eternalHealth™

Print Form | Clear Form

PROVIDER APPLICATION

Submit your completed form (all pages) and attachment(s)

- By Email: credentialing@rxadvance.com
- By Mail: ATTN: eternalHealth Provider, PO Box 641, Southborough, MA 01772
- By Fax: 866-347-8864

Please use NUCC (National Uniform Claim Committee) Codes for all relevant fields. Please see the attached Code List for your reference.
Required fields marked with with *****

Section 1: Personal Information & Professional IDs

Name

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

First Name*	Middle Initial	Last Name*	Suffix

Have you ever used another name? ☐ Yes ☐ No
If yes, please list all other names and their dates of use below.

Other First Name	Other M.I.	Other Last Name	Suffix

Date Started Using Other Name	Date Stopped Using Other Name

Provider Type

Provider Type	
Do you practice exclusively within the inpatient setting? (e.g. pathologists, anesthesiologists, ER physicians, nurse practitioners, radiologists, physician assistants, etc.)	☐ Yes ☐ No

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.

Gender* ☐ Male ☐ Female	Date of Birth* (MM/DD/YYYY)	City of Birth	State of Birth	Country of Birth

SSN*	Foreign National Identification Number (FNIN)	FNIN Country of Issue

Please enter all non-English languages you speak below.

eternalHealth

PROVIDER APPLICATION

Section 1: Personal Information & Professional IDs (cont.)		
Home Address		
Street Address		Apt Number
City	State	Zip Code
Phone Number		

Contact Information	
This is the information we will use for any follow-ups.	
Email	
Fax	Preferred Method of Contact* ☐ Email ☐ Fax

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, please include additional information as an attachment to the completed form.	
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

eternalHealth

PROVIDER APPLICATION

Section 1: Personal Information & Professional IDs (cont.)

Professional IDs (cont.)

- 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, please include additional information as an attachment to the completed form.

State Licensing Number	License Issue Date
License Issuing State	License Expiration Date
If this is a state license, are you currently practicing in this state? ☐ Yes ☐ No	
License Status (e.g. active, pending, limited, etc.)	License Type
State Licensing Number	License Issue Date
License Issuing State	License Expiration Date
If this is a state license, are you currently practicing in this state? ☐ Yes ☐ No	
License Status (e.g. active, pending, limited, etc.)	License Type

Other ID Numbers

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-US/Canadian Graduate Only)	ECFMG Certificate Issue Date (MM/DD/YYYY)

PROVIDER APPLICATION

Section 2: Education & Training

Undergraduate School

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

Official Name of Undergraduate School			
Street Address			
City	State	Zip/Postal Code	Country
Start Date (MM/YYYY)	End/Graduation Date (MM/YYYY)	Degree Awarded	
Did you complete your undergraduate education at this school?	☐ Yes ☐ No		

Professional School

- 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 attach information about the Fifth Pathway institution where you completed to the completed form.
- If you have additional Undergraduate or Professional Schools to report, please include additional information as an attachment to the completed form.

Graduate Type*	☐ U.S. or Canadian Graduate ☐ Non-U.S./Canadian Graduate ☐ Fifth Pathway Graduate

U.S. or Canadian School

Name of U.S./Canadian School		
Start Date* (MM/YYYY)	End/Graduation Date* (MM/YYYY)	Degree Awarded
Did you complete your graduate education at this school?	☐ Yes ☐ No	

PROVIDER APPLICATION

Section 2: Education & Training (cont.)

Professional School

Non-U.S. or Canadian School

Official Name of Non-U.S/Canadian School		
Street Address		
City	Country	Postal Code
Start Date* (MM/YYYY)	End/Graduation Date* (MM/YYYY)	Degree Awarded
Did you complete your graduate education at this school?	☐ Yes ☐ No	

Training

- List all training programs you attended. Use one section per institution.
- If you have additional post-graduate programs, include additional information as an attachment to the completed form.
- Please explain 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.

Institution/Hospital Name		School (e.g. affiliated medical school)	
Street Address			
City	State	Zip/Postal Code	Country
Telephone		Fax	

Did you complete this training program at this institution? ☐ Yes ☐ No
If not, please use the space below to explain.

PROVIDER APPLICATION

Training

- List each department separately, if applicable.
- List Internship/Residency, Fellowship, or Other programs separately.

Type ☐ Internship/Residency ☐ Fellowship ☐ Other	Start Date (MM/YYYY)	End Date (MM/YYYY)
	Department/Specialty (do not abbreviate)	
	Name of Director	
Type ☐ Internship/Residency ☐ Fellowship ☐ Other	Start Date (MM/YYYY)	End Date (MM/YYYY)
	Department/Specialty (do not abbreviate)	
	Name of Director	
Type ☐ Internship/Residency ☐ Fellowship ☐ Other	Start Date (MM/YYYY)	End Date (MM/YYYY)
	Department/Specialty (do not abbreviate)	
	Name of Director	

eternalHealth

PROVIDER APPLICATION

Section 3. Professional/Medical Specialty Information

Primary Specialty

Specialty	Initial Certification Date (MM/DD/YYYY)	Do you wish to be listed in the directory under this specialty?
		HMO ☐ Yes ☐ No **PPO** ☐ Yes ☐ No **POS** ☐ Yes ☐ No
Board Certified? ☐ Yes ☐ No	Recertification Date (MM/DD/YYYY)	
Certifying Board Code	Expiration Date (MM/DD/YYYY)	

If you are not board certified, please select one of the following.

