



KANSAS HEALTH SOLUTIONS CREDENTIALING APPLICATION

This application must be legible and completed in its entirety. Failure to do so will result in it being returned to you, and may delay its final review. Professional practice cannot begin until your application has been approved by the KHS Credentialing Committee. All practitioners have the right to review information acquired to evaluate their application and to correct erroneous information obtained from any outside source.

DATE OF APPLICATION _____

DATE OF HIRE (If group practice) _____

IDENTIFYING DATA

NAME _____
LAST FIRST MI (OTHER SURNAMES) DEGREE/PROFESSIONAL DESIGNATION

HOME ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE # _____ DATE OF BIRTH ____/____/____

U.S. CITIZEN? (Please check) ____YES ____NO GENDER ____MALE ____FEMALE
(If "NO", please attach copy of current visa.)

SOCIAL SECURITY NUMBER _____ NPI NUMBER _____

KMAP NUMBER _____ TAXONOMY NUMBER _____
(ATTACH KMAP WELCOME LETTER FOR VERIFICATION)

SPECIALTY _____ E-MAIL ADDRESS _____

LANGUAGE(S), other than English, in which clinical services are offered: _____

AGENCY INFORMATION

NAME _____ COUNTY _____

ADDRESS _____
STREET CITY STATE ZIP

PHONE _____ FAX _____

FEDERAL TAX (FEIN) ID# _____ BILLING NPI# _____

PROVIDER PRACTICE LOCATION

ADDRESS _____
STREET CITY STATE ZIP

PHONE _____ FAX _____ E-MAIL _____

Is office phone answered 24 hours? YES NO If no, please list after hours number: _____
Does your office meet ADA Accessibility Standards? YES NO

CREDENTIALING CONTACT _____

PHONE _____ FAX _____ E-MAIL _____

LICENSURE, CERTIFICATION(S), REGISTRATION

STATE LICENSURE (Please list all licenses currently held and attach copy of each.)

STATE _____ LICENSE TYPE _____ LICENSE NO _____ DATE ISSUED ____/____/____ EXPIRATION DATE ____/____/____

STATE _____ LICENSE TYPE _____ LICENSE NO _____ DATE ISSUED ____/____/____ EXPIRATION DATE ____/____/____

CERTIFICATION(S) (Please attach a copy of current certification(s).)

STATE _____ CERTIFICATION TYPE _____ DATE ISSUED ____/____/____ EXPIRATION DATE ____/____/____

STATE _____ CERTIFICATION TYPE _____ DATE ISSUED ____/____/____ EXPIRATION DATE ____/____/____

CERTIFIED HOME BASED FAMILY THERAPY PRACTITIONER _____ YES _____ NO (If yes, attach a copy of HBFT Certificate for 90847HK)

I intend to provide Home Based Family Therapy starting on: Date ____/____/____

(Training must be completed one year from this date. Please forward certificate upon completion.)

REGISTRATION(S) (Please attach a copy of current registration(s))

FEDERAL DEA

REGISTRATION NUMBER: _____ DATE ISSUED ____/____/____ EXPIRATION DATE ____/____/____

STATE CDS REGISTRATION NUMBER _____ DATE ISSUED ____/____/____ EXPIRATION DATE ____/____/____

EDUCATIONAL BACKGROUND

Note: If you attended more than one college/university in pursuit of an undergraduate or graduate degree OR if you attended more than one medical school, please include information for each additional academic affiliation on a separate sheet.

UNDERGRADUATE

COLLEGE OR UNIVERSITY _____ COURSE OF STUDY _____

ADDRESS _____ STREET _____ CITY _____ STATE _____ ZIP _____

DATES ATTENDED ____/____/____ to ____/____/____ DEGREE RECEIVED _____ DATE OF GRADUATION ____/____/____

MEDICAL SCHOOL OR GRADUATE STUDY

COLLEGE/UNIVERSITY OR MEDICAL SCHOOL _____ COURSE OF STUDY _____

ADDRESS _____ STREET _____ CITY _____ STATE _____ ZIP _____

DATES ATTENDED ____/____/____ to ____/____/____ DEGREE RECEIVED _____ DATE OF GRADUATION ____/____/____

IF A GRADUATE OF A FOREIGN MEDICAL SCHOOL, ARE YOU CERTIFIED BY THE EDUCATION COUNCIL FOR FOREIGN MEDICAL GRADUATES (ECFMG)? IF YES, PLEASE COMPLETE THE FOLLOWING AND ATTACH A COPY OF YOUR CERTIFICATE WITH THIS APPLICATION.

