



Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield Practitioner Credentialing Application

Regence contracts with physicians, dentists, other health care and dental professionals to form provider networks essential for the delivery of health care services to our members. Regence requires all providers to meet credentialing criteria prior to contracting, and remain in compliance with those criteria at all times. Please refer to the *Practitioner Credentialing Criteria for Participation and Termination* for details.

You will receive an email confirmation once you have successfully completed credentialing. You will receive another email when your agreement documents are available for viewing and signature.

NOTE: If you practice at a clinic that has a Regence *Participating Medical Group Agreement*, you will be added to the group's agreement and you do not need to sign any additional documents.

To begin the credentialing verification process, please:

1. Provide the email address and name of the individual who is responsible for reviewing and electronically signing the agreement documents:

All agreement documents are sent electronically. Please provide the following information to receive your documents electronically. Failure to fill out this portion will delay your documents.	
First Name:	
Last Name:	
Email:	

2. Complete the application online in its entirety and print it.
3. Attach a copy of your CP 575 or 147C letter, obtained from the Internal Revenue Service (IRS). If you do not have a 147C letter, please contact the IRS at 1 (800) 829-4933.
4. Sign pages 11 and 13 and return them along with any supporting documentation to Regence via one of the following methods:
 - a. Email: Sign and scan pages 11 and 13. Attach the signed, scanned pages and supporting documentation to an email and send to **regence_credentialing@regence.com**. Your email should include the completed application, a copy of your CP 575 or 147C letter, pages 11 and 13 which have been signed, and supporting documentation.
 - b. Fax: Print your completed application. Sign pages 11 and 13 and fax the entire application together with a copy of your CP 575 or 147C letter and any supporting documentation to 1 (888) 335-3002.
5. Retain the printed application for your records.

You have the right to review information submitted to support your credentialing application, including review of information submitted from outside sources, e.g., malpractice insurance and state licensing boards. You may also request information about the status of your application or reapplication. All requests should be submitted to the Credentialing department by e-mail at **regence_credentialing@regence.com**. Application status requests are responded to and tracked in your credentialing file. Information that is allowed to be shared

includes the current status, outstanding requests and process timeframes. Peer-protected and confidential information prohibited by law cannot be disclosed.

In the event that erroneous or conflicting information is discovered in a credentialing application, you will be notified in writing of the right to dispute and/or correct the information (subject to any restrictions provided by a verification source, or otherwise prohibited by law). You must submit a detailed explanation of all clarifications and corrections in writing, within fifteen (15) business days of the request, to the Credentialing department via e-mail or by fax at 1 (888) 335-3002. The credentialing staff documents receipt of corrected credentialing information in your credentialing file.

To learn more about the credentialing process and eContracting, visit the Contracting and credentialing section of our provider website at **regence.com**. If you have questions about the process or the status of your application, please contact our Credentialing department by email at **regence_credentialing@regence.com**.

Washington Practitioner Application

To use the Washington Practitioner Application (WPA), follow these instructions:

- ❖ **Keep an unsigned and undated copy of the application on file for future requests.** When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate.
- ❖ Please sign and date pages 11 and 13.
- ❖ Please document any YES responses on the Attestation Question page.
- ❖ Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- ❖ Attach copies of requested documents each time the application is submitted.
- ❖ If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- ❖ If a section does not apply to you, please check the provided box at the top of the section.
- ❖ Expect addendums from the requesting organizations for information not included on the WPA.

This application is submitted to:

<p>1. INSTRUCTIONS</p> <p>This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. <i>Please do not use abbreviations.</i> Current copies of the following documents must be submitted with this application: (all are required for MDs, DOs; as applicable for other health practitioners).</p> <ul style="list-style-type: none"> • DEA Certificate • Face Sheet of Professional Liability Policy or Certificate • Curriculum Vitae (Not an acceptable substitute for completing the application. Dates need to be listed in mm/yyyy Format) <p style="text-align: center;">** All sections must be completed in their entirety. **</p>