☐ I have taken exam, results pending for Certifying Board Code	☐ I intend to sit for an exam on (MM/DD/YYYY)	☐ I do not intent to take a certified board exam.

If you have indicated that you do not intend to take a certifying board exam, please use the space below to explain your decision.

PROVIDER APPLICATION

Section 3. Professional/Medical Specialty Information (cont.)

Secondary Specialty

If you have additional Professional/Medical Specialties to report, please include additional information as an attachment to the completed form.

Specialty	Initial Certification Date (MM/DD/YYYY)	Do you wish to be listed in the directory under this specialty?
		HMO ☐ Yes ☐ No **PPO** ☐ Yes ☐ No **POS** ☐ Yes ☐ No
Board Certified? ☐ Yes ☐ No	Recertification Date (MM/DD/YYYY)	
Certifying Board Code	Expiration Date (MM/DD/YYYY)	

If you are not board certified, please select one of the following

☐ I have taken exam, results pending for	☐ I intend to sit for an exam on	☐ I do not intent to take a certified board exam.
Certifying Board Code	(MM/DD/YYYY)	

If you have indicated that you do not intend to take a certifying board exam, please use the space below to explain your decision.

Certifications

Do you hold the following certifications? If yes, provide expiration dates.

	Yes	No	Expiration Date (MM/DD/YYYY)
Basic Life Support*	◯	◯	
CPR*	◯	◯	
Advanced Cardiac Life Support*	◯	◯	
Neonatal Advanced Life Support*	◯	◯	
Advanced Life Support in OB*	◯	◯	
Advanced Trauma Life Support*	◯	◯	
Pediatric Advanced Life Support*	◯	◯	

PROVIDER APPLICATION

Section 3. Professional/Medical Specialty Information (cont.)

Practice Interests

Please provide additional areas of professional practice interest, activities, procedures, diagnoses, or populations.

Primary Credentialing Contact

Check this box to use the office manager and the primary practice location as the primary credentialing contact. Otherwise, complete the following information.		☐
First Name	Middle Initial	Last Name
Mailing Address (Street, City, State, Zip)		
Phone		Fax
Email Address		

PROVIDER APPLICATION

Section 4. Practice Location Information

Primary Practice Location

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

- If you have additional practice locations, please include additional information as an attachment to the completed form.
- "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.
- Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise.

Are you currently practicing at this address?* Yes No	If no, what is your expected start date (MM/DD/YYYY)?
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)	
Street Address*	Suite/Building

City*	State*	Zip Code*
Send general correspondence here? ◯ Yes ◯ No	Office Phone*	Fax
Email Address		
Individual Tax ID	Group Tax ID	Please indicate what to use as the Primary Tax ID. Individual Tax ID Group Tax ID

Office Manager or Business Office Staff Contact

First Name	Middle Initial	Last Name
Mailing Address (Street, City, State, Zip)		
Phone	Fax	
Email Address		

PROVIDER APPLICATION

Section 4. Practice Location Information (cont.)

Billing Contact

Check here if the billing contact is the same as the office manager. ☐

First Name	Middle Initial	Last Name

Mailing Address (Street, City, State, Zip)

Phone	Fax

Email Address

Payment and Remittance

Check here if the payee information is the same as the office manager. ☐

First Name	Middle Initial	Last Name

Mailing Address (Street, City, State, Zip)

Phone	Fax

Email Address

Electronic Billing Capabilities?*	Billing Department (if hospital-based)
☐ Yes ☐ No	

Checks Payable to*

Office Hours

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

	Start Time (HH:MM)	End Time (HH:MM)		Start Time (HH:MM)	End Time (HH:MM)
Monday			Friday		
Tuesday			Saturday		
Wednesday			Sunday		
Thursday					

24/7 Phone Coverage?* ☐ Yes ☐ No

If yes

☐ Answering Service ☐ Voicemail with Instructions to Call Answering Service ☐ Voicemail with Other Instructions

eternalHealth

PROVIDER APPLICATION

Section 4. Practice Location Information (cont.)

Open Practice Status

	Yes	No		Yes	No
Accept New Patients Into This Practice?*	☐	☐	Accept All New Patients?*	☐	☐
Accept Existing Patients with Change of Payor?*	☐	☐	Accept New Medicare Patients?*	☐	☐
Accept New Patients with Physician Referral?*	☐	☐	Accept New Medicaid Patients?*	☐	☐

If any of the above information varies by plan, please explain.

Are there any practice limitations?* ☐ Yes ☐ No

If yes, provide the following information.

