse Practitioner, School	692	Registered Nurse, Hospice
669	Nurse Practitioner, Women's Health	694	Registered Nurse, Infection Control
537	Nutritionist	693	Registered Nurse, Infusion Therapy
538	Nutritionist, Nutrition, Education	695	Registered Nurse, Lactation Consultant
555	Occupational Therapist	696	Registered Nurse, Maternal Newborn
556	Occupational Therapist, Ergonomics	697	Registered Nurse, Medical-Surgical
557	Occupational Therapist, Hand	699	Registered Nurse, Neonatal Intensive Care
558	Occupational Therapist, Human Factors	700	Registered Nurse, Neonatal, Low-Risk
559	Occupational Therapist, Neurorehabilitation	701	Registered Nurse, Nephrology
560	Occupational Therapist, Pediatrics	702	Registered Nurse, Neuroscience
561	Occupational Therapist, Rehabilitation, Driver	698	Registered Nurse, Nurse Massage Therapist (NMT)
563	Optician	703	Registered Nurse, Nutrition Support
565	Optometrist	719	Registered Nurse, Obstetric, High-Risk
566	Optometrist, Corneal and Contact Management	720	Registered Nurse, Obstetric, Inpatient
567	Optometrist, Low Vision Rehabilitation	721	Registered Nurse, Occupational Health
571	Optometrist, Occupational Vision	722	Registered Nurse, Oncology
568	Optometrist, Pediatrics	725	Registered Nurse, Ophthalmic
569	Optometrist, Sports Vision	724	Registered Nurse, Orthopedic
570	Optometrist, Vision Therapy	726	Registered Nurse, Ostomy Care
573	Pharmacist	723	Registered Nurse, Otorhinolaryngology & Head-Neck
574	Pharmacist, General Practice	704	Registered Nurse, Pain Management
807	Pharmacist, Geriatric	706	Registered Nurse, Pediatric Oncology
575	Pharmacist, Nuclear	705	Registered Nurse, Pediatrics
576	Pharmacist, Nutrition Support	710	Registered Nurse, Perinatal
808	Pharmacist, Oncology	714	Registered Nurse, Plastic Surgery
577	Pharmacist, Pharmacotherapy	708	Registered Nurse, Psych/Mental Health
578	Pharmacist, Psychiatric	709	Registered Nurse, Psych/Mental Health, Adult
580	Physical Therapist	707	Registered Nurse, Psych/Mental Health, Child & Adolescent
581	Physical Therapist, Cardiopulmonary	810	Registered Nurse, Registered Nurse First Assistant
583	Physical Therapist, Electrophysiology, Clinical	712	Registered Nurse, Rehabilitation
582	Physical Therapist, Ergonomics	713	Registered Nurse, Reproductive Endocrinology/Infertility
584	Physical Therapist, Geriatrics	715	Registered Nurse, School
585	Physical Therapist, Hand	716	Registered Nurse, Urology
586	Physical Therapist, Human Factors	718	Registered Nurse, Women's Health Care, Ambulatory
587	Physical Therapist, Neurology	717	Registered Nurse, Wound Care
590	Physical Therapist, Orthopedic	617	Respiratory Therapist, Certified
588	Physical Therapist, Pediatrics	618	Respiratory Therapist, Certified, Critical Care
589	Physical Therapist, Sports	620	Respiratory Therapist, Certified, Educational
592	Physician Assistant	619	Respiratory Therapist, Certified, Emergency Care
593	Physician Assistant, Medical	622	Respiratory Therapist, Certified, General Care
594	Physician Assistant, Surgical	621	Respiratory Therapist, Certified, Geriatric Care
840	Poetry Therapist	623	Respiratory Therapist, Certified, Home Health
828	Psychoanalyst	628	Respiratory Therapist, Certified, Neonatal/Pediatrics
596	Psychologist	627	Respiratory Therapist, Certified, Palliative/Hospice
597	Psychologist, Addiction (Substance Use Disorder)	629	Respiratory Therapist, Certified, Patient Transport
598	Psychologist, Adult Development & Aging	624	Respiratory Therapist, Certified, Pulmonary Diagnostics
599	Psychologist, Cognitive & Behavioral	626	Respiratory Therapist, Certified, Pulmonary Function Technologist
602	Psychologist, Clinical Child & Adolescent	625	Respiratory Therapist, Certified, Pulmonary Rehabilitation
600	Psychologist, Clinical	630	Respiratory Therapist, Certified, SNF/Subacute Care
601	Psychologist, Counseling	631	Respiratory Therapist, Registered
604	Psychologist, Exercise & Sports	632	Respiratory Therapist, Registered, Critical Care
605	Psychologist, Family	634	Respiratory Therapist, Registered, Educational
606	Psychologist, Forensic	633	Respiratory Therapist, Registered, Emergency Care
607	Psychologist, Health	636	Respiratory Therapist, Registered, General Care
609	Psychologist, Mental Retardation & Developmental Disabilities	635	Respiratory Therapist, Registered, Geriatric Care
830	Psychologist, Prescribing	637	Respiratory Therapist, Registered, Home Health
610	Psychologist, Psychoanalysis	642	Respiratory Therapist, Registered, Neonatal/Pediatrics
611	Psychologist, Psychotherapy	641	Respiratory Therapist, Registered, Palliative/Hospice
612	Psychologist, Group Psychotherapy	643	Respiratory Therapist, Registered, Patient Transport
613	Psychologist, Rehabilitation	638	Respiratory Therapist, Registered, Pulmonary Diagnostics
614	Psychologist, School	640	Respiratory Therapist, Registered, Pulmonary Function Technologist
672	Registered Nurse	639	Respiratory Therapist, Registered, Pulmonary Rehabilitation
673	Registered Nurse, Addiction (Substance Use Disorder)	644	Respiratory Therapist, Registered, SNF/Subacute Care
674	Registered Nurse, Administrator	646	Social Worker, Clinical
711	Registered Nurse, Ambulatory Care	648	Specialist/Technologist, Other, Biomedical Engineering
681	Registered Nurse, Cardiac Rehabilitation	506	Speech-Language Pathologist
676	Registered Nurse, Case Management	649	Technician, Other, Biomedical Engineering
677	Registered Nurse, College Health	502	Other, Not Listed
678	Registered Nurse, Community Health		
680	Registered Nurse, Continence Care		