2. PRACTITIONER INFORMATION – Legal Name Required			
Last Name: (include suffix; Jr., Sr., III)	First:	Middle:	Degree(s):
List any other name(s) under which you have been known by reference, licensing and or educational institutions, including the date of name change(s) if known (mm/dd/yyyy):			
Home Mailing Address:		City:	
		State:	Zip Code:
Home Telephone Number: ()	Pager Number: ()	Cell Phone Number: ()	E-Mail Address:
Birth Date: (mm/dd/yyyy)	Birth Place (city, state, country):	Citizenship:	Race/Ethnicity (Optional):
Social Security Number:	<input type="checkbox"/> "Male" <input type="checkbox"/> "Female" <input type="checkbox"/> "X"		Languages Spoken Fluently by Practitioner:
Have you ever voluntarily opted-out of Medicare? Yes <input type="checkbox"/> No <input type="checkbox"/>			
NPI:	Medicare Number: (WA)	Medicaid (DSHS) Number(s):	L & I Number(s):
Specialty primarily practicing:		Sub specialties primarily practicing:	
Other Professional Interests in Practice, Research, etc.:			

3. PRIMARY PRACTICE INFORMATION Practitioner Start Date (MM/YYYY): **CHECK ALL THAT APPLY**

Practice Setting <input type="checkbox"/> Clinic/Group <input type="checkbox"/> Solo Practice <input type="checkbox"/> Home Based <input type="checkbox"/> Hospital Based <input type="checkbox"/> Primary Care Site <input type="checkbox"/> Urgent Care <input type="checkbox"/> Other													
Practitioner Profile <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Both PCP & OB OB in your practice <input type="checkbox"/> Yes <input type="checkbox"/> No Deliveries <input type="checkbox"/> Yes <input type="checkbox"/> No													
Do you offer Telehealth? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you exclusively Telehealth? <input type="checkbox"/> Yes <input type="checkbox"/> No													
Name of Practice / Affiliation or Clinic Name: _____													
Department Name (if hospital based): _____													
Primary Office Street Address: _____													
City: _____ State: _____													
Zip Code: _____ Org. NPI#: _____													
Patient Appointment Telephone Number: _____ ()													
Fax Number: _____ ()													
Mailing Address: (if different from above)													
Billing Address: (if different from above)													
Office Manager / Administrator Name: _____													
Administration Telephone Number: _____ ()													
Practice Website: _____													
E-mail Address: _____													
Fax Number: _____ ()													
Credentialing Contact (if different from above): _____													
Telephone Number: _____ ()													
Credentialing Address: (if different from above)													
E-mail Address: _____													
Fax Number: _____ ()													
Name Affiliated with Tax ID Number: _____													
Federal Tax ID Number: _____													
Is the office wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No Are Gender Affirming treatment services offered? <input type="checkbox"/> Yes <input type="checkbox"/> No or <input type="checkbox"/> Unknown													
Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you limited your practice in any way (e.g. 18 years or older?) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____ _____ _____													
Do you currently supervise ARNP's or PA's? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the name and specialty below: _____ _____ _____													
Please list languages fluently spoken by office staff: _____ _____ _____													
Office Hours Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____ Sunday: _____ Do you provide 24 hour coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain how your patients obtain advice and care after hours: _____ _____ _____													
A. Hospital Inpatient Coverage Plan (for those without admitting privileges) Does Not Apply <input type="checkbox"/>													
Name of Admitting Physician/Practice/Clinic/Group: _____													
Hospital Where privileged: _____													
B. Office Covering Practitioners/Call Group Does Not Apply <input type="checkbox"/>													
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Provider Name, Degree</th> <th style="width: 25%;">Specialty</th> <th style="width: 25%;">Address</th> <th style="width: 25%;">Phone Number</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>		Provider Name, Degree	Specialty	Address	Phone Number								
Provider Name, Degree	Specialty	Address	Phone Number										
Attach a list of additional admitting physician/practice/clinic/group or covering practitioners if needed													

