# CREDENTIALING INFORMATION SHEET

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| **PERSONAL INFORMATION (all information is required)** |
|  **Last Name: First Name: Middle Initial:**  |
| **DOB: City of Birth: Country of Birth:**  |
| **SS#: Home Address:**  |
| **City: State: Zip:**  |
| **Email: PH: Cell:**  |
| **I approve AMP RCM to electronically sign applications/contracts on my behalf: (initial) \_\_\_\_\_\_\_\_** |
|  **PROFESSIONAL INFORMATION (\* are required)**  |
| **Practice Name:**  |
| **Physical Address: City, State & Zip:**  |
| **Practice PH#: Fax: Billing PH#: Fax:**  |
| **Date Incorporated: Group NPI#: IND NPI#: Tax ID#:**  |
| **Owner/ Managing Member Full Name: DOB: SS#:**    |
| **Home Address of Owner/ Managing Member:**    |
| **Medical School: Month/YR Started: Month/YR Grad:**  |
| **Internship: Location Month/YR Started: Month/YR Grad:**  |
| **License #: State: Eff Date: Exp Date:**  |
| **DEA #: State: Eff Date: Exp Date:**  |
| **Certification # (if mid- State: Eff Date Exp Date: level):**  |
| **Board Cert #: Board through: Date Cert: Exp Date:**  **Yes No**  |
| **Hospital Privileges: Name: Name: Name:**  **Yes No**  |
| **If no, to above, who do you us to admit PTs: Specialty (must match Admitting MD NPI#: your specialty):**  |
| **Other Languages Spoken: Any Adverse HX: \*CAQH #:**  **Yes No**  |
| **\*NPPES Username: \*NPPES Password: \*CAQH Username: \*CAQH Password:**  |

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| **LIST THREE PROFESSIONAL REFERENCES (If you are ARPN, you must list ARPNs)**  |
| **Name & Specialty: Address: City/ State/ Zip:**  |
| **PH: Cell: Email:**  |
| **Name & Specialty: Address: City/ State/ Zip:**  |
| **PH: Cell: Email:**  |
| **Name & Specialty: Address: City/ State/ Zip:**  |
| **PH: Cell: Email:**  |

**Please be sure to attach the following documents:**

* **Degree**
* **Certifications**-
* **Board Certification Certificates** and renewal dates
* **State Medical License**
* **Controlled Substance (DEA) Registration Certificate**
* **CV** (including all degrees, institutions, CEU’s, CEC’s, and years) Dates must be in MM/YY format.
* **W-9**; if not with an already established group working with AMPRCM
* **Proof of Medical Liability Coverage** and Letter describing any Case(s) (if applicable)
* **Voided Business Bank Account Check**, if not with an already established group working with AMRPM Solutions
* **Copy of IRS generated document** confirming the applicant’s Legal Business Name and Tax ID number (Tax payment voucher, or the form can be requested from IRS) \*Needed if starting a new group/practice (Required by Medicare)

 **AMP RCM www.amprcm.com (405) 253-5320** \*If you have any questions, please contact us. If any changes need to be made, please contact us right away. **Please Note**: Any inaccurate information may slow down the credentialing process.

**Please email all information to amprcmsolutions@gmail.com or fax to (405)253-5320.**