_____ YES _____ NO ECFMG NUMBER _____

Applicant Initials

Date

EDUCATIONAL BACKGROUND (cont'd.)

INTERNSHIP (I) DOCTORATE (D)	PRACTICUM (P) POST DOCTORATE (PD)
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HOSPITAL OR AGENCY _____ DATE STARTED AND COMPLETED ____/____/____ to ____/____/____

ADDRESS _____ STREET _____ CITY _____ STATE _____ ZIP _____

PROGRAM TYPE ____ (I) ____ (P) ____ (D) ____ (PD) PROGRAM SPECIALTY _____

HOSPITAL OR AGENCY _____ DATE STARTED AND COMPLETED ____/____/____ to ____/____/____

ADDRESS _____ STREET _____ CITY _____ STATE _____ ZIP _____

PROGRAM TYPE ____ (I) ____ (P) ____ (D) ____ (PD) PROGRAM SPECIALTY _____

NOTE: If more space is needed, please include above information for all programs on a separate sheet.

RESIDENCY

INSTITUTION _____ DATE STARTED AND COMPLETED ____/____/____ to ____/____/____

ADDRESS _____ STREET _____ CITY _____ STATE _____ ZIP _____

SPECIALTY _____ DEPT. CHAIRMAN _____

INSTITUTION _____ DATE STARTED AND COMPLETED ____/____/____ to ____/____/____

ADDRESS _____ STREET _____ CITY _____ STATE _____ ZIP _____

SPECIALTY _____ DEPT. CHAIRMAN _____

SPECIALTY / BOARD CERTIFICATION

Board Certified? (MD/DO only--check appropriately) ____ YES ____ NO (Please attach a copy of the specialty or board certificate.)

1. SPECIALTY CERTIFICATION OR BOARD NAME _____ DATE CERTIFIED ____/____/____ DATE RE-CERTIFIED ____/____/____ (IF APPLICABLE)

SPECIALTY _____

2. SPECIALTY CERTIFICATION OR BOARD NAME _____ DATE CERTIFIED ____/____/____ DATE RE-CERTIFIED ____/____/____ (IF APPLICABLE)

SPECIALTY _____

If you are not certified, please indicate your current status by checking appropriately below:

____ I do not intend to become Board certified. ____ I intend to sit for the Board examination on ____/____/____.

Applicant Initials

Date

MALPRACTICE CLAIMS HISTORY

Are you currently or have you within the last five (5) years been involved in a malpractice suit or claim in which your care or treatment of a patient was at issue? YES NO (Please include pending or dismissed cases or claims settled before or during trial or settled to avoid a lawsuit. If "YES", please answer the following questions for each incident. Use an additional sheet if necessary.)

Your Involvement in the Case (Attending, Consulting, etc.) _____ Date of Occurrence ____/____/____

Your Status in the Case (Primary Defendant, Co-Defendant, etc.) _____ Date Claim Filed ____/____/____

Describe the Allegations Against You: _____

Describe the Alleged Injury to the Patient: _____

Present Status of Claim: Open _____ Closed _____ Dismissed _____ Pending _____

Settlement Amount Paid on Your Behalf: _____

ADDITIONAL INFORMATION

Please answer the following questions by checking appropriately beside each question being asked. If the answer to any of the questions is "Yes", please attach a brief explanation on a separate sheet of paper. (A "Yes" answer does not automatically disqualify a practitioner for network participation.) ALL QUESTIONS MUST BE ANSWERED.

Yes No If applicable, has your DEA/CDS registration ever been denied, revoked, suspended, reduced or not renewed, voluntarily or involuntarily surrendered, restricted, not renewed, denied renewal, or has probation ever been invoked or have proceedings toward any of those ends ever been instituted?