Gender Limitations	Age Limitations	
☐ Male Only ☐ Female Only ☐ None	Minimum Age	
	Maximum Age	

Please list any other limitations.

Mid-Level Practitioners

Do mid-level practitioners (nurse practitioners, physician assistants, etc.) care for patients in your practice?* ☐ Yes ☐ No

If yes, please provide the information below.

First Name	Middle Initial	Last Name
Practitioner Type (e.g. PA, CNP, NP)		
Practitioner License/Certificate Number		Practitioner State

PROVIDER APPLICATION

Mid-Level Practitioners		
First Name	Middle Initial	Last Name
Practitioner Type (e.g. PA, CNP, NP)		
Practitioner License/Certificate Number		Practitioner State
First Name	Middle Initial	Last Name
Practitioner Type (e.g. PA, CNP, NP)		
Practitioner License/Certificate Number		Practitioner State
First Name	Middle Initial	Last Name
Practitioner Type (e.g. PA, CNP, NP)		
Practitioner License/Certificate Number		Practitioner State
First Name	Middle Initial	Last Name
Practitioner Type (e.g. PA, CNP, NP)		
Practitioner License/Certificate Number		Practitioner State

PROVIDER APPLICATION

Section 4. Practice Location Information (cont.)

Languages

Please list all Non-English Languages Spoken by Office Personnel in the space below.

Interpreters Available? ☐ Yes ☐ No

If yes, please list all languages available in the space below.

Accessibility

Does this office meet ADA accessibility requirements? ☐ Yes ☐ No

Does this site offer handicapped access for the following:	Building?*	☐ Yes ☐ No
	Parking?*	☐ Yes ☐ No
	Restroom?*	☐ Yes ☐ No
	Other Handicapped Access	
Does the site offer other services for the disabled?*	Text Telephony (TTY)*	☐ Yes ☐ No
	American Sign Language*	☐ Yes ☐ No
	Mental/Physical Impairment Services*	☐ Yes ☐ No
	Other Disability Services	
Accessibility by public transportation?*	Bus*	☐ Yes ☐ No
	Subway*	☐ Yes ☐ No
	Regional Train*	☐ Yes ☐ No
	Other Transportation Access	

PROVIDER APPLICATION

Section 4. Practice Location Information (cont.)

Services

Does this location provide any of the following services?

Laboratory Services?	☐ Yes ☐ No	If yes, provide accrediting/certifying program (e.g. CLIA, COLA, MLE)			
Radiology Services?	☐ Yes ☐ No	If yes, provide X-ray certification type			

EKGs?	☐ Yes ☐ No	Allergy Injections?	☐ Yes ☐ No	Allergy Skin Testing?	☐ Yes ☐ No
Routine Office Gynecology (Pelvis/PAP)?	☐ Yes ☐ No	Drawing Blood?	☐ Yes ☐ No	Age Appropriate Immunizations?	☐ Yes ☐ No
Flexible Sigmoidoscopy?	☐ Yes ☐ No	Tympanometry/ Audiometry Screening?	☐ Yes ☐ No	Asthma Treatment?	☐ Yes ☐ No
Osteopathic Manipulation?	☐ Yes ☐ No	IV Hydration/ Treatment?	☐ Yes ☐ No	Cardiac Stress Test?	☐ Yes ☐ No
Pulmonary Function Testing?	☐ Yes ☐ No	Physical Therapy?	☐ Yes ☐ No	Care of Minor Lacerations?	☐ Yes ☐ No

Is Anesthesia Administered in Your Office? ☐ Yes ☐ No	If yes, what class/category do you use?	
	If yes, who administers it?	

Type of Practice (select one)	☐ Solo Practice ☐ Single Specialty Group ☐ Multi-Specialty Group

Please list any additional office procedures provided (including surgical procedures).

PROVIDER APPLICATION

Section 4. Practice Location Information (cont.)

Partners/Associates

If you have additional partners/associates at THIS location, please include additional information as an attachment to the completed form. Be certain to note that the additional partners/associates are for the "Primary Location".

List all partners/associates at this practice.

First Name	Middle Initial	Last Name	
Specialty Code	Covering Colleague ☐ Yes ☐ No	Provider Type	
First Name	Middle Initial	Last Name	
Specialty Code	Covering Colleague ☐ Yes ☐ No	Provider Type	
First Name	Middle Initial	Last Name	
Specialty Code	Covering Colleague ☐ Yes ☐ No	Provider Type	
First Name	Middle Initial	Last Name	
Specialty Code	Covering Colleague ☐ Yes ☐ No	Provider Type	

Covering Colleagues

If you have additional partners/associates at THIS location, please include additional information as an attachment to the completed form. Be certain to note that the additional covering colleagues are for the "Primary Location".

List all covering colleagues that are <u>not</u> partners/associates at this practice.

First Name	Middle Initial	Last Name
Specialty Code	Provider Type	
First Name	Middle Initial	Last Name
Specialty Code	Provider Type	

PROVIDER APPLICATION

Covering Colleagues		
First Name	Middle Initial	Last Name
Specialty Code	Provider Type	
First Name	Middle Initial	Last Name
Specialty Code	Provider Type	

PROVIDER APPLICATION

Section 5. Hospital Affiliations

Admitting Arrangements

Do you have hospital privileges?* ☐ Yes ☐ No

If you do not admit patients, what type of admitting arrangements do you have?