Practitioner Start Date at SECONDARY Practice location (MM/YYYY)		CHECK ALL THAT APPLY	
Practice Setting			
<input type="checkbox"/> Clinic/Group <input type="checkbox"/> Solo Practice <input type="checkbox"/> Home Based <input type="checkbox"/> Hospital Based <input type="checkbox"/> Primary Care Site <input type="checkbox"/> Urgent Care <input type="checkbox"/> Other			
Practitioner Profile			
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Both PCP & OB OB in your practice <input type="checkbox"/> Yes <input type="checkbox"/> No Deliveries <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you offer Telehealth? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Telehealth:	
Are you exclusively Telehealth? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Audio <input type="checkbox"/> Visual <input type="checkbox"/> Both	
Name of Secondary Practice / Affiliation or Clinic Name:		Department Name (if hospital based):	
Primary Office Street Address:		City:	
		State:	Zip Code: Org. NPI#
Patient Appointment Telephone Number: ()		Fax Number: ()	
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Office Manager / Administrator Name:		Administration Telephone Number: ()	Practice Website:
E-mail Address:		Fax Number: ()	
Credentialing Contact (if different from above):		Telephone Number: ()	
Credentialing Address: (if different from above)			
E-mail Address:		Fax Number: ()	
Name Affiliated with Tax ID Number:		Federal Tax ID Number:	
Is the office wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No		Office Hours	
Are Gender Affirming treatment services offered? <input type="checkbox"/> Yes <input type="checkbox"/> No or <input type="checkbox"/> Unknown			
Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you limited your practice in any way (e.g. 18 years or older?) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____			
Do you currently supervise ARNP's or PA's? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide the name and specialty below: _____			
Please list languages fluently spoken by office staff: _____		Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____ Sunday: _____ Do you provide 24 hour coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain how your patients obtain advice and care after hours: _____	
A. Hospital Inpatient Coverage Plan (for those without admitting privileges)			Does Not Apply <input type="checkbox"/>
Name of Admitting Physician/Practice/Clinic/Group:		Hospital Where privileged:	
B. Office Covering Practitioners/Call Group			Does Not Apply <input type="checkbox"/>
Provider Name, Degree	Specialty	Address	Phone Number
Attach a list of additional admitting physician/practice/clinic/group or covering practitioners if needed			
LIST OTHER OFFICE LOCATIONS WITH THE ABOVE INFORMATION ON A SEPARATE SHEET			

4. PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS (Attach Additional Sheet if Necessary)					
Washington State Professional License/Registration/Cert Number:		Issue Date:		Expiration Date:	
Name of Sponsor if required by licensure, (e.g. Physician's Assistant).					
Pharmacists Collaborative Drug Therapy Agreement (CDTA) Number(s):					
Drug Enforcement Administration (DEA) Registration Number:				Expiration Date:	
ECFMG Number (applicable to foreign medical graduates):				Date Issued:	
5. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS					
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
6. UNDERGRADUATE EDUCATION (Do not abbreviate) Does Not Apply <input type="checkbox"/>					
School/College/University/Vocational Education:		Degree Received (be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)	
Mailing Address:		City:	State:	Zip Code:	
College or University Name:		Degree Received (be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)	
Mailing Address:		City:	State:	Zip Code:	
7. MASTER DEGREE PROGRAM OR POST GRADUATE EDUCATION Does Not Apply <input type="checkbox"/>					
Institution:	Address		City	State	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Program or Course of Study:				
Faculty Director:	Degree:				
8. MEDICAL/PROFESSIONAL EDUCATION (Do not abbreviate)					
Medical/Professional School:	Start Date: (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received		
Mailing Address:	City:	State:	Zip Code:		
Medical/Professional School:	Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received		
Mailing Address:	City:	State:	Zip Code:		

9. INTERNSHIP/PGYI (Attach Additional Sheet if Necessary)				Does Not Apply <input type="checkbox"/>
Institution:	Phone Number:	Fax Number:	Program Director:	
Mailing Address:	City:	State:	Zip Code:	
Type of Internship:	Specialty:	From (mm/yyyy):	To (mm/yyyy):	
10. RESIDENCIES (Attach Additional Sheet if Necessary)				Does Not Apply <input type="checkbox"/>
Institution:	Phone Number:	Fax Number:	Program Director:	
Mailing Address:	City:	State:	Zip Code:	
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):	
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)				
Institution:	Phone Number:	Fax Number:	Program Director:	
Mailing Address:	City:	State:	Zip Code:	
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):	
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)				
11. FELLOWSHIPS (Attach Additional Sheet if Necessary)				Does Not Apply <input type="checkbox"/>
Institution:	Phone Number:	Fax Number:	Program Director:	
Mailing Address:	City:	State:	Zip Code:	
Course of Study:		From (mm/yyyy):	To (mm/yyyy):	
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)				
Institution:	Phone Number:	Fax Number:	Program Director:	
Mailing Address:	City:	State:	Zip Code:	
Course of Study:		From (mm/yyyy):	To (mm/yyyy):	
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)				
12. PRECEPTORSHIP (Attach Additional Sheet if Necessary)				Does Not Apply <input type="checkbox"/>
Institution:	Address:	City:	State:	Zip Code:
Telephone Number ()	Fax Number ()	Email Address		
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Training:	Department Chairman:		