Code Lists

Specialty Boards - Allied Providers

940 Academy of Certified Social Workers	350 American Nurses Credentialing Center
1150 ACNM Certification Council	740 American Psychological Association
360 American Academy of Ambulatory Care Nursing	750 American Psychological Society
1550 American Academy of Anesthesiologist Assistants	760 American Psychotherapy Association
230 American Academy of Audiology	290 American Society of Addiction Medicine
370 American Academy of Experts in Traumatic Stress	1650 American Speech-Language-Hearing Association
270 American Academy of Health Providers in the Addictive Disorders	250 Biofeedback Certification Institute of America
200 American Academy of Medical Acupuncture	1430 Board of Pharmaceutical Specialties
405 American Academy of Nurse Practitioners	1250 Commission on Dietetic Registration
380 American Academy of Nursing	960 Employee Assistance Professionals Association
1330 American Academy of Optometry	780 National Association for the Advancement of Psychoanalysis
1480 American Academy of Physician Assistants	1450 National Association of Boards of Pharmacy
1110 American Association for Marriage and Family Therapy	1600 National Association of Nurse Anesthetists
390 American Association of Critical Care Nurses	770 National Association of School Psychologists
1590 American Association of Nurse Anesthetists	980 National Association of Social Workers
330 American Association of Pastoral Counselors	1310 National Board for Certification in Occupational Therapy
1010 American Association of Sex Educators, Counselors and Therapists	1490 National Board for Certification of Orthopaedic Physician Assistants
710 American Board Medical Psychotherapists	790 National Board for Certified Clinical Hypnotherapists
280 American Board of Addiction Medicine	310 National Board for Certified Counselors
950 American Board of Examiners in Clinical Social Work	1630 National Board for Respiratory Care
720 American Board of Medical Psychotherapists & Psychodiagnosticians	300 National Board of Addiction Examiners
400 American Board of Nursing Specialties	800 National Board of Cognitive Behavioral Therapists
1240 American Board of Nutrition	1350 National Board of Examiners in Optometry
1300 American Board of Occupational Medicine	1090 National Certification Board for Therapeutic Massage and Bodywork
1360 American Board of Ophthalmology	210 National Certification Commission for Acupuncture and Oriental Medicine
1510 American Board of Physical Therapy Specialties	1440 National Institute for Standards in Pharmacist Credentialing
700 American Board of Professional Psychology	220 Other - Not Listed
1130 American Naturopath Certification Board	

Specialty Boards - MD / DDS / DMD / DO / DPM

MD Boards

044 American Board of Allergy & Immunology
045 American Board of Anesthesiology
046 American Board of Colon & Rectal Surgery
047 American Board of Dermatology
048 American Board of Emergency Medicine
049 American Board of Family Medicine
050 American Board of Internal Medicine
051 American Board of Medical Genetics
052 American Board of Neurological Surgery
053 American Board of Nuclear Medicine
054 American Board of Obstetrics & Gynecology
055 American Board of Ophthalmology
109 American Board of Oral & Maxillofacial Surgeons
056 American Board of Orthopaedic Surgery
057 American Board of Otolaryngology
058 American Board of Pathology
059 American Board of Pediatrics
060 American Board of Physical Medicine & Rehabilitation
061 American Board of Plastic Surgery
062 American Board of Preventive Medicine
063 American Board of Psychiatry & Neurology
064 American Board of Radiology
065 American Board of Surgery
066 American Board of Thoracic Surgery
067 American Board of Urology
142 Boards other than ABMS/AOA

Dental Boards

113 American Board of Endodontics
114 American Board of Oral & Maxillofacial Pathology
117 American Board of Oral & Maxillofacial Radiology
109 American Board of Oral & Maxillofacial Surgeons

108 American Board of Orthodontics
112 American Board of Pediatric Dentistry
111 American Board of Periodontology
115 American Board of Prosthodontics
106 American Board of Public Health Dentistry
120 Boards other than ABMS/AOA

DO Boards

118 American Osteopathic Board of Anesthesiology
119 American Osteopathic Board of Dermatology
120 American Osteopathic Board of Emergency Medicine
121 American Osteopathic Board of Family Practice
123 American Osteopathic Board of Internal Medicine
124 American Osteopathic Board of Neurology and Psychiatry
125 American Osteopathic Board of Neuromuskuloskeletal Medicine
126 American Osteopathic Board of Nuclear Medicine
127 American Osteopathic Board of Obstetrics and Gynecology
128 American Osteopathic Board of Ophthalmology and Otolaryngology
129 American Osteopathic Board of Orthopedic Surgery
130 American Osteopathic Board of Pathology
131 American Osteopathic Board of Pediatrics
132 American Osteopathic Board of Preventive Medicine
133 American Osteopathic Board of Proctology
134 American Osteopathic Board of Radiology
135 American Osteopathic Board of Rehabilitation Medicine
136 American Osteopathic Board of Surgery

DPM Boards

140 American Board of Medical Specialists in Podiatry
137 American Board of Podiatric Orthopedics and Primary Podiatric Medicine
138 American Board of Podiatric Surgery
139 American Council of Certified Podiatric Surgeons and Physicians