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, please include additional information as an attachment to the completed form.
- Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

Primary Hospital

Hospital Name			
Street Address			
Suite/Building	City	State	Zip Code
Telephone		Fax	
Department Name			
Department Director's First Name		Department Director's Last Name	
Affiliation Start Date (MM/DD/YYYY)		Affiliation End Date (MM/DD/YYYY)	
Full, Unrestricted Privileges? ☐ Yes ☐ No		Are Privileges Temporary? ☐ Yes ☐ No	

PROVIDER APPLICATION

Hospital Privileges			
Admitting Privilege Status (e.g. none, full unrestricted, provisional, temporary)			
Of your total annual admissions, what percentage is to this hospital?		%	
Other Hospital			
Hospital Name			
Street Address			
Suite/Building	City	State	Zip Code
Telephone		Fax	
Department Name			
Department Director's First Name		Department Director's Last Name	
Affiliation Start Date (MM/DD/YYYY)		Affiliation End Date (MM/DD/YYYY)	
Full, Unrestricted Privileges? ☐ Yes ☐ No		Are Privileges Temporary? ☐ Yes ☐ No	
Admitting Privilege Status (e.g. none, full unrestricted, provisional, temporary)			
Of your total annual admissions, what percentage is to this hospital?		%	
Please explain terminated affiliation, if applicable.			

eternalHealth

PROVIDER APPLICATION

Professional Liability Insurance Carrier

IMPORTANT. If you do not carry malpractice insurance, check this box and skip this section. ☐

Carrier or Self-Insured Name*	Self-Insured?* ☐ Yes ☐ No
Street Address*	

Suite/Building	City*	State*	Zip Code*

Original Effective Date* (MM/DD/YYYY)	Effective Date* (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)

Type of Coverage?* ☐ Individual ☐ Shared

Do you have unlimited coverage with this insurance carrier? ☐ Yes ☐ No	Amount of Coverage per Occurrence $	Amount of Coverage Aggregate $

Policy Includes Tail Coverage? ☐ Yes ☐ No

Policy Number

Other Carrier(s)

- 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, please include additional information as an attachment to the completed form.

Carrier or Self-Insured Name*	Self-Insured?* ☐ Yes ☐ No
Street Address*	

Suite/Building	City*	State*	Zip Code*

Original Effective Date* (MM/DD/YYYY)	Effective Date* (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)

Type of Coverage?* ☐ Individual ☐ Shared

Do you have unlimited coverage with this insurance carrier? ☐ Yes ☐ No	Amount of Coverage per Occurrence $	Amount of Coverage Aggregate $

Policy Includes Tail Coverage? ☐ Yes ☐ No

Policy Number

PROVIDER APPLICATION

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, please include additional information as an attachment to the completed form.

Practice/Employer Name		
Street Address		Suite/Building
City	State	Zip Code
Phone	Fax	
Country	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Reason for Departure (if applicable)		

Practice/Employer Name		
Street Address		Suite/Building
City	State	Zip Code
Phone	Fax	
Country	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Reason for Departure (if applicable)		

PROVIDER APPLICATION

Section 7. Work History and References (cont.)

Work History

Practice/Employer Name			
Street Address		Suite/Building	
City	State		Zip Code
Phone		Fax	
Country		Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Reason for Departure (if applicable)			

Gaps in Professional/Work History

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 a shorter duration if required by the organization for which you are being credentialed.

- If you have additional professional/work history gaps, please include additional information as an attachment to the completed form.

Gap Start Date	Gap End Date
Please include your explanation below.	

PROVIDER APPLICATION

Section 7. Work History and References (cont.)

Professional References

Provide three professional references to whom you are not related or are not partners in your practice.
NOTE: You are required to provide exactly 3 references. Your application will not be complete without this information.

First Name*	Last Name*	Provider Type*
Street Address*	Suite/Building	
City*	State*	Zip Code*
Phone	Fax	

First Name*	Last Name*	Provider Type*
Street Address*	Suite/Building	
City*	State*	Zip Code*
Phone	Fax	

First Name*	Last Name*	Provider Type*
Street Address*	Suite/Building	
City*	State*	Zip Code*
Phone	Fax	

PROVIDER APPLICATION

Section 8. Disclosure Questions

Answer all questions. For any "Yes" response, please include your explanation for each of the questions with your submission on a separate page. Be sure to mark the question for which you are providing an explanation in your response.