13. FACULTY/TEACHING APPOINTMENTS (Attach Additional Sheet if Necessary)				Does Not Apply <input type="checkbox"/>	
Institution:		Address:	City:		State: Zip Code:
Telephone Number ()		Fax Number ()		Email Address	
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)		Position:		Faculty Director:	
14. BOARD CERTIFICATION				Does Not Apply <input type="checkbox"/>	
Are you board or otherwise professionally certified?					
<input type="checkbox"/> Yes If "Yes", please complete below:		<input type="checkbox"/> No If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.			
Issuing Board/Entity and State Issued	Specialty		Date Certified	Date Recertified	Expiration Date (if any)
Have you applied for certification other than those indicated above? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If so, list certification and date:					
Certification number if applicable:					
If you participate in a specialty which does not have board certification, please indicate specialty:					
15. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (e.g., Fluoroscopy, Radiography, etc.) (Attach Certificate if Applicable)					
Type:		Number:		Expiration Date:	
Type:		Number:		Expiration Date:	
16. HOSPITAL, MILITARY, & OTHER INSTITUTIONAL AFFILIATIONS				Does Not Apply <input type="checkbox"/>	
Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you (A) Current Hospital affiliation, (B) Previous Hospital Affiliations, (C) Current Military Affiliation, (D) Previous Military Affiliations (E) Applications in process This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.					
A. CURRENT HOSPITAL AFFILIATIONS (Do not abbreviate)					
Name of Primary Admitting Hospital:			Department:		
Mailing Address			City, State, Zip		
Phone number:			Fax Number:		
Status (active, provisional, courtesy, temporary, etc.):		Appointment Date (mm/yyyy):	Medical Staff/Credentialing E-mail Address:		
Can you admit / follow clients of your primary, secondary, other practice locations? Does Not Apply <input type="checkbox"/>					
<input type="checkbox"/> Primary practice admits only		<input type="checkbox"/> Secondary Practice admits only		<input type="checkbox"/> can admit to for all locations	
Name of Secondary Admitting Hospital:			Department:		
Mailing Address			City, State, Zip		
Phone number:			Fax Number:		
Status (active, provisional, courtesy, temporary, etc.):		Appointment Date (mm/yyyy):	Medical Staff/Credentialing E-mail Address:		
Can you admit / follow clients of your primary, secondary, other practice locations? Does Not Apply <input type="checkbox"/>					
<input type="checkbox"/> Primary practice admits only		<input type="checkbox"/> Secondary Practice admits only		<input type="checkbox"/> Can admit to for all locations	

Name of Other Institutions:		Department:	
Mailing Address		City, State, Zip	
Phone number:		Fax Number:	
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date (mm/yyyy):	Medical Staff/Credentialing E-mail Address:	
Can you admit / follow clients of your primary, secondary, other practice locations? <input type="checkbox"/> Primary practice admits only <input type="checkbox"/> Secondary Practice admits only <input type="checkbox"/> Can admit to for all locations		Does Not Apply <input type="checkbox"/>	
B. PREVIOUS HOSPITAL AFFILIATIONS (Do not abbreviate)			
Name of Admitting Hospital:		Department:	
Mailing Address		City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):		From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		Medical Staff E-mail Address:	
Name of Admitting Hospital:		Department:	
Mailing Address		City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):		From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		Medical Staff E-mail Address:	
Name of Admitting Hospital:		Department:	
Mailing Address		City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):		From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		Medical Staff E-mail Address:	
C. CURRENT MILITARY AFFILIATIONS (Do not abbreviate) Please include Military Reserves			
Name of Primary Base:		Division	
Mailing Address		City, State, Zip	
Phone number:		Fax Number:	
Status (active, provisional, courtesy, temporary, etc.):		Appointment Date (mm/yyyy):	
D. PREVIOUS MILITARY AFFILIATIONS (Do not abbreviate)			
Name of Primary Base:		Division	
Mailing Address		City, State, Zip	
Phone number:		Fax Number:	
Status (active, provisional, courtesy, temporary, etc.):		Appointment Date (mm/yyyy):	

E. APPLICATIONS IN PROCESS (Do not abbreviate)

Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted(mm/yyyy)	
Mailing Address:	City:	State:	Zip Code:

17. WORK HISTORY (Do not abbreviate)

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. Curriculum vitae is not sufficient.