Yes No Have you ever voluntarily or involuntarily relinquished or surrendered your license to practice in any state or has it been suspended, revoked, subject to a consent order or stipulation, or has probation ever been invoked?

Yes No Have you ever had a complaint filed against you with a professional association or a certifying, licensing or registering body for unethical behavior or unprofessional conduct?

Yes No Have you ever been reported to the National Practitioner Data Bank?

Yes No Has any state, jurisdiction, providence or professional organization ever denied your application for credentialing or professional membership?

Yes No Have you ever had any previous or pending challenges to, or ever voluntarily or involuntarily relinquished any medical staff membership, clinical privilege(s), professional license(s), or narcotics registration as the result of any investigation or disciplinary action?

Applicant Initials

Date

- Yes No Have you ever been disciplined by any State Board of Medical Examiners, or by any Professional Conduct Board, or have you ever been reprimanded, or fined by any state or federal agency that disciplines physicians or allied health professionals?
- Yes No Have you ever been reprimanded, censured, excluded, suspended or disqualified by Medicare, Medicaid, or any other agency for which you provide services?
- Yes No Have you ever received notice of a proposed or actual exclusion from any healthcare program funded in whole or part by the federal government or any state healthcare program, including Medicare or Medicaid?
- Yes No Have you ever withdrawn your application for participation or membership in any healthcare program, hospital medical staff, administrative service organization, managed care program or behavioral health organization?
- Yes No Have you ever voluntarily relinquished membership in a professional organization while under investigation?
- Yes No Have you ever voluntarily relinquished any medical/professional staff appointment or clinical privilege(s) to avoid disciplinary action or while under investigation?
- Yes No Have you ever been convicted of a felony or misdemeanor other than a routine traffic violation?
- Yes No If applicable, has your specialty certification or eligibility ever been denied, revoked, relinquished, not renewed, suspended, reduced or have proceedings toward any of those ends ever been instituted?
- Yes No Have any professional liability judgments or settlements ever been made on your behalf?
- Yes No Do you currently have any professional liability lawsuits pending?
- Yes No Have you ever been denied professional liability insurance or has your policy ever been cancelled or subject to limitations?
- Yes No Have your clinical privileges at any hospital or health care institution ever been limited, suspended, revoked, not renewed, or subjected to probationary conditions, or have proceedings toward any of those ends been instituted by a standing medical/professional staff committee or governing body?

Applicant Initials

Date

KANSAS HEALTH SOLUTIONS

CONFIDENTIAL MEDICAL INFORMATION

**** USE OF THIS INFORMATION FOR CREDENTIALING PURPOSES ONLY****

Please check each of the following questions appropriately regarding your ability to perform professional staff duties and job related functions.

1. Do you know of any reason why you cannot perform the essential functions of the privileges and staff duties for which you are applying, with or without reasonable accommodations?
 Yes No (If yes, please explain.)

2. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?
 Yes No (If yes, please explain.)

3. Do you currently use illegal drugs? Yes No (If yes, please explain.)

4. Do you currently abuse legal drugs? Yes No (If yes, please explain.)

5. Do you currently use any chemical substances (including alcohol) that would in any way impair or limit your ability to practice your profession and perform the functions of your position with reasonable skill and safety? Yes No (If yes, please explain.)

I ATTEST THAT THESE QUESTIONS AND ANY SUPPLEMENTAL INFORMATION REGARDING THEM ARE ANSWERED TRUTHFULLY, COMPLETELY, AND TO THE BEST OF MY KNOWLEDGE.

Signature

____/____/____
Date

Printed Name

KANSAS HEALTH SOLUTIONS

CREDENTIALS VERIFICATION RELEASE, LIABILITY WAIVER, AND ATTESTATION
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I understand, acknowledge, and agree that I have the burden of producing adequate information for proper evaluation of my qualifications for staff appointment and/or clinical privileges as specified in the policies and procedures of Kansas Health Solutions.