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

PROVIDER APPLICATION

Section 8. Disclosure Questions	
Other Sanctions or Investigations	
12. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other 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?*	☐ Yes ☐ No
13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*	☐ Yes ☐ No
14. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g. CLIA, OSHA, etc.)?*	☐ Yes ☐ No
15. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined, or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*	☐ Yes ☐ No
16. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*	☐ Yes ☐ No
Professional Liability Insurance Information and Claims History	
17. Has your professional liability coverage ever been cancelled, restricted, declined, or not renewed by the carrier based on your individual liability history?*	☐ Yes ☐ No
18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*	☐ Yes ☐ No
Malpractice Claims History	
19. Have you ever had any professional liability actions (pending, settled, arbitrated, mediated, or litigated) within the past 10 years?* **IF YES,** you must complete the Supplemental Malpractice Claims Explanation Form for each malpractice claim.	☐ Yes ☐ No
Criminal/Civil History	
NOTE: A criminal record will not necessarily be 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.	
20. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*	☐ Yes ☐ No
21. In the past ten years, have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse, or a sexual offense or sexual misconduct?*	☐ Yes ☐ No
22. Have you ever been court-martialed for actions related to your duties as a medical professional?*	☐ Yes ☐ No
Ability to Perform Job	
23. 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 is 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.)	☐ Yes ☐ No

PROVIDER APPLICATION

Section 8. Disclosure Questions	
24. Do you use any chemical substances that would in any way impair of limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*	☐ Yes ☐ No
25. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?*	☐ Yes ☐ No
26. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*	☐ Yes ☐ No

eternalHealth

PROVIDER APPLICATION

Malpractice Claims Explanation

NOTE: You only need to complete this form if you answered "Yes" to Question 19 in the Disclosure Questions section.

Date of Occurrence* (MM/DD/YYYY)		Date Claim Was Filed* (MM/DD/YYYY)	
Status of Claim* (if case is pending, select Open) ☐ Open ☐ Closed		If settled, enter date claim was settled (MM/DD/YYYY)	
Professional Liability Carrier Involved*			
Street Address*			
Suite/Building	City*	State*	Zip Code*
Telephone	Policy Number		
Amount of Award or Settlement* $	Method of Resolution* ☐ Dismissed ☐ Settled ☐ Mediation ☐ Arbitration ☐ Judgment for Defendant(s) ☐ Judgment for Plaintiff(s)		
Description of Allegations*			
Were you the primary defendant or co-defendant?* ☐ Primary Defendant ☐ Co-Defendant		Number of Other Co-Defendants, if any	
Your Involvement in the Case* (attending, consulting, etc.)			
Description of Alleged Injury to Patient			
Did the alleged injury result in death? ☐ Yes ☐ No			
To the best of your knowledge, is the case included in the National Practitioner Data Bank (NPDB)?* ☐ Yes ☐ No			

PROVIDER APPLICATION SUPPLEMENTAL INFORMATION

You may use the below space to provide additional information in your submission. Be sure to note what sections and details you are providing additional information for.

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. 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.

STANDARD AUTHORIZATION, ATTESTATION, AND RELEASE

(Not for Use for Employment Purposes)

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 out 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)*

Date Signed*

CODE LIST — PROVIDER TYPE

MD/DO

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

CODE LIST — PROVIDER TYPE

295 Pediatrics, Clinical & Laboratory Immunology
462 Pediatrics, Developmental – Behavioral Pediatrics
354 Pediatrics, Medical Toxicology
356 Pediatrics, Neurodevelopmental Disabilities
345 Pediatrics, Pediatric Allergy & Immunology
346 Pediatrics, Pediatric Cardiology
347 Pediatrics, Pediatric Critical Care Medicine
463 Pediatrics, Pediatric Emergency Medicine
349 Pediatrics, Pediatric Endocrinology
350 Pediatrics, Pediatric Gastroenterology
351 Pediatrics, Pediatric Hematology- Oncology
352 Pediatrics, Pediatric Infectious Diseases
355 Pediatrics, Pediatric Nephrology
359 Pediatrics, Pediatric Pulmonology
361 Pediatrics, Pediatric Rheumatology
398 Pediatrics, Sports Medicine
365 Physical Medicine & Rehabilitation
468 Physical Medicine & Rehabilitation, Pain Medicine
389 Physical Medicine & Rehabilitation, Pediatric Rehabilitation Medicine
466 Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine
469 Physical Medicine & Rehabilitation, Sports Medicine
419 Plastic Surgery
470 Plastic Surgery, Plastic Surgery Within the Head and Neck
407 Plastic Surgery, Surgery of the Hand
242 Preventive Medicine, Aerospace Medicine
429 Preventive Medicine, Medical Toxicology
112 Preventive Medicine, Occupational Medicine
471 Preventive Medicine, Sports Medicine
431 Preventive Medicine, Undersea and Hyperbaric Medicine
114 Preventive Medicine/Occupational Environmental Medicine
370 Psychiatry & Neurology, Addiction Medicine
473 Psychiatry & Neurology, Addiction Psychiatry
371 Psychiatry & Neurology, Child & Adolescent Psychiatry
313 Psychiatry & Neurology, Clinical Neurophysiology
274 Psychiatry & Neurology, Forensic Psychiatry
373 Psychiatry & Neurology, Geriatric Psychiatry
472 Psychiatry & Neurology, Neurodevelopmental Disabilities
100 Psychiatry & Neurology, Neurology
311 Psychiatry & Neurology, Neurology with Special Qualifications in Child Neurology
474 Psychiatry & Neurology, Pain Medicine
368 Psychiatry & Neurology, Psychiatry
475 Psychiatry & Neurology, Sports Medicine
476 Psychiatry & Neurology, Vascular Neurology
366 Public Health & General Preventive Medicine
252 Radiology, Body Imaging
173 Radiology, Diagnostic Radiology
430 Radiology, Diagnostic Ultrasound
314 Radiology, Neuroradiology
319 Radiology, Nuclear Radiology
360 Radiology, Pediatric Radiology
380 Radiology, Radiation Oncology
477 Radiology, Radiological Physics
381 Radiology, Therapeutic Radiology
384 Radiology, Vascular & Interventional Radiology
434 Supplier
399 Surgery
418 Surgery, Pediatric Surgery
420 Surgery, Plastic and Reconstructive Surgery
405 Surgery, Surgery of the Hand
425 Surgery, Surgical Critical Care
413 Surgery, Surgical Oncology
423 Surgery, Trauma Surgery
400 Surgery, Vascular Surgery
421 Thoracic Surgery (Cardiothoracic Vascular Surgery)
442 Transplant Surgery
424 Urology