Name of Practice / Employer:	Contact Name:	Telephone Number: ()			
Reason for Leaving:	Email Address	Fax Number: ()			
Mailing Address	City:	State:	Zip:	From (mm/yyyy)	To (mm/yyyy)

Name of Malpractice Carrier During Employment:

Name of Practice / Employer:	Contact Name:	Telephone Number: ()			
Reason for Leaving:	Email Address	Fax Number: ()			
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

Name of Malpractice Carrier During Employment:

Name of Practice / Employer:	Contact Name:	Telephone Number: ()			
Reason for Leaving:	Email Address	Fax Number: ()			
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

Name of Malpractice Carrier During Employment:

18. GAPS IN HISTORY. Please account for all gaps between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable:

	From (mm/yyyy):	To (mm/yyyy):

19. PEER REFERENCES

List at least **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who, through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. **Please provide approximate From and To dates you have known the identified peer reference.** If you have been out of residency or fellowship for a period of less than three years, one reference must be from the Program Director. Allied Health Providers must provide at least one reference from their same discipline.

Name of Reference:		Title and Specialty:		E-mail Address:	
Mailing Address:		City:		State:	Zip Code:
Telephone Number: () ()	Fax Number: () ()	Cell Phone Number: (Optional) () ()		From (MM/YY)	To (MM/YY):

Name of Reference:		Title and Specialty:		E-mail Address:	
Mailing Address:		City:		State:	Zip Code:
Telephone Number: () ()	Fax Number: () ()	Cell Phone Number: (Optional) () ()		From (MM/YY)	To (MM/YY):

Name of Reference:		Title and Specialty:		E-mail Address:	
Mailing Address:		City:		State:	Zip Code:
Telephone Number: () ()	Fax Number: () ()	Cell Phone Number: (Optional) () ()		From (MM/YY)	To (MM/YY):

20. PROFESSIONAL AFFILIATIONS (Do not abbreviate)

Please List Membership In All Professional Societies Complete Name of Society:	Date Joined	Current Member
	/ / .	<input type="checkbox"/> YES <input type="checkbox"/> NO
	/ / .	<input type="checkbox"/> YES <input type="checkbox"/> NO

21. PROFESSIONAL LIABILITY (Do not abbreviate)

A. Current Insurance Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

**B. PREVIOUS PROFESSIONAL LIABILITY CARRIERS WITHIN THE LAST TEN YEARS (Do not abbreviate)
(Attach Additional Sheet if Necessary)**

Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

WASHINGTON PRACTITIONER ATTESTATION QUESTIONS - To be completed by the practitioner

Please answer all of the following questions. If your answer to any of the following questions is "Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