I hereby authorize and consent to the release of records and information requested by Kansas Health Solutions, including that which may be governed by the Health Insurance Portability Accountability Act of 1996 ("HIPAA") and the Department of Health and Human Services ("DHHS") security and privacy regulations, to facilitate the assessment of my qualifications for network participation. I authorize representatives of Kansas Health Solutions to consult with others who have been associated with me and/or who may have information bearing on my competence and qualifications, and I authorize persons consulted to provide such information. I understand that all recommendations and references solicited by Kansas Health Solutions regarding my professional competence and qualifications will be held in confidence and will be used for the purposes of credentialing or recredentialing only.

I release from any liability all individuals, corporations and organizations who in good faith provide information, including otherwise privileged or confidential information to Kansas Health Solutions representative(s) without malice concerning my ability, training, experience, background, professional ethics, character, physical and mental health, emotional stability, and other qualifications relating to my application.

This "Credentials Verification Release, Liability Waiver, and Attestation" shall remain in force for six (6) months from the date signed by me unless I notify Kansas Health Solutions writing by certified mail of my desire to revoke it.

I AFFIRM THAT THE INFORMATION GIVEN ON THIS APPLICATION AND ATTACHMENTS IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT DELIBERATE FALSE STATEMENTS OR MISREPRESENTATIONS COULD BE CONSIDERED GROUNDS FOR DENIAL OF MY APPLICATION.

Signature

____/____/____
Date

Print Name



**DEA/CDS ATTESTATION
(For ARNPs and PAs Only)**

Note to Applicant: Please Mark as Appropriate

In conjunction with this application, I attest that maintaining a current, unrestricted DEA (Drug Enforcement Administration) and/or CDS (Controlled Dangerous Substance)

Certificate ____ **(is)** ____ **(is not)** a protocol requirement of my employment with

_____. I also understand that a “pending”
(Name of Employer)

DEA/CDS is not acceptable unless written documentation is received by KHS from the issuing agency indicating that I am authorized to write prescriptions.

Practitioner’s Signature/Title

Date

Practitioner’s Printed Name/Title

KANSAS HEALTH SOLUTIONS

Note to Applicant: This Page To Be Completed By Agency Representative (if appropriate)

This is to notify you that as of _____, the following practitioner,
(Date of Hire)

_____, has professional liability
(Name of Practitioner/Employee)

insurance as provided by _____.
(Agency Name)

_____ Policy Number: _____
(Name of Insurance Company)

Effective Date: _____ Expiration Date: _____

Policy Limits: _____ (Each Person) _____ (Aggregate)

Health Care Stabilization Fund: _____ (Each Person) _____ (Aggregate)

Agency Representative

Date



Kansas Health Solutions, LLC
P.O. Box 1979
Topeka, KS 66603

SUPERVISION INFORMATION

APPLICABLE ONLY TO: **Licensed Marriage and Family Therapists**
 Licensed Professional Counselors
 Licensed Masters Social Workers
 Licensed Masters Level Psychologists
 Temporary Licensed Practitioners

The KHS Provider Contract (Pg. 3, Section 18), states that individuals having the credentials listed above must be supervised. The supervisor must be “a person who is eligible to provide Medicaid services and who is licensed at the clinical level or is a physician or psychiatric ARNP”.

If your credentials are listed above, please provide the following information regarding your supervisor.

Practitioner Name: _____

Clinical Supervisor Name: _____

Credentials: _____

Company Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Business Phone: _____



Kansas Health Solutions, LLC
P. O. Box 1979
Topeka, KS 66603

PROTOCOL INFORMATION

**APPLICABLE ONLY TO: Advanced Registered Nurse Practitioners (ARNPs)
Physician Assistants (PAs)**

The Kansas State Board of Nursing and the Kansas State Board of Healing Arts require that ARNPs and PAs provide services to clients only under a Protocol and Agreement with a responsible physician who is licensed in the State of Kansas. If your credentials are listed above, please provide the following information regarding the physician responsible for supervising your protocol.

Practitioner Name: _____

Physician Name: _____

Credentials (MD/DO): _____

Company Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Business Phone: _____