DDS / DMD

2 Dentist
13 Dentist, Dental Public Health
14 Dentist, Endodontics
438 Dentist, General Practice
16 Dentist, Oral and Maxillofacial Pathology
439 Dentist, Oral and Maxillofacial Radiology
20 Dentist, Oral and Maxillofacial Surgery
15 Dentist, Orthodontics and Dentofacial Orthopedics
17 Dentist, Pediatric Dentistry
18 Dentist, Periodontics
19 Dentist, Prosthodontics

DPM

3 Podiatrist
231 Podiatrist, Foot & Ankle Surgery
230 Podiatrist, Foot Surgery
225 Podiatrist, General Practice
227 Podiatrist, Primary Podiatric Medicine
226 Podiatrist, Public Medicine
228 Podiatrist, Radiology
229 Podiatrist, Sports Medicine

DC

1 Chiropractor
5 Chiropractor, Internist
6 Chiropractor, Neurology
7 Chiropractor, Nutrition
8 Chiropractor, Occupational Medicine
9 Chiropractor, Orthopedic
10 Chiropractor, Radiology
11 Chiropractor, Sports Physician
12 Chiropractor, Thermography

CODE LIST — ALLIED PROVIDERS

501 Acupuncturist
503 Audiologist
504 Audiologist, Assistive Technology Practitioner
505 Audiologist, Assistive Technology Supplier
531 Christian Science Practitioner
727 Clinical Nurse Specialist
728 Clinical Nurse Specialist, Acute Care
729 Clinical Nurse Specialist, Adult Health
730 Clinical Nurse Specialist, Chronic Care
731 Clinical Nurse Specialist, Community Health/Public Health
732 Clinical Nurse Specialist, Critical Care Medicine
733 Clinical Nurse Specialist, Emergency
734 Clinical Nurse Specialist, Ethics
735 Clinical Nurse Specialist, Family Health
736 Clinical Nurse Specialist, Gerontology
737 Clinical Nurse Specialist, Holistic
738 Clinical Nurse Specialist, Home Health
739 Clinical Nurse Specialist, Informatics
740 Clinical Nurse Specialist, Long-Term Care
741 Clinical Nurse Specialist, Medical-Surgical
742 Clinical Nurse Specialist, Neonatal
743 Clinical Nurse Specialist, Neuroscience
744 Clinical Nurse Specialist, Occupational Health
745 Clinical Nurse Specialist, Oncology
746 Clinical Nurse Specialist, Oncology, Pediatrics
747 Clinical Nurse Specialist, Pediatrics
748 Clinical Nurse Specialist, Perinatal
749 Clinical Nurse Specialist, Perioperative
750 Clinical Nurse Specialist, Psychiatric/Mental Health
751 Clinical Nurse Specialist, Psychiatric/Mental Health, Adult
752 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent
753 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family
754 Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill
755 Clinical Nurse Specialist, Psychiatric/Mental Health, Community
756 Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric
757 Clinical Nurse Specialist, Rehabilitation
759 Clinical Nurse Specialist, School
758 Clinical Nurse Specialist, Transplantation
760 Clinical Nurse Specialist, Women's Health
513 Counselor
514 Counselor, Addiction (Substance Use Disorder)
515 Counselor, Mental Health
516 Counselor, Professional
533 Dietitian, Registered
536 Dietitian, Registered, Nutrition, Metabolic
534 Dietitian, Registered, Nutrition, Pediatric
535 Dietitian, Registered, Nutrition, Renal
651 Licensed Practical Nurse
517 Marriage & Family Therapist
547 Massage Therapist
549 Midwife, Certified
652 Midwife, Certified Nurse
551 Naturopath
553 Neuropsychologist
653 Nurse Anesthetist, Certified Registered
654 Nurse Practitioner
655 Nurse Practitioner, Acute Care
656 Nurse Practitioner, Adult Health
658 Nurse Practitioner, Community Health
657 Nurse Practitioner, Critical Care Medicine
659 Nurse Practitioner, Family
660 Nurse Practitioner, Gerontology
661 Nurse Practitioner, Neonatal
662 Nurse Practitioner, Neonatal, Critical Care
670 Nurse Practitioner, Obstetrics & Gynecology
671 Nurse Practitioner, Occupational Health
663 Nurse Practitioner, Pediatrics
664 Nurse Practitioner, Pediatrics, Critical Care
666 Nurse Practitioner, Perinatal
667 Nurse Practitioner, Primary Care
665 Nurse Practitioner, Psych/Mental Health
668 Nurse Practitioner, School
669 Nurse Practitioner, Women's Health
537 Nutritionist
538 Nutritionist, Nutrition, Education
555 Occupational Therapist
556 Occupational Therapist, Ergonomics
557 Occupational Therapist, Hand
558 Occupational Therapist, Human Factors
559 Occupational Therapist, Neurorehabilitation
560 Occupational Therapist, Pediatrics
561 Occupational Therapist, Rehabilitation, Driver
563 Optician
565 Optometrist
566 Optometrist, Corneal and Contact Management
567 Optometrist, Low Vision Rehabilitation
571 Optometrist, Occupational Vision
568 Optometrist, Pediatrics
569 Optometrist, Sports Vision
570 Optometrist, Vision Therapy
573 Pharmacist
574 Pharmacist, General Practice
575 Pharmacist, Nuclear Pharmacy
576 Pharmacist, Nutrition Support
577 Pharmacist, Pharmacotherapy
578 Pharmacist, Psychopharmacy
580 Physical Therapist
581 Physical Therapist, Cardiopulmonary
583 Physical Therapist, Electrophysiology, Clinical
582 Physical Therapist, Ergonomics
584 Physical Therapist, Geriatrics
585 Physical Therapist, Hand
586 Physical Therapist, Human Factors
587 Physical Therapist, Neurology
590 Physical Therapist, Orthopedic
588 Physical Therapist, Pediatrics
589 Physical Therapist, Sports
592 Physician Assistant
593 Physician Assistant, Medical
594 Physician Assistant, Surgical