A. PROFESSIONAL SANCTIONS			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?		
	a.	License to practice any profession in any jurisdiction	YES <input type="checkbox"/> NO <input type="checkbox"/>
	b.	Other professional registration or certification in any jurisdiction	YES <input type="checkbox"/> NO <input type="checkbox"/>
	c.	Specialty or subspecialty board certification	YES <input type="checkbox"/> NO <input type="checkbox"/>
	d.	Membership on any hospital medical staff	YES <input type="checkbox"/> NO <input type="checkbox"/>
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES <input type="checkbox"/> NO <input type="checkbox"/>
	f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES <input type="checkbox"/> NO <input type="checkbox"/>
	g.	Professional society membership or fellowship	YES <input type="checkbox"/> NO <input type="checkbox"/>
	h.	Participation/membership in an HMO, PPO, IPA, PHO, Health Plan or other entity	YES <input type="checkbox"/> NO <input type="checkbox"/>
	i.	Academic Appointment	YES <input type="checkbox"/> NO <input type="checkbox"/>
	j.	Authority to prescribe controlled substances (DEA or other authority)	YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES <input type="checkbox"/> NO <input type="checkbox"/>
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES <input type="checkbox"/> NO <input type="checkbox"/>
B. CRIMINAL HISTORY			
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES <input type="checkbox"/> NO <input type="checkbox"/>
	a.	Do you have notice of any such anticipated charges?	YES <input type="checkbox"/> NO <input type="checkbox"/>
	b.	Are you currently under governmental investigation?	YES <input type="checkbox"/> NO <input type="checkbox"/>
C. AFFIRMATION OF ABILITIES			
1.	Do you presently use any drugs illegally?		YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Do you have any physical, mental health, or substance use condition that currently impairs, or could impair, your ability to practice your profession in a competent, ethical, and professional manner? If the answer to this question is yes, please complete Section 23 below.		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		YES <input type="checkbox"/> NO <input type="checkbox"/>
D. LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section, please document in Section 22. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court-ordered damage award) in a professional lawsuit?		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	Are there any such claims being asserted against you now?		YES <input type="checkbox"/> NO <input type="checkbox"/>
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g., reduced limits, restricted coverage, surcharged)?		YES <input type="checkbox"/> NO <input type="checkbox"/>
5.	Are any of the privileges that you are requesting <u>not</u> covered by your current malpractice coverage?		YES <input type="checkbox"/> NO <input type="checkbox"/>

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature: _____

Date _____

Type or Print name here _____



Practitioner Name:(print or type)

Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected PHI. Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.

Date and clinical details of the incident, with preceding events:

Date:

Details:

Your role and specific responsibility in the incident:

Subsequent events, including patient’s clinical outcome:

Date suit or claim was filed:

Name and Address of Insurance Carrier that handled the claim:

Your status in the legal action (primary defendant, co-defendant, other):

Current status of suit or other action:

Date of settlement, judgment, or dismissal:

If case was settled out-of-court, or with a judgment, settlement amount attributed to you? \$

23. Physician/Practitioner Health Program Disclosure

Does Not Apply

Please complete below details if you answered yes to Question C.2 above

Name of Monitoring Program

Address of Monitoring Program

Point of Contact Name:

Phone Number

Verification E-mail Address:

24. ATTESTATION

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A copy, or electronic PDF with signature authentication, of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name

Here: _____

Signature: _____

(Stamped signature is not acceptable)

Date: _____

Review dates and initials:

Healthcare Organization: -
And/or Designated Agent:

WASHINGTON PRACTITIONER APPLICATION AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this authorization and release of information form in conjunction with the Washington Practitioner Application (WPA) and/or the Washington Practitioner Attestation or Credentials Update (CU) form, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participating status with the Healthcare Organization(s)* indicated on the WPA for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications in a timely manner. I understand that the application will not be processed until the application is deemed complete by the healthcare organization.
2. I further understand and acknowledge that the Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to information exchange activities of the Healthcare Organization(s) as part of the verification and credentialing process.
3. I authorize all individuals, institutions and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Healthcare Organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with providing information, investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the Healthcare Organization(s) or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.
6. I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations, contractual agreements, and policies of the Healthcare Organization.
7. I acknowledge that I am responsible for notifying the Healthcare Organization of any changes/challenges to licensure, DEA, malpractice claims, criminal convictions, hospital privileges or other disciplinary actions.
8. I attest to the accuracy, currency and completeness of the information provided. I understand and agree that any misstatements in or omissions from the CU, WPA, Washington Practitioner Attestation and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.
9. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Healthcare Organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
10. I understand that completion and submission of the Authorization and Release does not automatically grant me membership or clinical privileges/participating status with the Healthcare Organization(s)* indicated on the WPA/CU or Attestation.
11. I hereby further authorize and consent to the release of information and/or reporting by the Healthcare Organization(s) to medical associations, licensing boards, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and other similar organizations regarding any pertinent information which the Healthcare Organization(s) may have concerning me as long as such release of information and/or reporting is done in good faith and without malice, and I hereby release from liability Healthcare Organization(s) and its staff and representatives for so doing.
12. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

Print Name
Here: _____

Signature: _____
(Stamped signature is not acceptable)

Date: _____

****Healthcare Organization (e.g. hospital, medical staff, medical group, independent practice association, professional review organization health plan, health maintenance organization, preferred provider organization, physician hospital organization, medical society, credentials verification organization, professional association, medical school faculty position or other health delivery entity or system).***