



Simply, the right choice.
COMMUNITY HEALTH PLAN

**ANCILLARY PROVIDER
CREDENTIALING APPLICATION**

SECTION I: PRACTICE INFORMATION

Name of Business: _____

Administrator: _____

Address _____

Street

City

County

State

Zip Code

Office Telephone () _____ Fax# () _____

Office Manager's Name: _____

Tax ID# _____ (Attach a copy of W9 form)

Medicare Provider # _____ Medicaid Provider # _____

National Provider ID# _____

Office Hours:

HOURS	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
A.M.						
P.M.						

Locations of all offices not listed above:

Street City County Zip Telephone

Street City County Zip Telephone

What counties are included in your service area?

Do you have 24 hour call service? YES NO

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**COMMUNITY HEALTH PLAN
STATEMENT OF APPLICATION**
(Please read carefully before signing)

All information submitted by me on behalf of the organization noted below in this Application, and all documentation submitted by me in support of this Application, is true to the best of my knowledge and belief. I fully understand that any misleading statement or material omission in this Application may constitute cause for denial of eligibility.

By applying for membership in Community Health Plan, I hereby authorize Community Health Plan and its representatives to seek relevant information, whether written or oral, from health maintenance organizations, health plans (including employer-sponsored), institutions, state licensing and other regulatory boards, and professional organizations with which our organization has been associated, and with others, including past and present malpractice carriers (Health Care and Related Entities), who may have information bearing on the professional competence, character, and ethical qualifications. I hereby further consent to the inspection by Community Health Plan and its representatives of all documents that may be material to an evaluation of the organization's qualifications and competence as well as moral and ethical qualifications for eligibility. I hereby further authorize all Health Care and Related Entities to release to Community Health Plan and its authorized representatives any information, whether written or oral, with respect to the organization's status with such Health Care and Related Entities pursuant to a written request from Community Health Plan, or its authorized representative, that such information be provided.

I hereby release from liability all representatives of Community Health Plan for their acts performed in good faith and without malice in connection with evaluating the Application.

I understand and agree that our organization, as an applicant for membership in Community Health Plan, have the burden of producing adequate information for proper evaluation of our professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications. As such, I will before and after approval of my Application, notify Community Health Plan in writing of any changes, errors or omissions with respect to the information I have provided in this Application.

I authorize any State Licensing Board to release any and all information regarding the organization's licensure, including any and all information regarding past or present, proved or alleged violations, complaints, letters of concern issued, reprimands and any past or present disciplinary actions relating to the organization's license.

A photocopy of this Certification, Authorization and Release shall be as effective as the original when so presented.

Organization: _____

Name and Title: _____
(Please print or type)

Signature: _____ Date: _____