CODE LIST — ALLIED PROVIDERS

596 Psychologist
597 Psychologist, Addiction (Substance Use Disorder)
598 Psychologist, Adult Development & Aging
599 Psychologist, Behavioral
602 Psychologist, Child, Youth & Family
600 Psychologist, Clinical
601 Psychologist, Counseling
603 Psychologist, Educational
604 Psychologist, Exercise & Sports
605 Psychologist, Family
606 Psychologist, Forensic
607 Psychologist, Health
608 Psychologist, Men & Masculinity
609 Psychologist, Mental Retardation & Developmental Disabilities
610 Psychologist, Psychoanalysis
611 Psychologist, Psychotherapy
612 Psychologist, Psychotherapy, Group
613 Psychologist, Rehabilitation
614 Psychologist, School
615 Psychologist, Women
672 Registered Nurse
673 Registered Nurse, Addiction (Substance Use Disorder)
674 Registered Nurse, Administrator
711 Registered Nurse, Ambulatory Care
681 Registered Nurse, Cardiac Rehabilitation
676 Registered Nurse, Case Management
677 Registered Nurse, College Health
678 Registered Nurse, Community Health
680 Registered Nurse, Continence Care
679 Registered Nurse, Continuing Education/Staff Development
675 Registered Nurse, Critical Care Medicine
682 Registered Nurse, Diabetes Educator
683 Registered Nurse, Dialysis, Peritoneal
684 Registered Nurse, Emergency
685 Registered Nurse, Enterostomal Therapy
686 Registered Nurse, Flight
688 Registered Nurse, Gastroenterology
687 Registered Nurse, General Practice
689 Registered Nurse, Gerontology
691 Registered Nurse, Hemodialysis
690 Registered Nurse, Home Health
692 Registered Nurse, Hospice
694 Registered Nurse, Infection Control
693 Registered Nurse, Infusion Therapy
695 Registered Nurse, Lactation Consultant
696 Registered Nurse, Maternal Newborn
697 Registered Nurse, Medical-Surgical
699 Registered Nurse, Neonatal Intensive Care
700 Registered Nurse, Neonatal, Low-Risk
701 Registered Nurse, Nephrology
702 Registered Nurse, Neuroscience
698 Registered Nurse, Nurse Massage Therapist (NMT)
703 Registered Nurse, Nutrition Support
719 Registered Nurse, Obstetric, High-Risk
720 Registered Nurse, Obstetric, Inpatient
721 Registered Nurse, Occupational Health
722 Registered Nurse, Oncology
725 Registered Nurse, Ophthalmic
724 Registered Nurse, Orthopedic
726 Registered Nurse, Ostomy Care
723 Registered Nurse, Otorhinolaryngology & Head-Neck
704 Registered Nurse, Pain Management
706 Registered Nurse, Pediatric Oncology
705 Registered Nurse, Pediatrics
710 Registered Nurse, Perinatal
714 Registered Nurse, Plastic Surgery
708 Registered Nurse, Psych/Mental Health
709 Registered Nurse, Psych/Mental Health, Adult
707 Registered Nurse, Psych/Mental Health, Child & Adolescent
712 Registered Nurse, Rehabilitation
713 Registered Nurse, Reproductive Endocrinology/Infertility
715 Registered Nurse, School
716 Registered Nurse, Urology
718 Registered Nurse, Women's Health Care, Ambulatory
717 Registered Nurse, Wound Care
617 Respiratory Therapist, Certified
618 Respiratory Therapist, Certified, Critical Care
620 Respiratory Therapist, Certified, Educational
619 Respiratory Therapist, Certified, Emergency Care
622 Respiratory Therapist, Certified, General Care
621 Respiratory Therapist, Certified, Geriatric Care
623 Respiratory Therapist, Certified, Home Health
628 Respiratory Therapist, Certified, Neonatal/Pediatrics
627 Respiratory Therapist, Certified, Palliative/Hospice
629 Respiratory Therapist, Certified, Patient Transport
624 Respiratory Therapist, Certified, Pulmonary Diagnostics
626 Respiratory Therapist, Certified, Pulmonary Function Technologist
625 Respiratory Therapist, Certified, Pulmonary Rehabilitation
630 Respiratory Therapist, Certified, SNF/Subacute Care
631 Respiratory Therapist, Registered
632 Respiratory Therapist, Registered, Critical Care
634 Respiratory Therapist, Registered, Educational
633 Respiratory Therapist, Registered, Emergency Care
636 Respiratory Therapist, Registered, General Care
635 Respiratory Therapist, Registered, Geriatric Care
637 Respiratory Therapist, Registered, Home Health
642 Respiratory Therapist, Registered, Neonatal/Pediatrics
641 Respiratory Therapist, Registered, Palliative/Hospice
643 Respiratory Therapist, Registered, Patient Transport
638 Respiratory Therapist, Registered, Pulmonary Diagnostics
640 Respiratory Therapist, Registered, Pulmonary Function Technologist
639 Respiratory Therapist, Registered, Pulmonary Rehabilitation
644 Respiratory Therapist, Registered, SNF/Subacute Care
646 Social Worker, Clinical
648 Specialist/Technologist, Other, Biomedical Engineering
506 Speech-Language Pathologist
649 Technician, Other, Biomedical

