WCH Service Bureau®
We Can Help

WCH Service Bureau, Inc
3047 Avenue U,
Brooklyn, NY 11229,
888-924-3973 tel.
347-371-9968 fax.
www.wchsb.com

CREDENTIALING INFORMATION FORM

Physician (MD, DO, DPM)

How did you find out about WCH Credentialing Services?

- □ **Postcard**
- □ **Website**
- □ **Referral**
- □ **Returned Client**
- □ **Other_____**

1. Name: _____
First Name Middle Name Last Name Degree

Client Contact Information:

Home Address: _____

City: _____ State: _____ Zip Code: _____

Cell# _____

Email: _____

CAQH ID: _____ User ID: _____ Password: _____

PECOS User ID: _____ Password: _____

2. Date of Birth: _____ **3. City & Country of Birth: _____**

4. Professional Data:

STATE LICENSE #	DEA#
SSN #	MEDICARE #
NPI #	MEDICAID #
CDS #	

5. Primary Specialty: _____ **□ Board Certified** **□ Board Eligible**

Name of Certifying Board: _____

Date of Certification: _____ **Expiration Date: _____**

6. Sub-Specialty: _____ **□ Board Certified** **□ Board Eligible**

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Name of Certifying Board: _____

Date of Certification: _____ Expiration Date: _____

7. Are there any Age Limitations? □ Yes □ No **Min/Max Age Limitation: _____**

8. Hospital Privileges:

Do you currently have hospital admitting privileges? □ Yes □ No

(If more than one hospital, indicate primary)

Hospital Name and Address: _____

_____

9. COVERING PROVIDER INFORMATION:

Covering provider should be participating provider or be in process of becoming provider in the plan you are applying to.

Name	Name	Name
Address	Address	Address
City	City	City
State/Zip	State/Zip	State/Zip
Phone	Phone	Phone
Specialty	Specialty	Specialty

10. PRACTICE INFORMATION

Please include all service location that you want to be listed under in insurance directory, starting with **1st PRIMARY LOCATION**

Business Name/DBA: _____

Group NPI: _____

Tax Id: _____

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Group Medicare #: _____

Group Medicaid #: _____

How many Practice Locations? _____ (if you have more than one practice locations, please copy this form)

Address: _____

City, State, Zip: _____

Office Phone: _____ Office Fax: _____

Contact Name: _____ Started to Work: _____

Hours of Practice

Mon _____ to _____ Wed _____ to _____ Fri _____ to _____

Tues _____ to _____ Thurs _____ to _____ Sat _____ to _____

24x7 Phone Coverage at this location? □ Yes □ No **Phone Coverage type: _____**

Billing Information:

Make Checks Payable To: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Contact Name: _____

Correspondence Information:

Specify address at which insurance can contact the doctor direct, if different from above.

Make Checks Payable To: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Contact Name: _____

ALL APPLICANTS

PLEASE ATTACH COPIES OF THE FOLLOWING, if applicable:

- State License

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- Curriculum Vitae
- Medical Liability Insurance Coverage: $1/3 million
- IRS Form W-9
- Board Certification (if applicable)
- Copy of Diploma
- Registration and Infection Control Training Certificate
- NPI Award Letter (Individual and Group)
- ECFMG Certificate

11. CONFIDENTIAL INFORMATION

Please include ALL information regardless of time limitation

1	Do you have <u>any</u> history of malpractice action (settlements, judgments, or otherwise)?	□Yes	□No
2	Do you have <u>any</u> malpractice cases pending?	□Yes	□No
3	Have you <u>ever</u> been convicted of fraud, narcotics or any other felony offense?	□Yes	□No
4	Has your license to practice medicine <u>ever</u> been subjected to any revocation, suspension, probation, or other disciplinary action by any state licensing authority or medical society?	□Yes	□No
5	Have you <u>ever</u> been barred from participation in Medicaid/Medicare programs?	□Yes	□No
6	Have clinical privileges <u>ever</u> been denied, revoked, suspended or restricted in anyway?	□Yes	□No
7	Do you have <u>any</u> physical or mental impairment that would cause you to be unable to perform the essential functions in your area of practice, without any threat to the health and safety of others?	□Yes	□No
8	Are you suffering from <u>any</u> communicable health condition that, considering the essential functions of your practice, could pose a health or safety risk to your patients?	□Yes	□No
9	Within the past three years have you had <u>any</u> substance abuse, or chemical dependency problems, which might affect your ability to practice medicine in your area of expertise in any way?	□Yes	□No

For each question to which you answered YES, please attach an explanation, including without limitation:

1. The incident(s) upon which the action(s) were based, including pertinent dates.
2. How the matter was resolved, including any conditions and whether they have been met or are still pending.
3. List any payments and whether the payments were a result of settlement or judgment.
4. Describe in detail the specific clinical steps or process you instituted to prevent the recurrence of this.
5. List any continuing education courses you attended relating to this situation, including dates of attendance.

DATE: _____ **SIGNATURE:** _____