CODE LIST — SPECIALTY BOARD

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 Orthopedic 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 Neuromusculoskeletal 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

Allied Providers

940 Academy of Certified Social Workers
1150 ACNM Certification Council
360 American Academy of Ambulatory Care Nursing
1550 American Academy of Anesthesiologist Assistants
230 American Academy of Audiology
370 American Academy of Experts in Traumatic Stress
270 American Academy of Health Providers in the Addictive Disorders
200 American Academy of Medical Acupuncture
405 American Academy of Nurse Practitioners
380 American Academy of Nursing
1330 American Academy of Optometry
1480 American Academy of Physician Assistants
1110 American Association for Marriage and Family Therapy
390 American Association of Critical Care Nurses
1590 American Association of Nurse Anesthetists
330 American Association of Pastoral Counselors
1010 American Association of Sex Educators, Counselors and Therapists
710 American Board Medical Psychotherapists
280 American Board of Addiction Medicine
950 American Board of Examiners in Clinical Social Work
720 American Board of Medical Psyhotherapists & Psychodiagnosticians
400 American Board of Nursing Specialties
1240 American Board of Nutrition
1300 American Board of Occupational Medicine
1360 American Board of Ophthalmology
1510 American Board of Physical Therapy Specialties
700 American Board of Professional Psychology
1130 American Naturopath Certification Board
350 American Nurses Credentialing Center
740 American Psychological Association
750 American Psychological Society
760 American Psychotherapy Association
290 American Society of Addiction Medicine
1650 American Speech-Language-Hearing Association
250 Biofeedback Certification Institute of America
1430 Board of Pharmaceutical Specialties
1250 Commission on Dietetic Registration
960 Employee Assistance Professionals Association

CODE LIST — SPECIALTY BOARD

780 National Association for the Advancement of Psychoanalysis
1450 National Association of Boards of Pharmacy
1600 National Association of Nurse Anesthetists
770 National Association of School Psychologists
980 National Association of Social Workers
1310 National Board for Certification in Occupational Therapy
1490 National Board for Certification of Orthopaedic Physician Assistants
790 National Board for Certified Clinical Hypnotherapists
310 National Board for Certified Counselors
1630 National Board for Respiratory Care
300 National Board of Addiction Examiners
800 National Board of Cognitive Behavioral Therapists
1350 National Board of Examiners in Optometry
1090 National Certification Board for Therapeutic Massage and Bodywork
210 National Certification Commission for Acupuncture and Oriental Medicine
1440 National Institute for Standards in Pharmacist Credentialing
220 Other - Not Listed